higher risk of polypharmacy. With increasing polypharmacy there is a greater risk for adverse drug-drug interactions (DDIs). The aim of this study was to determine if age, comorbidity, and number of DDIs differed based on the severity of polypharmacy among our UC patient population.

METHODS: A retrospective chart review UC patients at our institution from 2006 to 2011 was performed. Patient demographics, medical and surgical history, medications, and treatment history were obtained from the electronic medical record. Polypharmacy was classified as mild (2–4 medications), moderate (5–9 medications), and severe (>10 medications). Comorbidity was quantified using the Charlson Comorbidity Index (CCI). Potential DDIs were identified using Lexicomp® Online. The primary outcomes of interest were the proportion of patients with severe polypharmacy, number of DDIs, and number of DDIs involving UC medication for each of the 3 polypharmacy groups.

RESULTS: A total of 488 patients were included in the analysis. Moderate and severe polypharmacy was present in 38.3% and 11.1% of patients respectively: Polypharmacy was associated with increasing age (P < 0.01), functional GI disorders (P < 0.01), and psychiatric disease (P < 0.01). Charlson Comorbidity Index, number of DDIs, and number of DDIs involving a UC medication increased with greater polypharmacy severity. There were statistically significant differences in mean age, CCI, number of DDIs, and number of DDIs involving a UC medication among the 3 polypharmacy groups. A UC medication was involved in 30.2% of all DDIs.

CONCLUSION(s): Among our UC patient population, those with more severe polypharmacy were older, had increased comorbidity, and a greater number of DDIs, including a significant proportion involving UC medications. These factors should be considered when initiating IBD therapy in UC patients.

P098
Anti-TNF biologic therapy does not increase postoperative morbidity in pediatric Crohn’s patients
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BACKGROUND: Limited knowledge exists as to what impact preoperative biologic therapy has on post-operative complications in pediatric patients undergoing abdominal surgery for Crohn’s disease (CD). Therefore, we sought to determine the 30-day postoperative infectious complication rate among pediatric CD patients who received biologic therapy within 12 weeks of an abdominal operation.

METHODS: A retrospective chart review was performed on patients (<18 years old) who underwent an abdominal operation between 1/1/2008 and 12/31/2017. Patients were grouped according to whether they received an anti-TNF (infliximab, adalimumab, certolizumab pegol) or no biologic therapy within 12 weeks prior to the operation. The primary outcome was the overall 30-day postoperative infectious complication rate. Secondary outcomes included 30-day readmission rate and return to the operating room (IOR).

RESULTS: A total of 69 pediatric CD patients met inclusion criteria (n = 54 anti-TNF therapy, n = 15 received no biologic therapy). There were no differences between the anti-TNF and no biologic cohorts with respect to demographics or CD characteristics. No significant differences in overall 30-day postoperative infectious complications existed between patients exposed to anti-TNF agents and those with no preoperative exposure, or in its subcategories of surgical infectious complications and non-surgical infectious complications. There was also no difference in the rate of 30-day readmission or IOR.

CONCLUSION(s): Preoperative exposure to anti-TNF biologic therapy does not add to overall or infectious 30-day postoperative morbidity in pediatric CD patients.

P099
Comparative frequency of Clostridial infection in patients with ulcerative colitis receiving mesenchymal stromal cells and biological preparations
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BACKGROUND: Patients with inflammatory bowel disease (IBD) experienced more frequent development of Clostridial infection and much higher rates of morbidity and mortality compared to patients without IBD. Risk factors are immunosuppressive therapy.

METHODS: The aim is to compare the frequency of Clostridial infection (CI) in patients with ulcerative colitis (UC) receiving bone marrow mesenchymal stromal cells (MSC) and biological therapy.

MATERIALS AND METHODS: The patients were divided into 3 groups: the first group (n = 23) received the MSCs culture according to the scheme (6-1-2, then every 26 weeks); the second group of patients with UC (n = 21) received infliximab (IFX) in combination with azathioprine (AZA) according to the recommended scheme, the third group received only IFX according to the scheme. The toxins A and B of Clostridium difficile were determined by the enzyme immunoassay in the stool. The comparative analysis was carried out using the method of 4-field tables using non-parametric statistical criteria.

RESULTS: In patients of the 1-st group, toxin A was detected in 1/23 patients (4.3%), in the 2-nd group - in 2/21 (9.5%) (RR 0.45, 95% CI 0.04–4.6, χ2 0.46, P > 0.05), in the third - in 2/18 (11.1%) (RR 0.4, 95% CI 0.04–3.98, χ2 0.07, P > 0.05). In patients of the 1-st group, toxin B was detected in 23 patients (8.6%), in the second group in 3/21 (14.3%) patients (RR 0.6, 95% CI 0.1–3.3, χ2 0.3, P > 0.05), in the third - in 2/18 (11.1%) (RR 0.8, 95% CI 0.1-0.5, χ2 0.07, P > 0.05). In patients of the 1-st group toxins A and B were not detected - 0/23 (0.0%), in the 2-nd group toxins A and B were detected in 7/21 (33.3%) patients (χ2 19.5, P < 0.05), in the third - in 3/18 (27.8%) (χ2 7.3, P < 0.05).

CONCLUSION(S): The frequency of Clostridial infection in patients with ulcerative colitis receiving mesenchymal stromal cells is significantly lower than in patients with ulcerative colitis receiving biological immunosuppressive preparations.