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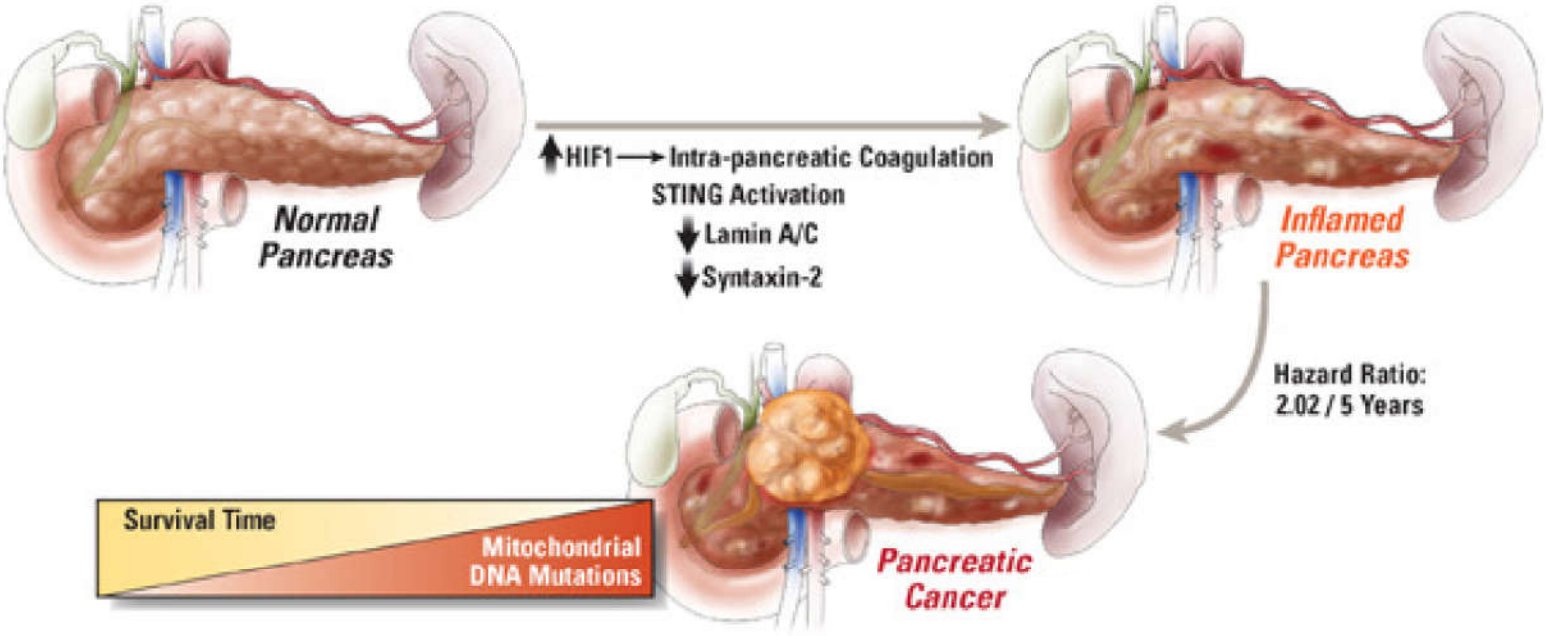

2018 DDW Abstracts

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among all racial/ethnic groups of both genders for age-adjusted CRC mortality and 5-year survival rates. This research study worked to identify salient factors influencing adherence to CRC screening among AA men in metropolitan Atlanta. **Methods:** The study population was comprised of AA men ages 45-75 years that resided in metropolitan Atlanta and received health care services within the largest safety net healthcare facility in Georgia. Study participants were purposively sampled and a total of 32 semi-structured in-depth interviews were conducted to assess needs, beliefs, experiences, fears, and vocabulary of participants related to CRC screening. All interviews were recorded and transcribed verbatim. Data analysis included initial memoing of verbatim transcripts to inform development of inductive codes to capture major domains. MAXQDA analysis software was used to facilitate the analytical process. Two coders were trained on reading and coding text and inter-rater reliabilities for the codes were computed (to assess consensus across coders). The analytical process involved extensive reading and re-reading of the text and memoing to identify patterns and themes in the data. **Findings:** Participants had limited knowledge of screening options and recommended screening intervals. The colonoscopy was most commonly discussed as the only method they were aware of for screening. Having a first degree relative who had undergone screening was a key factor that motivated participants to obtain CRC screening. Masculinity did emerge for some as a factor that hindered their willingness to go to the doctor and seek screening. However, others felt it was their duty to take care of their health. These were commonly participants who felt strained, particularly those who acted as the sole provider in the household. Overwhelmingly, participants felt that having an in-depth discussion of screening options, the benefits to screening, and treatment options if diagnosed with CRC was critical to enabling them to make an informed decision about choosing to get screened. **Discussion:** This research offers a practical application of how qualitative research methods can be applied in a clinical setting to gain further insight into the needs of a patient population. Additionally, this study provides an exploratory first step to strengthening our awareness of the critical information related to CRC screening that is most important to AA men.

Table 1. Distribution of study participants across age groups and respective study

Semi-structured In-depth Interviews			
Screening Status	Group Number	Age	Interviews (Total N=32)
Previously screened	#1	45-50 yrs	N=5
	#2	51-60 yrs	N=5
	#3	61 yrs +	N=7
Never screened	#4	45-50 yrs	N=5
	#5	51-60 yrs	N=5
	#6	61 yrs +	N=5
Relevant Domains of Qualitative Analysis			
1. Familial Engagement			
2. History of Disease and Illness			
3. Occupational Status (e.g., military)			
4. Diagnostic Fears (e.g., fatalistic views)			
5. CRC Awareness			
6. Provider Recommendation			

Sa1020

RACIAL DISPARITIES FOR SCREENING COLONOSCOPIES: DIFFERENCES IN THE ADENOMA DETECTION RATES (ADR) ACROSS THREE INSTITUTIONS

Yakira N. David, Lorenzo F. Ottaviano, Sadat Iqbal, Michelle Likhtshteyn, Samir T. Kumar, Brandon E. Lung, Helen Lyo, Ellen Li, Evan B. Grossman, Laura Martello-Rooney, Shivakumar Vignesh

Various initiatives have been developed to curb the racial disparities present in colon cancer screening. Despite this, African-Americans continue to have a higher incidence and mortality of colon cancer. This study seeks to compare the adenoma detection rates between an urban safety net hospital (USNH), urban university hospital (UUH), and a suburban university hospital (SUH) which serve different patient populations. **Methods** A retrospective chart review was performed on all average risk screening colonoscopies performed in 2012. Only patients between age 45-75 years were included. Patients were excluded if their colonoscopies were done for diagnosis or surveillance, or if their polyps were not resected or not retrieved. Adenoma detection rates (ADR) were calculated on all complete initial screening colonoscopies with at least a good bowel prep. Univariate analysis was done comparing ADRs between the 3 institutions and then comparing ADRs of teaching faculty gastroenterologists with community physician gastroenterologists. **Results** 2225 patients met the inclusion criteria. *(see Table 1)*. Patients at the USNH and the UUH were more-likely to be African-American compared to the SUH which was dominantly White. The USNH had significantly higher rates of uninsured patients compared with the UUH and the SUH. The majority of colonoscopies at the USNH were performed by community physicians compared with the other hospitals and ADRs were noted to be significantly lower among this group of community physicians when compared with teaching faculty (16%vs 26%, p=0.034). The ADR in 2012 at the USNH was significantly lower than at the UUH and SUUH (17 % vs 30% and 26% respectively p<0.0001). In 2017, a higher proportion of screening colonoscopies were performed by teaching faculty at the USNH and the ADR improved to 29% (p<0.0001) **Discussion** In our study, the ADR was lower in patients receiving colonoscopies at the USNH where the majority of the screening colonoscopies were performed by community physicians who had lower ADRs. This lower ADR does not appear to be due to inherent racial differences as the USNH and the UUH had similar racial profiles. Furthermore, in 2017, the adenoma detection rate was significantly higher at the USNH and was attributed to improved feedback to all endoscopists and a higher percentage of colonoscopies being performed by teaching faculty. When improving access to colon cancer screening for at risk populations, the quality of the colonoscopy must be monitored. The lower ADR may be a factor contributing to persisting increased incidence and mortality of colorectal cancers in African-American populations as they may have a higher incidence of missed lesions. Larger studies at other safety net hospitals are needed to validate these findings.

Table 1

		Urban Safety-Net Hospital (USNH)	Urban University Hospital (UUH)	Suburban University Hospital (SUUH)	P Value
PATIENT DEMOGRAPHIC	**N**	1134	444	647	N/A
	Median age	58	55	55	<0.0001
	% Male	32	38	40	
	Mean BMI	28.6	28.3	27.5	
RACE	**% White**	1.3	8	82	<0.0001
	% African-American	93	88	7	
	% Asian	<1	1.4	4.3	
	% American Indian	<1	0	<1	
ETHNICITY	**% Hispanic**	4	7.4	8.5	0.01
INSURANCE	**% Private**	17	29	67	<0.0001
	% Medicare	5	21	13	
	% Medicaid	36	42	16	
	% Self-Pay (uninsured)	42	7	3	
ENDOSCOPIST	**Teaching Faculty**	14	94.4	91.2	<0.0001
	Community Physician	86	5.6	8.8	
ADR	**Teaching Faculty**	26	30	25	<0.0001
	Community Physician	15.6	20	54	
	Total	17	30	26	

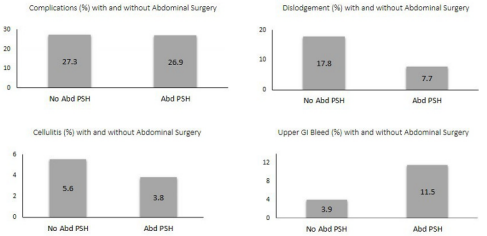
Table 1. Characteristics and Outcomes at the 3 Institutions

Sa1021

COMPLICATIONS FOLLOWING PEG PLACEMENT: A COMPARISON OF CLINICAL OUTCOMES IN PATIENTS WITH PRIOR ABDOMINAL SURGERY

Denzil Etienne, Daryl Ramai, Karl Zakhia, Emmanuel Ofori, Madhavi Reddy

Introduction: Percutaneous endoscopic gastrostomy (PEG) tube placement is a common procedure which provides long-term feeding access. Complication rates have been estimated to range from 0.4% to 13%, however, it remains unclear whether these rates are impacted by previous abdominal surgery. Our study aims to identify and compare the various co-morbidities and complications associated with PEG tube placement in patients with and without prior abdominal surgery. Methods: A retrospective analysis of inpatient PEG tube placement between January 2010 and December 2014, was conducted. Medical records of patients 18 years of age or older at the time of procedure were analyzed. A total of 459 patients met this criteria, 26 of which had abdominal surgery prior to their PEG procedure. Complications were classified into cellulitis, tube dislodgement and gastrointestinal (GI) bleeding (Figure 1). Pre-existing history of diabetes mellitus and concurrent use of SSRIs, anti-platelet, or anticoagulant medications were also noted. *Results:* Patients with a history of abdominal surgery showed no significant difference in the total complication rate when compared to those with no surgical history (27.3% vs 26.9%, respectively, p>0.05). There was also no significant difference in the prevalence of diabetes among patients who developed PEG site cellulitis vs. those who did not (37.2% vs 40.0%, respectively, p>0.05). Of patients with GI bleeding, 10% were on anticoagulation vs 5.9% who were not; 40.0% were on antiplatelet therapy vs 33.6% who were not. Of those patients who experienced a bleeding complication, 20% were on SSRIs compared to 40% on antiplatelets and 10% on anticoagulation. 25% of the bleeding patients who were on SSRIs were concurrently taking antiplatelet medication. Notably, 17.8% of patients with tube dislodgement had no prior abdominal surgery vs. 7.7% who had prior abdominal surgery (Figure 1). *Discussion:* These data indicate that history of abdominal surgery does not increase the risk of developing cellulitis and GI bleeding following PEG tube placement. Furthermore, history of abdominal surgery was shown to possibly confer some protection against future dislodgment. Patients on anticoagulation, antiplatelet or SSRIs may respectively have a higher risk of GI bleed associated with PEG tube placement. Further studies are necessary to compare complications in patients with PEG placements who have had prior abdominal surgery.



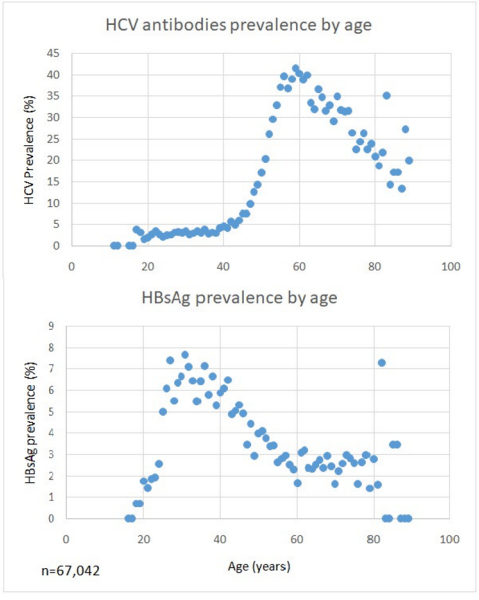
Sa1022

THE SHIFT IN HCV PREVALENCE FROM URBAN TO RURAL AREAS IN EGYPT

Gamal Soliman, Mahmoud S. Elzalabany, Tarek I. Hassanein, F. DeWolfe Miller

Background: Egypt has the highest HCV prevalence in the world, estimated to be up to 10% in the last 2015 Egyptian Health Issues Survey (EHIS). In an effort to control HCV infection, treatment centers were established across the country. The first center in Luxor was inaugurated in June 2016 and implemented a free screening program in South Upper Egypt (Luxor and Qena governorates), funded by Tahya Misr Fund, the Ministry of Health and local NGOs. **Methods:** Free screening for HCV and HBV was offered to individuals

older than 16 years. Demographic data and a blood specimen were collected. Sera were tested for HCV antibodies and HBsAg using third generation enzyme immunoassays (Enzygnost® Anti-HCV and HBsAg, Siemens, Germany). Between June 2016 and May 2017, 71,952 individuals were screened and positive patients were referred to treatment centers. **Results:** At the time of this analysis, data was available for 67,042 participants. 31,965 males (47.7%) and 35,077 females (52.3%) were screened with a mean age of 43.6±14.3 years. 9701 patients (14.5%) were positive for HCV antibodies and 2950 (4.4%) for HBsAg. Prevalence of HCV antibodies was significantly higher in males than females (19.67% vs. 9.73% OR= 2.27; CI 2.2 to 2.4; p<0.001) and the same for HBsAg (6.2% vs. 2.8% OR=2.3; CI 2.2 to 2.5; p<0.001). The prevalence of HCV antibodies was significantly associated with age (p<0.001) and ranged between 1-4% in individuals below the age of 40 years, then increased steadily until age 59 (41.6%). In contrast, HBsAg prevalence was lower than 2% in individuals younger than 25 years, and increased to 6% in the 25-44 years age group. Above 45 years of age the prevalence was 2-4% (Figure). HCV/HBV co-infection was found in 0.16% of individuals (107/67,042). HBsAg was positive in 1.1% of HCV positive patients versus 5% in negative individuals. **Conclusion:** This screening program in South Upper Egypt rural areas showed: 1) a higher prevalence of HCV (14.5%); 2) higher prevalence of HBsAg (4.4%) than the reported prevalence in the 2015 EHIS; 3) HCV prevalence was higher in males and in patients older than 40 years. In summary, this new data underscores the importance of extending infection control efforts and screening to rural areas.



Sa1023

THE TREND OF PEPTIC ULCER BLEEDING INCIDENCE OVER THE PAST 10 YEARS IN KOREAN NATIONAL HEALTH INSUARANCE SERVICE BIG DATA: THE EFFECT OF GENDER AND ECONOMIC STATUS

Yong Sung Kim, Suck Chei Choi, Jong Heon Park, Joon Ki Lee, Aesun Shin, Hwoon-Yong Jung

Introduction: Upper gastrointestinal peptic ulcer disease has been decreased during last decades, however the recent trend of peptic ulcer bleeding (PUB) incidence has not been reported. In this study, we investigated the incidence of hospitalization due to PUB during 2006-2015 using Korean national health insurance service big data. Methods: From the national health insurance data of 50 million people, admissions with peptic ulcer bleeding diagnostic code in Korean Classification of Diseases 6th revision were retrieved. This data was analyzed various clinical factors according to gender and economic status. Economic status was categorized into six classes by health insurance premiums. Results: During 2006-2015, 151,507 admissions with PUB over 20-year-old were identified. Male was more affected in the age group between the forties to seventies and female was more affected between the seventies to nineties. However, the incidence of PUB was increased with age regardless of gender and male showed higher incidence rate in all age groups. The annual hospitalization rate was 41.2 per 100,000 population and it was sustained during 2006-2015. The lowest economic class showed three-fold higher hospitalization rate compared to the rest five economic classes (91.7 vs 31.4, 33.7, 33.4, 30.7, 27.1 per 100,000 population, respectively). This discrepancy according to economic status had not improved during last 10 years. Moreover, the lowest economic class showed older age, higher proportion of gastric ulcer, rate of transfusion and 30-day mortality, and lower *H. pylori* eradication compared to the rest five economic classes. Conclusion: PUB hospitalization rates does not decrease during last 10 years and economic deprivation seems a major factor for development of PUB.

Sa1070

OBESITY, WEIGHT CHANGE AND RISK OF DIVERTICULITIS: A PROSPECTIVE COHORT STUDY IN WOMEN

Wenjie Ma, Manol Jovani, Po-Hong Liu, Long H. Nguyen, Yin Cao, Idy Tam, Kana Wu, Edward Giovannucci, Lisa Strate, Andrew T. Chan

Background & Aims: Adiposity has previously been associated with risk of diverticulitis or diverticular disease complicated by hospitalization or death in limited studies, primarily conducted in men. However, evidence is sparse for more common and mild presentations, especially among women. Additionally, the influence of abdominal adiposity and weight change on the etiopathogenesis of diverticulitis remains poorly understood. **Methods:** We conducted a prospective cohort study of 64,959 women enrolled in the Nurses' Health Study aged 43-70 years and free of diverticulitis, non-melanoma cancers, or inflammatory bowel disease at baseline in 1990. Participants reported their current body weight in biennial questionnaires. Data on waist circumference and waist-to-hip ratio were collected in 1986, 1996, and 2000. Weight change was assessed from early adulthood (age 18 years) to the current questionnaire cycle. From 2008 to 2014, participants were asked if they ever had a diagnosis of diverticulitis requiring antibiotic therapy or hospitalization and the year of their episode. We used time-varying exposures and covariates, and Cox proportional hazards models were applied to assess the associations with incident diverticulitis. **Results:** We documented 3,128 incident cases of diverticulitis over 24 years of follow-up encompassing 1,348,885 person-years. After adjustment for various lifestyle and dietary risk factors, compared to women with a BMI < 22.5 kg/m^2, the hazard ratios (HRs) (95% confidence intervals [CIs]) were 1.30 (1.16-1.46), 1.24 (1.09-1.42), 1.36 (1.20-1.54), and 1.47 (1.26-1.71; P-trend < 0.001) for those with a BMI 25.0-27.4, 27.5-29.9, 30.0-34.9, and ≥ 35.0 kg/m^2, respectively. Compared to women in the lowest quintile, the multivariable HRs were 1.37 (95% CI, 1.19-1.59; P-trend < 0.001) among those in the highest quintile of waist circumference and 1.38 (95% CI, 1.20-1.58; P-trend < 0.001) among those in the highest quintile of waist-to-hip ratio, and these associations remained significant with further adjustment for BMI. Compared to women maintaining their weight from age 18 years to the present, those who gained 2.0-5.9 kg had a 27% increased risk of diverticulitis (95% CI, 3%-57%), and those who gained 20 kg or more had a 65% increased risk (95% CI, 37%-100%; P-trend < 0.001). In stratified analyses, the association of BMI and weight change with diverticulitis did not appear to differ according to age, smoking status, or physical activity. **Conclusions:** Our results indicate an association between obesity, in particular abdominal adiposity, and risk of diverticulitis in a cohort of women. Weight gain during adulthood was also associated with increased risk. These findings have important clinical implications and provide further scientific rationale for maintaining a healthy weight and waist circumference throughout adulthood.

Sa1071

STATIN USE AT THE TIME OF INTRA-ABDOMINAL SURGERY REDUCES THE RISK OF POST-OPERATIVE SMALL BOWEL OBSTRUCTION AND ADHESION-RELATED COMPLICATIONS: A POPULATION-REPRESENTATIVE COHORT STUDY

Frank I. Scott, Ravy K. Vajravelu, Ronac Mamtani, Ben Boursi, Najjia N. Mahmoud, James D. Lewis

Introduction: Adhesion-related complications, including small bowel obstruction (SBO) and lysis of adhesions (LOA), are common complications of intra-abdominal surgery. Animal models suggest that local tissue hypoxia is a significant promotor of pro-fibrotic cytokines, contributing to adhesion formation. Statins, which have anti-fibrotic pleiotropic effects, have been shown to inhibit adhesion formation in murine models. This has not been measured in humans. We aimed to assess the impact of statin use on post-operative adhesion-related complications. **Methods:** To assess the association between statin use and post-operative adhesion-related complications, we performed a cohort study using The Health Improvement Network (THIN), a population-representative dataset with over 11 million patient lives. THIN has been previously validated for medical comorbidities, medications, smoking, surgeries, SBOs, and LOAs. Adults 18 years or older undergoing an incident intra-abdominal surgery were included. Individuals with inflammatory bowel disease, and those with documented SBO or LOA prior to an initial surgery were excluded. The primary outcome was an adhesion-related complication, consisting of a diagnostic code for SBO, LOA, or adhesions occurring after the initial surgery. Statin exposure was measured prior to and at the time of surgery. Covariates included gender, age at the time of surgery, surgical site, pre-surgical history of hypertension, hyperlipidemia, tobacco use, obesity, or primary or metastatic cancer which could involve the peritoneum. A Cox proportional hazards model was constructed to measure the association between statin use and adhesion-related complications, adjusting for other covariates, with backwards elimination of non-significant covariates that did not modify the HR for statin use by >10%. Sensitivity analyses included examining statin cessation prior to surgery and fibrate use. **Results:** 148,601 individuals met inclusion criteria. 2,060 (1.4%) experienced an adhesion-related complication, of which 1,489 were SBOs (Table 1). Statin use at the time of surgery was associated with a decreased risk of adhesion-related complications (adj. HR 0.84, 95% CI 0.73, 0.96) and SBO (adj. HR 0.83, 95% CI 0.72, 0.96) (Table 2). Age, tobacco use, bowel-specific surgery, and malignancy were associated with an increased risk, while obesity was associated with a decreased risk of adhesion-related complication. Former statin use (adj. HR 1.13, 95% CI 0.85, 1.50) and fibrates (adj. HR 1.10, 95% CI 0.65, 1.87) were not associated with adhesion-related complications. **Conclusion:** In this study, statin use at the time of intra-abdominal surgery was associated with a reduced risk of subsequent adhesion-related complications. Future studies are warranted to further explore the role of statins in reducing the rate of these complications.

Table 1: Demographic Values by Clinic with Chi-Square Test or T-test

Covariate	GI Clinic (*n*=192)	PCP Clinic (*n*=185)	Parametric *P*-value*
Patients achieving SVR, *n* (%)	184 (95.83%)	173 (93.51%)	0.32
MELD Score, mean (range) at SVR	8.50 (6.00-26.00)	8.41 (6.00-24.00)	0.93
CTP Score at SVR mean (range)	5.39 (5.00-11.00)	5.22 (5.00-8.00)	0.44
ALT at SVR, mean (range)	21.87 (6.00-60.00)	22.99 (7.00-173.00)	0.44
AST at SVR, mean (range)	25.87 (14.00-83.00)	27.29 (10.00-89.00)	0.25
Hemoglobin at SVR, mean (range)	14.71 (8.30-17.80)	14.65 (10.90-18.70)	0.75
T. Bilirubin at SVR, mean (range)	0.71 (0.20-4.60)	0.65 (0.10-2.30)	0.18
Albumin at SVR, mean (range)	3.99 (1.21-5.00)	4.00 (0.30-4.90)	0.98
Na at SVR, mean (range)	137.7(128.0-143.0)	137.2 (127.0-143.0)	0.08

Table 2: Outcomes by Clinic with Chi-Square Test or *t*-test

Mo1479

USING LONGITUDINAL PREDICTION MODELS TO EVALUATE DISEASE PROGRESSION AMONG 156,588 VETERANS WITH HEPATITIS C

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Background: Longitudinal predictive models leveraging historical data have been shown to predict outcomes in chronic hepatitis C (CHC). These models can be particularly helpful when trying to maximize treatment benefits in clinical practice. Using a CHC cohort in the Veterans Health Administration (VHA), we compared the accuracy of cross-sectional (CS) versus longitudinal data for predicting progression to cirrhosis. **Methods:** We used national VHA data to identify CHC patients with a positive HCV RNA, between January 1, 2000 to December 31, 2016. We excluded patients with an initial AST-to-platelet ratio index (APRI) > 2 during two consecutive periods or a diagnosis of hepatocellular carcinoma or hepatic complications recorded prior to enrollment. Enrollment was defined as entrance into the cohort at the date of the first APRI. Time zero was defined as 2 years after enrollment to leverage available longitudinal data during that time-period. We used a Cox model to predict the development of cirrhosis, defined as two consecutive APRI > 2. Two models were developed: (1) a CS model using predictors at or before time zero, (2) a longitudinal model using CS predictors plus longitudinal summary variables (maximum, minimum, maximum of slope, minimum of slope and total variation) between enrollment and time zero. Predictors for liver disease progression included lab ratios (lab/upper limit of normal) such as aspartate aminotransferase (AST) ratio, alanine aminotransferase (ALT) ratio, alkaline phosphatase ratio, AST/ALT, APRI, albumin, total bilirubin, body mass index, creatinine, blood urea nitrogen, glucose, hemoglobin, platelet count, and white blood cell count and demographics. The performance of the models was evaluated using both concordance and AuROC. **Results:** Out of 156,588 individuals with CHC, 25,554 (16%) developed cirrhosis during a mean follow-up of 6.6 years. Preliminary predictive models were developed using a subset of the cohort and patients were randomly split into a 70% training and 30% testing dataset. This was repeated 30 times to obtain stable estimates of model performance. The preliminary cohort had a median age of 65 years (range 25-110), was predominately male (97%) and mostly white (51%). We found improved predictive performance for the longitudinal model compared to the CS model, with a concordance of 0.76 vs 0.74 (p<.0001), respectively. The AuROC accuracy at 1,3,5 years after time zero also showed superior performance compared to the CS model (Table 1). **Conclusion:** Longitudinal models are statistically superior to cross-sectional models for predicting outcomes in CHC. However, both models provide excellent accuracy and are available to help guide clinical decision making. CS models can be incorporated and used in practice among patients at high-risk for progression to cirrhosis where longitudinal data are not available.

Table 1: Performance characteristics of cross-sectional and longitudinal models in a preliminary cohort (N=15,659).

Model	Concordance (N = 4061)	AuROC 1 year (N = 3605)	AuROC 3 year (N = 2884)	AuROC 5 year (N = 2266)
Cross-sectional Model	0.738(0.009) CI: 0.735-0.742	0.795(0.018) CI: 0.789-0.802	0.777 (0.011) CI:0.773-0.781	0.769 (0.011) CI: 0.765-0.773
Longitudinal Model	0.757(0.008) CI: 0.754-0.759	0.817(0.014) CI: 0.812-0.822	0.798(0.009) CI: 0.794-0.801	0.788(0.010) CI: 0.784-0.792
p-value	6*10^-19	2*10^-11	5*10-16	2*10-18

Mo1480

A RETROSPECTIVE ANALYSIS OF PEGYLATED-INTERFERON (PEG-IFN) TREATMENT OUTCOMES IN CHRONIC HEPATITIS B (CHB)

Ahsan Syed, Sam Lee, Heidi Israelson, Jacqui Pinto, Carla Coffin

Background: PEG-IFN is first-line therapy for CHB offering the advantage of a finite treatment, but is rarely used due to concerns about tolerability and efficacy. Nucleot(s)ide analogues (NUC) therapy are well tolerated but require prolonged therapy, with significant cost, and potential for adverse effects long-term. We aim to assess tolerability and outcomes in treatment-naive patients who received PEG-IFN for CHB. The primary outcome assessed was durability of off-treatment response (i.e., HBV DNA < 2000 IU/mL, normal ALT). Secondary outcomes assessed included the proportion of those who required subsequent NUC therapy, quantitative HBV surface antigen (qHBsAg) levels, and the proportion with side effects. Methods: In this retrospective cohort study, CHB patients who received antiviral therapy from January 1st, 2007 - July 1st, 2017 were identified via the Calgary Liver Hepatitis B database. Data collected included age, sex, ethnicity, FibroScan® results, labs (HBV DNA, genotype, qHBsAg, ALT), total treatment duration, on treatment virological response (HBV DNA and qHBsAg, if available) and reported side effects. Patients with hepatitis D coinfection treated with Peg-IFN (n=4) were excluded. Results: In total, 893 patients were in the database, of which 50 (5.6%) patients received PEG-IFN therapy. In the PEG-IFN treated patients, median age was 43±9.3 years, 72.3% male, 81% East Asian, 6% A, 30% B or C, 6% D, 57% unknown genotype.70.2% (33/47) completed the 48 weeks of PEG-IFN therapy. 29.2% (14/47) discontinued IFN early (64.2% due to treatment failure & 21.4% due to side effects). To date, 18/47 (38%) who received PEG-IFN did not receive NUC treatment during median follow-up of 34 months (±27.5, range 0.9-82.1), with normal ALT (median 24 ± 13.9, range 5-51 U/L) and median log HBV DNA levels 2.8 (±8.1, range 0-8.7 log IU/mL) on most recent follow-up. 3/47 (6%) are lost to follow-up or are being monitored to determine need for subsequent therapy. 55% (26/47) of patients had virological and biochemical rebound requiring initiation of NUC within a median of 19 months (±15.6, range 3.2-55.4) post PEG-IFN treatment. In those with sustained response to Peg-IFN, 13/18 had end-of-treatment qHBsAg which showed 8/13 (61.5%) had levels <1000 IU/mL. In 24/26 patients who failed PEG-IFN, end-of-treatment qHBsAg levels in 5/24 (20.8%) were <1000 IU/ml. Conclusion: In this single center cohort study, 38% of patients treated with Peg-IFN did not require subsequent antiviral therapy, including some with low qHBsAg levels (<1000 IU/mL), indicating robust immune control of HBV. Careful patient selection and adherence to treatment discontinuation rules based on qHBsAg levels will optimize usage of PEG-IFN management for CHB, until better finite anti-HBV therapies become available.

Mo1481

IS TREATMENT OF HEPATITIS C WITH CONTROLLED GENERIC DIRECT ACTING ANTIVIRAL DRUGS EFFECTIVE? AN EGYPTIAN EXPERIENCE

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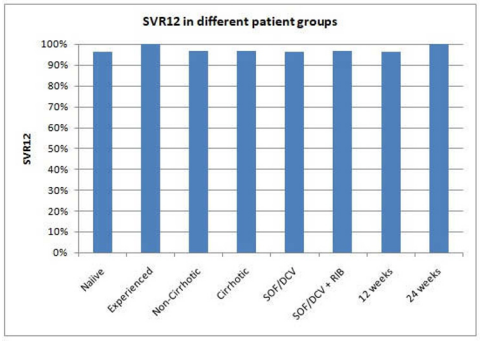
Background: Oral DAAs have revolutionized the treatment of HCV with shorter treatment duration and higher rates of SVR, albeit being very expensive. Egypt has very high HCV prevalence and the cost of treatment is prohibitive. Here, we report real life treatment outcomes using affordable generic sofosbuvir (SOF) and daclatasvir (DCV) at Tahya Misr HCV Treatment Center in Luxor, Egypt. **Methods:** Patients aged 18-75 years and positive for HCV RNA were enrolled into the treatment program, while patients with advanced cirrhosis (CTP B&C), hepatocellular carcinoma, extrahepatic malignancy, uncontrolled diabetes and pregnancy were excluded. Eligible patients were classified into two groups; Easy to treat (ET) (treatment naive, albumin ≥3.5 gm/dl, bilirubin ≤1.2 mg/dl, platelet count ≥150,000 cell/mm3, INR ≤1.2) and difficult to treat (DT) (interferon experienced, albumin <3.5 gm/dl, bilirubin >1.2 mg/dl, platelet count <150,000 cell/mm3, or INR >1.2). ET patients were treated with SOF 400 mg plus DCV 60 mg once daily for 12 weeks. Ribavirin (RBV) 600 mg daily was added for DT patients. Patients who previously failed SOF-based regimens were treated with SOF/DCV/RBV for 24 weeks. We analyzed the data of 522 patients treated at the center from June to September 2016. 12 patients (2.3%) did not complete treatment due to lack of adherence and 86 patients (16.5%) were lost to follow-up after finishing therapy. **Results:** Of the 424 patients included, 251 were males (59.2%). The mean age was 55.5±9.8 years. 389 patients (91.8%) were treatment naive, 15 patients (3.5%) were experienced to interferon and 20 patients (4.7%) to SOF-based regimens. 21.2% of the patients were cirrhotic. Six patients were positive for HBsAg with low HBV viral load. 262 patients (61.8%) were treated with SOF/DCV and 162 patients (38.2%) with SOF/DCV/RBV. 405 patients (95.5%) were treated for 12 weeks and 19 patients for 24 weeks. SVR12 was achieved in 410 patients (96.7%), while 14 patients (3.3%) failed therapy. SVR was not affected by the different variables (Figure). SVR was similar in both ET & DT groups. Side effects were reported in less than 10% and were mainly headaches, fatigue and nausea. **Conclusion:** 1) The combination of SOF/DCV is highly effective in curing HCV GT4; 2) Applying standard protocols, SVR rate in real life is similar to clinical trials; 3) Generic SOF/DCV is safe and as effective in treating HCV GT4 as brand DAAs. In summary, guaranteeing the quality of generic DAAs will impact HCV therapy in low income countries.



Mo1482

AWARENESS RATE OF CHRONIC VIRAL HEPATITIS IN THE UNITED STATES: A POPULATION-BASED STUDY

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Background: In 2014, the World Health Organization (WHO) set a goal of reducing the incidence of chronic viral hepatitis by 90%, and reducing the mortality rate by 65% between 2015 and 2030. In order to achieve that goal, it is crucial to assess the current awareness rate of viral hepatitis to implement the appropriate public health policy. It has been assumed that most people with chronic viral hepatitis are unaware of their infection. However, the current awareness rate of viral hepatitis in the United States is not fully understood. Thus, we aimed to investigate the awareness rate of chronic viral hepatitis in the United States, using the nationally representative data. **Methods:** Data were obtained from the National