prescription (0.5% vs. 0.3%, $p=0.008$), the intervention rate per 1000 patient-days (110.8 vs. 72.3, $p<0.001$) and incidences of clinically significant interventions (50.8 vs 22.5, $p<0.001$) were higher in the post-NCP group, respectively. In six medication types among the top 10 frequently intervened medications in the post-NCP period, no intervention was documented during the pre-NCP period were documented in six medication types.

Conclusion The presence of the designated NCP pharmacist had a positive impact on the patients' care in neurocritical care units. It was also associated with a significantly reduced ICU length of stay.

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No conflict of interest.

4CPS-266

ANALYSIS OF AN EPIDEMIOLOGICAL MODEL FOR THE TREATMENT OF HEPATITIS C VIRUS IN CO-INFECTED HIV/HCV DRUG ADDICTIONS VIA PARENTERAL

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Background The scale-up of HCV treatment for HIV/HCV coinfecting individuals is occurring, the majority with a history of injecting drug use.

Purpose We assess the implications for achieving the World Health Organisation HCV incidence elimination target (80% reduction from 2015–2030) among HIV-infected (HIV+) people who inject drugs (PWID) and all PWID, using dynamic modelling.

Material and methods A joint HIV and HCV transmission model among PWID was based on published data and the HERACLES cohort (prospective cohort of HIV/HCV coinfecting individuals in care from 2015–2017). The model was stratified by HIV stage, HCV stage and PWID status (young PWID (<10 years' injecting), old PWID (>10 years' injecting), ex PWID). We simulated: 45%/60% chronic HCV prevalence and 20%/40% HIV prevalence among PWID injecting for <10 years and >10 years, respectively, 54% chronic HCV among HIV +ever PWID (PWID +ex PWID). We assumed HCV treatment among diagnosed coinfecting ever-PWID of 10.5%/year from 2004–2014, and 33%/year from 2015 (from HERACLES). We projected the impact of current treatment, and scaled-up treatment (among HIV +PWID or all PWID) from 2018 on HCV prevalence/incidence among HIV +PWID and all PWID.

Results We projected that 28% and 32% of HCV +PWID and HCV +ex PWID, respectively, were HIV/HCV coinfecting in 2015. Current treatment rates could reduce the number of diagnosed coinfecting PWID by 75% from 2015–2030. However, this would only reduce HCV incidence by a relative 25% and 16% among HIV +PWID and all PWID, respectively. If all coinfecting PWID were diagnosed and treated annually from 2018, this could reduce chronic HCV prevalence by 74% among HIV+ PWID by 2030, but only halve the incidence. Greater impact could be achieved through scaling-up treatment to all PWID.

Conclusion HCV elimination among HIV +PWID will not be achieved by treating coinfecting PWID alone: efforts should focus on HCV diagnosis and treatment among both coinfecting and mono-infected PWID. Scaling-up treatment to all PWID.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-267

LACK OF HEPATITIS C VIRUS UPTAKE IN HIV/HCV CO-INFECTED PATIENTS

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Background Strategic plans have been developed to eradicate HCV worldwide.

Understanding patient factors associated with being untreated for HCV would help in supporting extra efforts in those patients to achieve HCV elimination in the coming years.

Purpose We evaluated the implementation of our country's strategy in HIV/HCV coinfecting patients and barriers to lower treatment implementation in this population.

Material and methods The HERACLES cohort is a multicentre, prospective observational cohort initiated in April 2015, which includes HIV-infected patients with active chronic HCV coinfection in follow-up at 19 centres for the care of HIV-infected patients from 1 May 2015 to 1 May 2017 (accession number: NCT02511496).

The main study outcome was receipt of HCV DAAs treatment from 1 May 2015 to 1 May 2017.

Variables identified as factors associated with lower treatment rate implementation were included in a logistic regression model for HCV treatment uptake.

Results Of the 15,556 HIV patients in care, 3075 (19.7%) presented with active chronic HCV infection and constituted the study population. By the end of the follow-up, 1957 patients initiated HCV therapy (63.6%).

In the multivariate analysis, an age lower than 50 years (OR (95% CI)=1,379 (1,109 to 1,713)), absence of or minimal liver fibrosis (F3: OR (95% CI)=9,866 (7,496 to 12,985); F4: OR (95% CI)=14,865 (10,786 to 12,985)), treatment-naïve patients (DAAs+Peg-IFN/RBV: OR: 95% CI=6.493: (3.081 to 10.878)), HCV genotype 3 infection (OR (95% CI)=0.689 (0.523–0.908)), people who injected drugs using opioid substitutive therapy (OST-PWIDs: OR: 95% CI=0.738: (0.588–0.927)), and recent PWIDs were identified as significant independent risk factors associated with low DAA implementation (OR: 95% CI=0.22 (0.005 to 0.092)).

Conclusion In the study period, a high number of HIV/HCV coinfecting patients from our cohort received DAA therapy.

We identified factors, which did not include prioritisation of DAAs uptake strategy, that limited the access to HCV therapy. The low treatment uptake in several populations seriously jeopardises the completion of the HCV elimination in the coming years.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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