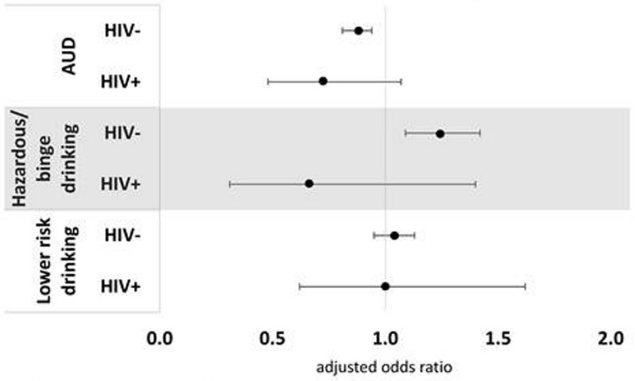
Figure 3. Associations between alcohol use and SVR12 by HIV status



Abbreviations: referent group = abstinent; AUD = alcohol use disorder
Notes: modeled separately by HIV status; adjusted for age, FIB-4, body mass index, and hepatic decompensation

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

2225. Acute Hepatitis C Virus Infections in HIV-Infected Persons in the Era of Direct-Acting Antiviral Therapy

Emily J. Cartwright, MD[1,2]; Nora Oliver, MD, MPH[1,2] and Jodie Guest, PhD[1,3]; [1]Emory University School of Medicine, Atlanta, Georgia, [2]Atlanta VA Medical Center, Decatur, Georgia, [3]Rollins School of Public Health, Atlanta, Georgia

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Background. Acute hepatitis C (HCV) infection can be sexually transmitted in HIV-infected men who have sex with men (MSM). Since 2014, direct-acting antivirals (DAA) have successfully cured many persons with chronic HCV infection. We examined the incidence of acute HCV infection in HIV-infected persons before and after the widespread use of DAA therapy.

Methods. We used the HIV Atlanta Veterans Affairs Cohort Study (HAVACS) to examine the incident rate (IR) of acute HCV infections during the period of 01 January 2013 to 31 December 2013 (pre-DAA era) and in the post-DAA era (January 1, 2017 to December 31, 2017). Acute HCV infection was identified using HCV seroconversion or HCV viremia with a negative HCV antibody. We also describe the demographic, clinical characteristics, and virologic outcomes of acute HCV infection cases observed since 2014.

Results. In the pre-DAA era, 56 cases of acute HCV were seen among 1,378 persons (IR: 40.6 per 1000). In the post-DAA era, 29 cases were seen among 1,433 persons (IR: 20.2 per 1,000). HAVACS persons seen in 2017 were 52% less likely to be diagnosed with acute HCV infection than those seen in 2013. Of the seven acute HCV cases examined in detail, the median age is 41 years (range 33–60 years). All cases were male and African American race. Two persons had active IV drug use in addition to unprotected anal intercourse as a risk factor for HCV infection. The median CD4 just prior to HCV infection was 753 cells/cm^2 (range: 590–1,046 cells/cm^2). One person had a detectable HIV viral load (527 copies/mL) just prior to HCV infection while the other 6 persons had undetectable HIV viral loads. The peak AST ranged from 147 to 1,256 IU/L (median: 798 IU/L) while the peak ALT ranged from 171 to 1,530 IU/L (median: 855 IU/L). The median total bilirubin is 3.5 mg/dL. One person spontaneously cleared his HCV infection, two were treated with DAA therapy, and the other four are under active monitoring.

Conclusion. Acute HCV infections have significantly decreased in HIV-infected persons in the DAA era. However, acute HCV infections can cause severe transaminitis and jaundice. More work is needed to prevent HCV infections in HIV-infected persons.

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

2226. Immune Checkpoint Inhibitors in Solid Tumor Patients with Chronic Hepatitis C Virus Infection: A Prospective Case-Series

Jeff Hosry, MD[1,2]; Aung Naing, MD[3] and Harrys Torres, MD[1,4]; [1]Infectious Diseases, Infection Control, and Employee Health, The University of Texas MD Anderson Cancer Center, Houston, Texas, [2]Infectious Diseases, The University of Texas Health Science at Houston, Houston, Texas, [3]Investigational Cancer Therapeutics, Division of Cancer Medicine, The University of Texas MD Anderson Cancer Center, Houston, Texas, [4]Gastroenterology, Hepatology and Nutrition, The University of Texas MD Anderson Cancer Center, Houston, Texas

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Background. Immune checkpoint inhibitors are a novel class of targeted therapy that activates T cell-mediated tumor cell death. Controversies exist about the safety and efficacy of immunotherapy in patients with chronic viral infections affecting T cells, such as hepatitis C virus (HCV). Herein, we analyzed the effect of immune checkpoint inhibitors on HCV viremia and HCV-related hepatic outcome.

Methods. HCV-infected patients with solid tumors seen at MD Anderson Cancer Center (November 2012–April 2018) were enrolled in a prospective observational study. Patients were monitored for the development of HCV reactivation (HCV-RNA ≥1 $\log_{10}$IU/mL over baseline), hepatitis flare (alanine transaminase increase to ≥3 times upper limit of normal) and HCV-associated hepatitis (HCV reactivation and hepatitis flare) while on cancer treatment.

Results. Out of 205 chronically infected patients with solid tumors, 12 (6%) received immunotherapy and were seen in the HCV clinic, but only four (2%) returned for regular monitoring (Table 1). They were followed for 9 months. None of the four patients received concomitant chemotherapy or steroids. Hepatitis flare occurred in three patients, but HCV reactivation or HCV-associated hepatitis was not detected in any study patient. Immune checkpoint inhibitors were discontinued in one patient (25%) due to hepatitis flare unrelated to HCV.

Conclusion. The use of immune checkpoint inhibitors appears to be safe in solid tumor patients with HCV infection.

Table 1. Demographics, Types of Cancer, Immunotherapy Received, and Changes in Serum HCV-RNA

Patient	Age, years	Sex	HCV Genotype	Cirrhosis	Type of Cancer	Immunotherapy	Baseline HCV-RNA (log10IU/mL)	Highest HCV-RNA After Baseline (log10IU/mL)	Hepatitis Flare
1	67	Male	1a	Yes	Hepatocellular carcinoma	Nivolumab + ipilimumab	5.45	5.08	Yes [a]
2	52	Male	1a	No	Melanoma	Nivolumab + ipilimumab	6.97	6.95	Yes [b]
3	57	Male	3	No	Melanoma	Pembrolizumab	5.72	6.39	No
4	55	Male	1a	No	Melanoma	Ipilimumab	5.75	7.18 [c]	Yes [c]

[a] After partial hepatectomy.

[b] Negative infectious work-up including hepatitis A, B, E, cytomegalovirus, and herpes simplex virus.

[c] Six months after completing immunotherapy, HCV-associated hepatitis occurred after starting high-dose steroids for brain metastasis.

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2227. Short-Duration of Direct-Acting Antivirals in Hepatitis C Virus-Infected Cancer Patients

Jeff Hosry, MD[1,2]; Georgios Angelidakis, MD[2]; Bruno Granwehr, MD[2] and Harrys Torres, MD[2,3]; [1]Infectious Diseases, The University of Texas Health Science at Houston, Houston, Texas, [2]Infectious Diseases, Infection Control, and Employee Health, The University of Texas MD Anderson Cancer Center, Houston, Texas, [3]Gastroenterology, Hepatology and Nutrition, The University of Texas MD Anderson Cancer Center, Houston, Texas

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Background. Short-duration with an 8-week course of ledipasvir/sofosbuvir (LDV/SOF) or glecaprevir/pibrentasvir (GLE/PIB) is considered adequate to treat hepatitis C virus (HCV) infection in selected patients. However, immunocompromised patients with HCV/HIV are not eligible for this approach. Herein, we study the efficacy and safety of an 8-week therapy with direct-acting antivirals (DAAs) in HCV-infected cancer patients.

Methods. HCV-infected patients with any type of cancer followed at MD Anderson Cancer Center (June 2014–April 2018) and treated with an 8-week course of LDV/SOF or GLE/PIB were enrolled in a prospective observational study. Efficacy was calculated based on achieving sustained virologic response at 12 weeks (SVR12) after end of treatment per intention to treat (ITT) analysis. A posthoc per-protocol (PP) analysis was done in patients with 12 weeks of follow-up post DAAs. Safety was assessed by emergence of adverse events (AEs) and clinically significant drug–drug interactions (DDIs).

Results. Twenty-four patients were treated with a short-duration of DAAs, 22 with LDV/SOF and two with GLE/PIB. General characteristics are described in Table 1. Five patients received concomitant cancer treatment (nivolumab, sorafenib, lenalidomide, tamoxifen and leuprolide), without DDIs noted. Among the patients who have completed DAAs, SVR rates were 87% per ITT (20/23) and 100% PP (20/20) analyses. No patients had grade 2, 3 or 4 AEs.

Conclusion. This is the first prospective study to evaluate the use of short-duration of DAAs in HCV-infected cancer patients where these regimens were found to be effective and safe.