Introduction: To determine whether temporary fecal diversion for refractory colonic and/or perianal Crohn’s disease (CD) can lead to clinical remission of disease and restoration of intestinal continuity after optimizing medical therapy.

Methods: We performed a retrospective chart review of adults with IBD at the University of Maryland (UMB) from 2004-2014. Patients (pts) with an established diagnosis of colonic, perianal, or colonic-perianal CD who had temporary fecal diversion were included. Demographic and post-surgical data was collected using the UMB IBD data repository and by chart extraction. Takedown and colectomy rates were calculated at varying time points from ileostomy formation.

Results: Thirty pts with colonic and/or perianal CD who had fecal diversion were identified; of these, 15 were female and 23 were Caucasian. Majority (n=25) were diagnosed before age 40, and 16 were current or former smokers. The median duration of disease was 8.4 +/- 7.2 yrs. Fecal diversion was performed for PD in 37%, colonic disease in 33%, or iatrogenic causes in 7% of cases. Ninety-five percent of pts with PD had complex fistulas. Loop diversion rather than end stoma was performed in 63%. Sixty-seven percent of pts received treatment with biologic therapy prior to ileostomy formation. During the 2-year follow-up period, 12 (40%) patients underwent ileostomy reversal; of these, 70% had colonic disease alone. There was a trend for pts with complex PD remaining diverted (p=0.02). Pts with prior fistulectomy (p < 0.03), incision and drainage (p < 0.005), or setons (p=0.001) were more likely to remain diverted. Pts treated with adalimumab and on chronic narcotics pre-operatively were more likely to remain diverted (p < 0.01 post-operatively). A greater percentage of pts (p=0.001) who had colonoscopy performed pre-operatively were more likely to remain diverted (p < 0.01 vs. p < 0.05, respectively). Six (20%) pts underwent colectomy with end ileostomy. Of these, 50% had complex PD, all had received 2 or more biologics before ileostomy, and two-thirds were on combination therapy at the time of ileostomy formation.

Conclusion: Our study found that 80% of pts with medically refractory colonic and/or severe perianal Crohn’s disease treated with temporary fecal diversion and optimization of post-operative medical therapy remain diverted or require colectomy within two years after ileostomy formation. Pts diverted for iatrogenic causes or colonic disease alone had better outcomes. Fecal diversion may not be a viable treatment option for patients with severe, refractory perianal disease and those with biologic exposure pre-operatively.

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Aeromonas Gastrointestinal Infection Associated With Inflammatory Bowel Disease
Patlas N. Aherra, MD, MSCP; Laurel Glaser, MD, PhD; Lying Nachman, DVPH; MPH; DVARJMBY. 1. Prewoman School of Medicine, University of Pennsylvania, Philadelphia, PA; 2. Department of Pathology and Laboratory Medicine, Prewoman School of Medicine, University of Pennsylvania, Philadelphia, PA; 3. Division of Pathology and Laboratory Medicine, Prewoman School of Medicine, University of Pennsylvania, Philadelphia, PA.

Introduction: Aeromonas species are gram-negative bacilli ubiquitously found in multiple environmental sources as well as drinking water and food. Infection with these organisms can be a cause of infectious gastroenteritis and several case reports suggest an association between inflammatory bowel disease and Aeromonas infection in the gastrointestinal tract.

Methods: In this case-control study all Aeromonas positive stool culture cases between 2009-2014 were identified and compared to a control group (1:2) of Campylobacter and Salmonella positive stool cultures from the same time period at our tertiary care medical center. Using ICD-9 coding and review of the medical record inflammatory bowel disease (IBD) was queried as risk factor for Aeromonas infection.

Results: A total of 49 cases of Aeromonas positive stool cultures were identified during the study period (8% of all positive stool cultures). Subjects with Aeromonas infection were more likely to have inflammatory bowel disease than those with other community-acquired causes of gastroenteritis (p=0.0044), odds ratio of 5.8 (95% CI=1.7-19.8). Of the ten subjects with IBD, seven have ulcerative colitis and three have Crohn’s disease. Four patients required hospitalization for symptom management and four received antibiotic therapy. Three patients were being treated with anti-TNF therapy at the time of illness. Interest-ingly, two of the subjects were newly diagnosed with IBD, ulcerative colitis, in the setting of Aeromonas infection.

Conclusion: Inflammatory bowel disease appears to be associated with Aeromonas infection compared to other common causes of bacterial gastroenteritis. Aeromonas infections can be severe, requiring hospitalization and antibiotic therapy. Since symptoms may overlap with IBD flares, and not all laboratories routinely culture stools for Aeromonas spp., a directed culture for this pathogen may be considered.

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Visceral Transplantation for End-Stage Crohn’s Disease: 25 Years of Experience at a Single Center
Guilherme Costa1, Ray Cruz1, Darlyne Korticky1, Hiroshi Sogawa1, David McMichael2, Custom Nyanhera2, Abhinav Humar2, Kareem Abu-Elmagd2. 1. University of Pittsburgh Medical Center, Pittsburgh, PA; 2. Cleveland Clinic Foundation, Cleveland, OH.

Introduction: Intestinal and multivisceral transplantation has recently evolved and more frequently utilized for patients with irreversible intestinal and TPN failure. End-stage Crohn’s disease (CD) has been the second leading indication in adults. This is the largest worldwide series of CD patients who received visceral transplantation at a single center. Long-term efficacy is addressed with special reference to disease recurrence.

Methods: Over 25 years, 57 CD patients underwent visceral transplantation for a recalcitrant disease with a mean duration of 5 years. 15% of patients failed TPN due to multiple line infections (84%), limited venous access (83%) and significant liver damage (80%). Male to female ratio was 1:1.7 with a mean age of 43+10 years. All patients underwent multiple abdominal operations with proctocolectomy in 37% (65%). Simultaneous hepatic replacement was required in 12 (21%) patients with a mean serum biliru-bin of 9+11mg/dl. Remaining 45 (79%) received liver-free visceral allografts with intestine alone in 43 and modified multivisceral graft including stomach, duodenum, pancreas, and intestine in 2. Rejection prophylaxis was tacrolimus based with induction therapy in 8 (14%) and recipient pretreatment in 7 (13%) recipients.

Results: With a mean follow-up of 54+48 months, 33 (58%) patients were alive with a retransplantation rate of 7%. Rejection was the leading cause of graft loss with an overall incidence of 56%. Actuarial patient survival was 90% at 1 year, 56% at 5 years, and 43% at 10 years with respective graft survival of 86%, 53%, and 42%. Inclusion of donor liver was associated with better outcome with a 10-year survival rate of 57%. Recipient pretreatment significantly improved patient survival with respective 1, 5, and 10-year survival rates of 92%, 61% and 61%. All survivors achieved full nutritional autonomy. Disease recurrence was historically documented in 4 (7%) allografts at 3, 15, 18, and 19 months from date of transplant with no impact on graft function. There was no significant (P=0.6) difference in survival between CD and non-CD patients with a higher cumulative risk of rejection induced graft loss among CD patients.

Conclusion: Visceral transplantation is an effective life-saving treatment for patients with end-stage CD. Disease recurrence is low with no significant impact on functional survival.

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Efficacy of Empiric Antibiotic Therapy for Induction of Remission in Patients With An Acute Exacerbation of UC: A Cochrane Systematic Review and Meta-analysis

Introduction: Acute exacerbation of Ulcerative Colitis (UC) can result from a wide range of factors including stress, medications, infections, etc. Clinical trials have reported discordant outcomes following empiric treatment of an acute exacerbation of UC with antibiotics. The primary outcome measure was...