occurred in patients receiving treatment doses for either psoriasis or CD. To our knowledge, there have been no preceding case reports of sCD development following either infliximab or ustekinumab. With respect to the onset of sCD in our reported case, the temporal onset of symptoms succeeding the patient’s infusion reaction to infliximab and commencement of ustekinumab therapy does raise the possibility of an association, however it may be a mere coincidence. Further research into the possible long-term neurologic effects of infliximab and ustekinumab is warranted.

**P085**

Hypercoagulability in patients undergoing abdominopelvic surgery for inflammatory bowel disease: insights from thromboelastography

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BACKGROUND: Hypercoagulability in patients with inflammatory bowel disease (IBD) is a heterogeneous, extra-intestinal manifestation thought to be driven by the gut inflammatory response. However, mechanisms driving the coagulation abnormalities are poorly understood. The aim of this study is to characterize coagulation profiles in IBD surgical patients using thromboelastography (TEG).

METHODS: A single center, single surgeon retrospective study was performed after IRB approval. Consecutive patients with Crohn’s disease (CD) or ulcerative colitis (UC) who underwent bowel surgery from June to September 2018 were included. All patients (100%) received preoperative VTE chemoprophylaxis. A total of 18 patients were included in the retrospective chart review. A coagulopathy profile based on TEG results was defined by any combination of (1) low r-value, (2) high angle, (3) high maximum amplitude (MA), (4) elevated coagulation index. Short-term (30-day) surgical outcomes including length of stay (LOS), readmission, reoperations, and major (Clavien-Dindo grade 3/4) complications were reported. Figures represent frequency (proportion) or median (range).

RESULTS: A total of 19 IBD patients had a TEG prior to surgery. The age was 33 (23–70), more were women (63%, n = 12) and most patients had CD (78%, n = 15). Overall 11 (58%) of patients were receiving steroids and 10 (53%) had been receiving biologics, while 6 (32%) of patients were hospitalized pre-operatively. Surgery was laparoscopic in 11 (58%) with 1 conversion to laparotomy: All patients (100%) received VTE chemoprophylaxis peri-operatively. Overall, 14 (74%) patients had a hypercoagulable TEG profile with 7 of these patients (50%, or 37% overall) having more than one hypercoagulability feature (elevated high r-value or high MA or high coagulation angle). Patients with a single hypercoagulability feature had a median of 7 (range). Patients with 2 hypercoagulability features had high angle (increased fibrinogen concentration/function), and 8 (42%) patient had low r-value (hyperfunctioning coagulation cascade) The coagulation index, indicating hypercoagulability, was abnormally high in 2 (10%) patients. The median LOS was 7 days (1, 42). Clavien-Dindo grade 3 complications occurred in 3 (16%) patients, there were no unplanned reoperations, while 3 (16%) of patients were re-admitted. A total of 16 of 18 eligible patients (88%) received extended post-discharge VTE chemoprophylaxis; one patient (5.5%) with unexplained tachycardia was diagnosed with a groin VTE 14 days post-operatively prior to discharge and required additional anticoagulation. Major complications included 3 (16%) patients with a 30-day mortality rate of 3.4% (6 patients).

CONCLUSION(S): The Kock pouch procedure, despite its technical complexity, has an acceptable short-term safety profile, and remains an option for a selective group of motivated patients who cannot have IPAA and/or who defer end-ileostomy.

**P087**

Defining the economic burden of venous thromboembolism after surgery for inflammatory bowel disease: A national inpatient sample study

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BACKGROUND: Venous thromboembolism (VTE) may be considered an extra-intestinal manifestation of inflammatory bowel disease (IBD) related to inflammation associated hypercoagulability, and at risk of patients requiring surgery for IBD develop a VTE post-operatively. However, the economic burden associated with VTE after surgery for IBD has not been reported. Therefore we aimed to use a large national database to define the rate of post-operative VTE, and VTE-associated healthcare costs.

METHODS: A retrospective, cross-sectional analysis was performed using National Inpatient Sample (NIS) dataset from 2010 to 2014. The International Classification of Disease 9th edition (ICD-9) diagnosis and procedure codes were used to identify patients with primary diagnosis of Crohn’s disease (CD) or Ulcerative colitis (UC) who underwent major abdominopelvic surgery. VTE included deep venous thrombosis, pulmonary embolism, and cerebrovenous sinus thrombosis. The national VTE rate and VTE associated costs were estimated using the sampling weights provided and following explicit instructions given by Healthcare Cost and Utilization Project (HCUP). Univariate and multivariate logistic regression models were used to control for confounding characteristics and outcomes between VTE and non-VTE groups. The total average direct costs in dollars were then compared between the 2 groups using linear regression accounting for complex survey design, and the resulting difference, in dollars, extrapolated to the national population.

RESULTS: Any VTE was identified in 1,656 (5.3%) out of a total of 31,242 patients. On univariate analysis, older age, white race, higher Elixhauser comorbidity score, UC diagnosis, hospital transfer prior to surgery, larger body size and urban teaching hospital were associated with VTE; conversely, elective surgery, laparoscopic approach and colectomy (compared to proctectomy and >1 type of resection) were associated with lower risk of VTE. On multivariate analysis age, Elixhauser score, resection type, transfer status, hospital bed size, location and teaching status of hospital were independently associated with VTE. Proctectomy and >1 type of resection were independent factors associated with increased risk of VTE compared to colectomy alone (OR 1.95, 95% CI 1.3–1.9; OR 1.4, 95% CI 1.2–1.6 respectively both P < 0.001). In terms of outcomes, patients who developed VTE had an increased length of stay (11 vs 7.6 days, P < 0.001) and higher inpatient mortality (5.4% vs 3.7%, OR 1.5, 95% CI 1.2–1.8; P < 0.001) compared to the non-VTE cohort. Direct costs were significantly higher in the VTE group, with an addition cost of $41,993 (95% CI $32,566–$51,710, P < 0.001 per admission. After adjusting for clinically relevant covariates, the cost difference was $10,507 (95% CI $9,649–$11,365, P < 0.001). Nationally, the additional cost of VTE was estimated to be $17,013,847 annually.

CONCLUSION(S): VTE after abdominopelvic surgery for IBD occurs in ~5% of patients nationally, and is associated with additional costs of $10,000 per patient, translating into over $17 million dollars in the United States annually. Novel screening and prophylactic regimens are sorely needed to reduce this morbidity, costly, and potentially avoidable complication.

**P086**

Kock pouches in the 21st century: A descriptive study of short-term (30-day) outcomes in a national cohort of 177 patients

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BACKGROUND: In 1972, Professor Niels Kock in Gothenburg Sweden developed the continent ileostomy (Kock pouch or KP) as an alternative to permanent end ileostomy. However, the KP was largely supplanted by the ileal pouch-anal anastomosis (IPAA). In the 21st century, KP’s are rarely performed, and often only in highly select patients who are not candidate for an IPAA. Presently, there are only single institution case series with which to guide surgeons and patients’ expectations for postoperative outcomes including length of stay, readmission and complication rates. Thus we aimed to report surgical outcomes in a large national retrospective cohort using the National Surgical Quality Improvement Project (NSQIP).

METHODS: Using the NSQIP Participant User File from 2005 to 2017 we identified patients who underwent a KP (CPT 44386). Baseline characteristics, operative variables, and postoperative outcomes are reported. Figures represent frequency (proportion) or median (interquartile range).

RESULTS: Over an 11-year period, a total of 507,146 colorectal operations were performed; of these, we identified a sample of 177 patients who underwent Kp pouch procedures. The median age was 56 (46–76), 50.2% were women, and the median body mass index was 25.3 (22–30). Any comorbidity was present in 105 (59%), with a median of 1 (0–2) comorbidities. A total of 13 (7.3%) and 16 (8.5%) were on steroids or had recent weight loss, respectively, and the median albumin was 3.8 (2.8–4.1) mg/dl. Most patients were ASA class 2 (78, 44%). Operative time was 198 (129.5–298.5) minutes, and 127 (72%) had other procedures by the same surgical team, while only 24 (14%) had concurrent procedures by a different surgical team. In terms of short-term outcomes, reoperation was required in 19 (10%) of patients, the post-operative length of stay was 8 (5–14) days. Readmission occurred in 14 (7.9%) of patients. VTE occurred in 4 patients (2.3%). Overall any complication of any severity occurred in 67 (38%) patients. The 30-day mortality rate was 3.4% (6 patients).

CONCLUSION(S): The Kock pouch procedure, despite its technical complexity, has an acceptable short-term safety profile, and remains an option for a selective group of motivated patients who cannot have IPAA and/or who defer end-ileostomy.