studies. Patients with MDRAB had longer length of stay than control groups across all study settings. However, the differences were significant in two of three studies. Mean costs tended to be higher for MDRAB patients, but methods varied across studies. Trends in mortality rates were mixed, with many studies reporting higher mortality in MDRAB patients than in the control group, though few reported statistically significant differences. Receipt of appropriate therapy was associated with lower mortality, though not statistically significantly different. Few studies included detail on treatment provided. CONCLUSIONS: There was limited and variable research conducted, including references published between 2011 and 2014, using Medline, Embase, the Cochrane library and relevant websites as potential sources. All populations were similar and the aim was to create a clinical practice guideline on the management of SSTIs in the ambulatory setting. The overall incidence of SSTIs increased 40% from 2.4 million in 2000 to 3.3 million in 2014. The corresponding number needed to treat (NNT) to prevent one death is 128 if treated after FIB4 > 1.5 and 169 if treated after FIB4 > 3.25. There is a clear detrimental effect on treatment effectiveness due to a reduction in the likelihood that treated patients would achieve viral load reductions without adversely impacting their clinical outcome. Retrospective cohort data from the Veterans Health Administration [VA] were used to estimate the impact on patient risk of initiating treatment before versus after the patient’s FI64 levels became elevated.

METHODS: Essentially all VA HIV patients with one or more reported F4 values during the study period were included in the analysis. Primary outcome measures were: time to death, and time to the first occurrence of a composite of liver-related clinical events. The impact of treatment initiation relative to three different definitions of an elevated F4 level was estimated using a time-dependent Cox proportional hazards models. RESULTS: 187,860 patients met study requirements. Initiating treatment before F4>1.00 reduced morbidity by 41% and death by 36%. Initiating treatment after F4>3.25 was less effective but still reduced the morbidity risk reduction achieved to 30%. However, outcomes were worse if treatment initiation was delayed until after F4>3.25. The risk associations with treatment initiation before F4>3.25 were 34% for the composite event and 45% for death, but if initiated after F4>3.25 were only 11% and 25%, respectively. The corresponding number needed to treat (NTT) to prevent one death, is 142 for treatment before F4>1.00 and 180 if treatment is initiated before F4>3.25. The estimated NNT is 128 if treated after F4>1.00 but increases to 325 if treated after F4>3.25. These detrimental effects of delaying treatment until F4>3.25 were due to a reduction in the likelihood that treated patients would achieve viral load suppression as well as a reduced impact of viral load suppression on morbidity and mortality. CONCLUSION: A clear benefit to later a patient’s F4 level exceeds 3.25 had a clear detrimental effect on treatment effectiveness.

P105 PNEUMOCOCCAL VACCINATION COVERAGE IN ADULTS WITH HIGH-RISK CONDITIONS: MISSED OPPORTUNITIES CONTINUE

Yang H, Zhang S, Zhao C, Grabenstein H

METHODS: The National Health and Nutrition Examination Survey (NHANES) surveys were conducted, including references published between 2011 and 2014, using Medline, Embase, the Cochrane library and relevant websites as potential sources. All populations were similar and the aim was to create a clinical practice guideline on the management of SSTIs in the ambulatory setting. The overall incidence of SSTIs increased 40% from 2.4 million in 2000 to 3.3 million in 2014. The corresponding number needed to treat (NNT) to prevent one death is 128 if treated after FIB4 > 1.5 and 169 if treated after FIB4 > 3.25. There is a clear detrimental effect on treatment effectiveness due to a reduction in the likelihood that treated patients would achieve viral load reductions without adversely impacting their clinical outcome. Retrospective cohort data from the Veterans Health Administration [VA] were used to estimate the impact on patient risk of initiating treatment before versus after the patient’s FI64 levels became elevated.

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