treatable NADCs in early adulthood. This is higher than incidence among people with HIV non-perinatally-acquired and the general population within this age group. By age 30, about one in three have T2DM, two in five have hypercholesteremia, one in two have hypertriglyceridemia, one in four have hypertension, and one in three have CKD. About one in five have hypercholesteremia and hypertriglyceridemia even before entering adult HIV care. Screening for these conditions in PHIV may need to occur at younger ages to ensure treatment and management are initiated in a timely way. Future work is planned to conduct sensitivity analyses of the comorbidity definitions.

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Tobacco Use in Older People with HIV: Cessation Status Associated with Greater Age and Co-Morbidities

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Background: People with HIV (PWH) are two to three times more likely to smoke than the general population. However, smoking in older PWH is understudied. Behavioral health outcomes including depression and loneliness may be higher in older PWH who use tobacco, which can have implications for HIV treatment and care. We hypothesized that tobacco exposure would be associated with greater depression and loneliness as well as more medical co-morbidities

Methods: PWH in clinical care, age 50 and older, were randomly selected to complete a biopsychosocial survey that included questions about nicotine/tobacco use history, cessation attitudes, and quit attempts. Self-reported measures of depression were collected with the CES-D 10, loneliness with the UCLA loneliness scale, and medical co-morbidities by self-report and analysis of the electronic medical record.

Results: Of 324 respondents, the mean age was 59 years (SD=6.4), 107 (33%) were female and 146 (48%) identified as Black/African American/Caribbean. Overall, 189 (58%) respondents indicated that they had used tobacco, and of those who had ever smoked, 76 (40%) actively used tobacco. ANOVA analysis showed that age differed between those who never used (mean 59.0 years (SD: 6.8)), quit (61.0 (SD:6.4)), and currently used tobacco (57.5 (SD: 5.0)) ($p<0.01$). In pairwise comparisons, those who quit tended to be older than never and current users ($p=0.047$, $p=0<0.01$, respectively). Of active tobacco users, 46 (64%) indicated high desire to quit, 65 (86%) had a discussion with their doctor about quitting, and 42 (60%) tried some form of nicotine replacement therapy in the past year.

The median CES-D 10 score was 9 (IQR= 5, 14). There was no difference in mean CES-D score between those who endorsed never using tobacco, quit, and current use by ANOVA ($p=0.95$). The median UCLA loneliness score was 23 (IQR= 16, 31) with no difference in mean UCLA loneliness screen score between groups by ANOVA ($p=0.16$). In a linear regression model, there was a trend towards current tobacco use being associated with lower mean UCLA loneliness scores compared to never smokers (B= -2.54, $p=0.08$) controlling for age, sex and racial group.

Respondents had, on average, 4 chronic medical conditions (SD= 2). There was a significant difference between groups by ANOVA ($p=0.049$), with a trend towards those who currently use tobacco having fewer medical conditions than those who had quit ($p=0.052$) in a pairwise comparison. A multivariable linear regression model did not demonstrate any difference in chronic conditions in those who had quit tobacco/nicotine compared to those who had never used, and age was associated with number of chronic conditions (B= 0.12 ($p<0.01$)).

Conclusions: There is a high level of tobacco exposure among older PWH, and those who had quit tobacco tended to be older and have more co-morbid medical conditions than those who never used or currently use tobacco. Depression and loneliness were highly prevalent, however there were no significant differences in depression or loneliness. Active tobacco users commonly indicated a desire to quit, with missed opportunities to discuss cessation with their doctor and to obtain connection to cessation resources.