initiated STRs; 1.681 (47%) initiated MTRs. Median persistence (95% confidence interval) was 36.5 (13.8, 38.9) months on STRs and 13.2 (11.9, 15.0) months on MTRs (difference 23.3, P < 0.001). Within the subgroups persisted for the first 6 months, median persistence on MTRs was 26.1 (24.2, 28.3) and on STRs was 47.6 (41.2, 54.3) months. Limiting the MTR analysis to those patients who had persistence ≥ 6 months revealed that overall STR persistence (range: 40.0-114.0) was significantly greater than MTR persistence (range: 5-100). EQ-SD Index and EQ-VAS scores were significantly lower with worsening disease severity. Among patients who had completed treatment, EQ-SD scores were higher for patients who achieved sustained virologic response (SVR) compared to those who did not (EQ-SD Index = -0.873 vs. -0.660, P = 0.0035). Regression models suggested higher age and worsening disease severity were significantly associated with lower EQ-SD Index and EQ-VAS scores. CONCLUSIONS: In a real-world national sample of HIV patients in France, utilities vary and are significantly associated with disease progression, SVR, and age. This information will be used to understand the benefits of treating patients and preventing disease progression.

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CHARACTERISTICS, TREATMENT RATES, QUALITY OF LIFE (QOL), AND ACTIVITY LIMITATION AMONG UNITED STATES ADULTS WITH HEPATITIS C—AN ANALYSIS BY BIRTH COHORT
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OBJECTIVES: In 2012, the US Centers for Disease Control and Prevention published a report of one-time Hepatitis C virus (HCV) screening for adults born between 1945 and 1964. In 2015, the US Preventive Services Task Force suggested that this population may provide insights that could be increasingly relevant to payers and health care providers. METHODS: Unique respondent data from the US National Health and Wellness Survey (NHWS) were analyzed. Individuals who self-reported a Hepatitis C diagnosis were stratified into 3 cohorts based on birth year: pre-1946, 1946-1964, and post-1964. Characteristics, treatment rates, QOL (SF-12) scores, and activity impairments were described. RESULTS: Individuals born between 1946-1964 represented 64% of respondents with Hepatitis C (13.0% were older; 22.3% younger). The 1946-1964 cohort had a higher proportion of males than the younger population (65.5% vs. 59.3%, respectively, P < 0.05); 64.2% pre-1946 were treatment naïve compared to 57.0% in the older cohort (65.5%) versus the 1946-1964 (75.5%) or younger (70.2%) cohort. Reported current HCV treatment use was lower (P < 0.05) in the older cohort (3.2%) versus 1946-1964 (10.7%) or post-1964 (21.4%). More than half in each cohort were treatment naive (64.2% vs. 1946-1964, 53.5%; 1946-1964, 53.4%; post-1964, a lower (P < 0.05) proportion (10.3%) of treatment naïve respondents born pre-1946 had a prior doctor recommendation for HCV therapy (versus 21.0% 1946-1964 or 21.1% post-1964). Mean percentage active treatment was lower (P < 0.05) among pre-1946 cohort (34.8%) versus 1946-1964 (45.3%) or post-1964 (45.1%). Mean Mental Summary Scores worsened from oldest to youngest cohorts (pre-1946=50.6; 1946-1964=46.3; post-1964=39.5). Mean Physical Summary Scores were higher for the younger cohort (43.4%) versus 1946-1964 (40.2) or pre-1946 (41.2). CONCLUSIONS: In this Hepatitis C population analyzed by birth segment, individuals born 1946-1964 represented the largest segment of the population. Results suggest that differences by birth cohort may exist regarding their characteristics, treatment rates, and patient-reported outcomes.

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SIGNS, SYMPTOMS, AND EXISTING PATIENT REPORTED OUTCOME (PRO) MEASURES IN COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): A SYSTEMATIC REVIEW
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OBJECTIVES: No standardized methods to measure outcomes related to community-acquired bacterial pneumonia (CABP) have been developed since release of the FDA Patient Reported Outcome (PRO) Guidance. The purpose of this literature review was to identify signs, symptoms, and measurement tools associated with patient experience of CABP. The results will be used to inform the development of a standardized measurement tool for CABP that is consistent with the FDA PRO Guidance. METHODS: A search was conducted using OVID MEDLINE (1966-present) and EMBASE (1988-2012) were searched using terms related to signs and symptoms of CABP and existing measurement and diagnostic tools. RESULTS: The search identified 2158 abstracts. 940 were excluded based on pre-specified criteria. The remaining 1218 articles were scrutinized for eligibility resulting in 39 meeting the inclusion criteria. Thirty-four articles focusing on CABP signs and symptoms were included in the literature. The most commonly reported symptoms were cough, chest pain, dyspnea, sputum production, and fatigue. The literature revealed that standardized instruments and PROs to measure CABP symptoms are lacking. Ten pre-CABP symptoms have been used in CABP studies. Four CABP-specific instruments that assess patient-reported symptoms revealed notable methodological limitations including: (1) using non-validated PROs; (2) capturing symptoms at the time of diagnosis; (3) excluding symptoms like fever, chills, and cough; and (4) not capturing or interpreting CABP symptoms in the context of clinical circumstances. There is a paucity of evidence on the most well-defined, reliable, reproducible, and feasible method for measuring efficacy outcomes in CABP trials. Establishing an appropriate PRO endpoint for CABP is essential. Existing CABP-specific instruments were identified to identify the most logical limitations. CABP-specific instruments have all been developed prior to the FDA PRO Guidance. There is a need to develop a new PRO instrument in accordance with FDA guidance for PRO measures. The instrument should address limitations of current tools and accurately capture data on concepts and outcomes most important to patients.