Table 2: Demographics Among HCV RNA + (*n* = 488)

Demographics	n (%)
People Born 1945–1965	178 (36.5%)
People Not Born 1945–1965	310 (63.5%)
Women Age 18–45	77 (15.8%)
Known IDU	154 (31.6%)
People Not Born 1945–1965 With No Known IDU	179 (36.7%)

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933. Serum Albumin Is Associated With Higher Inflammation and Carotid Atherosclerosis in Treated HIV Infection

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Session: 115. HIV-Related Comorbidities and Complications
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Background. Lower serum albumin has recently been associated with cardiovascular disease and non-AIDS malignancies in HIV. This analysis explores the associations between serum albumin and markers of inflammation and atherosclerosis.

Methods. We conducted a nested study within in the SATURN-HIV trial in which 147 HIV+ adults on stable antiretroviral therapy (ART), were virally suppressed, and had an LDL-cholesterol level <130 mg/dL were randomized to 10 mg daily rosuvastatin or placebo. Measures of serum albumin, carotid intima media thickness (IMT, surrogate marker of atherosclerosis), inflammation, T-cell and monocyte immune activation were assessed at baseline, 24, 48, and 96 weeks later. Spearman correlations and linear-mixed effects models with random intercept and slope were conducted to assess associations with albumin.

Results. Mean age was 45 years, 80% were male, 69% were African American, and 46% were receiving protease inhibitors. Mean serum albumin was not significantly different between the groups at any time points (4.05–4.08 g/dL in statin arm vs. 4.01–4.11 g/dL in placebo arm, $P = 0.08$–0.35). Low serum albumin significantly correlated with elevated levels of interleukin-6 (IL6), d-dimer, fibrinogen, and high sensitivity C-reactive protein (hsCRP) at all time points ($P \leq 0.04$). Low serum albumin also correlated with higher inflammatory monocytes (CD14+CD16+) at week 24 and week 96 ($P \leq 0.03$) but not with markers of T-cell activation at any time point ($P \geq 0.10$). Lower baseline albumin significantly predicted larger changes in IMT ($P = 0.03$), IL6, d-dimer, tumor necrosis factor-α receptor 1, fibrinogen, and hsCRP ($P \leq 0.02$) over 96 weeks. After adjusting for age, gender, smoking, body mass index, vascular cell adhesion molecule and creatinine clearance, every 1 g/dL decrease in albumin remained associated with a 0.5 mm increase in IMT over 96 weeks ($P = 0.05$).

Conclusion. Lower serum albumin in controlled HIV is associated with higher markers of chronic inflammation, hypercoagulation, and monocyte activation, which could explain the prior observation that albumin predicts non-AIDS events in HIV. Our findings suggest that serum albumin may predict progression of carotid atherosclerosis independent of traditional risk factors.

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934. Incidence of Skin and Soft-tissue Infection in People Living With HIV in a Large Urban Public Health Care System in Houston, Texas, 2009–2014

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Background. Skin and soft-tissue infections (SSTIs) disproportionately impact patients with HIV. Recent declines have been noted in the incidence of SSTIs in the non-HIV population. We set out to study the epidemiology and microbiology of SSTIs in a population of 8,597 patients followed for HIV primary care in a large urban county system from January 1, 2009 to December 31, 2014.

Methods. SSTIs were identified from the electronic medical record (EMR) by the use of ICD-9 billing codes. Charts were reviewed to confirm the diagnosis of acute SSTI and abstract culture and susceptibility data. We calculated yearly SSTI incidence using Poisson regression with clustering by patient.

Results. 2202 SSTIs were identified. Of 503 (22.8%) cultured SSTIs, 332 (66.0%) included *S. aureus* as a pathogen, of which 287/332 (86.4%) featured *S. aureus* as the sole pathogen. Of *S. aureus* isolates with susceptibilities, 231/331 (69.8%) were methicillin-resistant, and the proportion did not vary by year (P = NS).

The observed incidence of SSTI was 78.0 per 1,000 person-years (95% CI 72.9–83.4) and declined from 96.0 infections per 1,000 person-years in 2009 to 56.5 infections per 1,000 person years in 2014 ($P < 0.001$). Other significant predictors of SSTI incidence in both univariate as well as multivariate analysis included CD4 count, viral load, and being a Spanish-speaking Hispanic.

Conclusion. Although SSTI rates in a large urban HIV-infected outpatient cohort declined approximately 40% between 2009 and 2014, SSTIs remain a significant problem.

Figure 1. SSTI incidence per 1000 person-years, 2009–2014

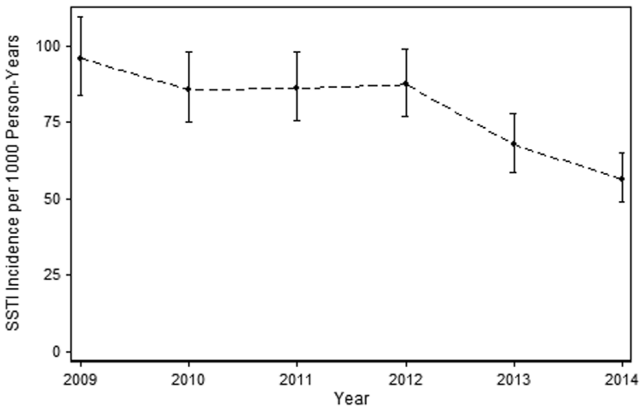

Table 1: Univariate and Multivariate Poisson Regression Results

Factor	Univariate IRR (95% CI)	Multivariate IRR (95% CI)
Male gender	1.06 (0.92–1.22)	–
MSM	1.09 (0.95–1.25)	–
Race/ethnicity		
White/Asian/other	Ref	Ref
Non-Hispanic African-American	0.92 (0.76–1.11)	0.86 (0.71–1.04)
English-speaking Hispanic	0.88 (0.69–1.12)	0.88 (0.69–1.12)
Spanish-speaking Hispanic	0.46¥ (0.36–0.60)	0.48¥ (0.37–0.62)
CD4 count (cells/μL)		
100+	Ref	Ref
50–100	1.56* (1.19–2.04)	1.23 (0.93–1.62)
<50	2.28¥ (1.80–2.90)	1.49* (1.16–1.92)
Viral load (copies/mL)		
<1,000	Ref	Ref
1,000+	2.17¥ (1.91–2.46)	1.90¥ (1.66–2.19)
Year		
2009	Ref	Ref
2010	0.89 (0.75–1.06)	0.92 (0.78–1.10)
2011	0.90 (0.75–1.07)	0.96 (0.80–1.15)
2012	0.91 (0.76–1.09)	0.99 (0.83–1.19)
2013	0.71¥ (0.58–0.85)	0.77* (0.64–0.93)
2014	0.59¥ (0.49–0.71)	0.65¥ (0.54–0.79)

*$P < 0.01$.

¥$P < 0.001$.

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935. Repeat Pregnancies Among Women Living With HIV: Evaluating Temporal Changes in HIV Disease Status and Exploring the Association Between Preterm Birth and Protease Inhibitor Use in Pregnancy

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