Conclusion. Overall, FQHCs served the CDC target baby boomer population age group. Findings show Hepatitis C treatment can be successfully undertaken at FQHCs including difficult to treat populations such as PWID. The SVR viral load shows efficacy of treatment at both FQHCs.

Disclosures. **All authors:** No reported disclosures.

2231. Long-Term Immunogenicity of Four Doses and Four Double Doses vs. Standard Doses of Hepatitis B Vaccination in HIV-Infected Adults: An Extension of a Randomized Controlled Trial

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Session: 239. HIV and Viral Hepatitis Co-Infection
Saturday, October 6, 2018: 12:30 PM

Background. Previous studies showed that the response rate to standard hepatitis B (HepB) vaccination schedule among HIV-infected patients ranged between 33.3 and 65% due to an impaired response. However, we have reported that the response rate was not different from four doses and four double doses schedule. This study followed those patients for at least 3 years aimed to evaluate the efficacy of the three regimens.

Methods. From February 4, 2011 to May 4, 2012, 132 HIV-infected adults who had CD4+ cell counts >200 cells/mm^3, undetectable plasma HIV-1 RNA, and were negative for all hepatitis B virus markers were 1:1:1 randomly assigned to receive one of three recombinant vaccine (Hepavax-Gene® Berna, Korea) regimens: 20 μg IM at months 0, 1, and 6 (standard doses group, n = 44), 20 μg IM at Months 0, 1, 2, 6 (four doses group, n = 44), or 40 μg IM at Months 0, 1, 2, and 6 (four double doses group, n = 44). Between January 2015 and January 2016, 126 participants were evaluated; 42 in the "standard doses group", 43 in the "four doses group", and 41 in the "four double doses group."

Results. At a median duration of 49.6 months (range 40.6, 53.7) after vaccine regimen completion, the percentages of responders with anti-HBs ≥10 mIU/mL were 57.1% (95% CI, 41.5–72.8%) in the Standard doses group; 76.7% (95% CI 63.6–89.9%) in the Four doses group (P = 0.067); and 80.5% (95% CI 67.8–93.2%) in the Four double doses group (P = 0.033 vs. the standard group). Factor associated with a responder was vaccination schedule (either four standard doses or four double doses) and younger age.

Conclusion. Despite highly effective of standard HBV vaccination schedule at 6 months after completion of vaccine regimen, long-term immunogenicity was lower than the four double doses regimen among HIV-infected adults with CD4+ cell counts >200 cells/mm^3 and undetectable plasma HIV-1 RNA.

Disclosures. **All authors:** No reported disclosures.

2232. Zinc deficiency and advanced liver fibrosis among HIV/HCV co-infected persons in Russia

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Session: 239. HIV and Viral Hepatitis Co-Infection
Saturday, October 6, 2018: 12:30 PM

Background. Liver disease in people living with HIV (PLWH) co-infected with hepatitis C virus (HCV) is a common cause of non-AIDS-related death in Russia. HIV accelerates liver fibrosis in the setting of HCV co-infection thus PLWH have increased risk of cirrhosis, hepatocellular carcinoma, and liver-related mortality. Injection drug use is common among Russian PLWH and zinc deficiency is common among PLWH and people who inject drugs. We hypothesize that zinc deficiency facilitates the underlying mechanisms of liver fibrosis. We investigated the association between zinc deficiency and advanced liver fibrosis (ALF) in a cohort of HIV/HCV co-infected persons in Russia.

Methods. Anti-retroviral naïve HIV-infected Russians with a recent history of heavy drinking were recruited into a clinical trial of zinc supplementation. A subset of participants (N = 204) were HCV co-infected (qualitative HCV RNA positive) at baseline. The primary dependent variable in this cross-sectional study was advanced liver fibrosis defined as either (1) FIB-4 >3.25, (2) FIB-4 ≥1.45 or ≤3.25 with elastography suggestive of ALF (≥10.5 kPa), or (3) APRI ≥1.5. Zinc deficiency, the main independent variable, measured at baseline, was defined as <0.75 mg/L for the primary analysis. In secondary analyses, zinc level was categorized into tertiles. Analyses were conducted using multivariable logistic regression adjusted for potential confounders: demographics including BMI, HIV-related factors, and substance use including alcohol and cocaine.

Results. Participant characteristics were: 33 years [median age]; 25% female; 25% with ALF, and 42% injection drug use in the past 30 days. Among those with zinc deficiency (N = 65) compared with those with normal zinc levels (n = 139), the prevalence of ALF was similar (27.7% vs. 23.0%, respectively). We did not detect an association between zinc deficiency and ALF in the adjusted regression model (aOR: 1.28, 95% CI: 0.62–2.61, P = 0.51). No significant association between zinc deficiency and ALF was found in secondary analyses. Of the covariates, CD4 count <350 cells/μL was significantly associated with ALF (aOR: 2.2, 95% CI: 1.05–4.62, P = 0.04).

Conclusion. In this cohort of HIV/HCV co-infected Russians, we did not detect an association between zinc deficiency or zinc levels and advanced liver fibrosis.

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2233. Hepatitis C Eradication: Who Is Being Left Behind in the HIV Population?

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Session: 239. HIV and Viral Hepatitis Co-Infection
Saturday, October 6, 2018: 12:30 PM

Background. HCV treatment has increased since direct-acting antivirals became available. HIV clinics are scaling-up treatment to eradicate HCV. Little is known about HIV patients and access to HCV treatment.

Methods. We retrospectively analyzed all HIV/HCV co-infected patients within our safety-net hospital system who received outpatient care in our HIV clinics from November 1, 2015 to October 31, 2017. Data were abstracted on demographics, insurance, HIV RNA, drug use, homelessness, and number of visits. No visits for >1 year was lost to care and missed visits was missing >1 primary care visit. We examined the association of these variables to risk of having a detectable HCV RNA (surrogate marker for HCV treatment) through multivariate logistic regression.

Results. We identified 914 with HIV/HCV (72% male, 55% Black, 35% Medicaid, 29% Medicare, 16% Ryan White, 13% homeless) of which 47% were heterosexual, 36% MSM, and 14% IDU. HIV was undetectable in 74%, 69% were between age 46 and 65, 17% had active alcohol use and 33% had drug use. HCV RNA was available for 868 and was detected in (57%). Whites and Hispanics compared with Blacks were less likely to have detectable HCV RNA. Detectable HCV RNA was more likely in those >50 years of age compared with <40 years, with detectable HIV viral load, >1 missed visit, and lost to care.

Conclusion. We found that those at risk for not being treated for HCV were Blacks, older patients and those not engaged in HIV care or not suppressed on HIV treatment. To achieve HCV eradication will require efforts to engage older patients, Blacks, those noncompliant with ART, and not engaged in HIV care.

	HCV Virus Detected (n = 497)	HCV Virus Undetected (n = 371)	AOR (95% CI)
Race/ethnicity			
Black	311 (63)	171 (46)	Reference
White	126 (25)	116 (31)	0.54 (0.38, 0.77)***
Hispanic	56 (11)	70 (19)	0.55 (0.35, 0.86**
Other	4 (0.8)	14 (4)	0.25 (0.08, 0.81)**
Age group			
< 40	56 (11)	63 (17)	Reference
40–49	84 (17)	78 (21)	1.35 (0.80, 2.25)
50–59	229 (46)	146 (39)	1.83 (1.14, 2.91)*
> = 60	128 (60)	84 (23)	2.29 (1.35, 3.89)*
HIV detected			
no	341 (69)	310 (84)	Reference
yes	156 (31)	61 (28)	1.92 (1.33, 2.76) ***
Lost to care			
no	395 (79)	336 (91)	Reference
yes	102 (21)	35 (9)	2.17(1.39, 3.39)***
Missed >1 visit			
No	214 (43.1)	229(61.7)	reference
Yes	283 (56.9)	142 (38.3)	1.77 (1.31, 2.39)***

*** P < 0.001 P < 0.01 P < 0.05.

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2234. Implementing a Co-located HCV Clinic Within an HIV Clinic: Four Year Experience

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