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 increased 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.

CONCLUSIONS: 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 pediatric (<18 years of age) CD patients 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 (ROR).

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 deaths, readmission, or ROR.

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 stem cell 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 stem 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 (0.1–2.2 weeks, 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 stools. 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 0.44–4.6, χ2 = 0.46, P > 0.05), in the third - in 2/21 (11.1%) (RR 0.4, 95% CI 0.4–3.9, χ2 = 0.7, 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 0.0–1.3, χ2 = 0.3, P > 0.05), in the third - in 2/21 (11.1%) (RR 0.8, 95% CI 0.0–2.3, 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 = 9.5, P < 0.05), in the third - in 3/21 (28.6%) (χ² = 7.3, P < 0.05). Totally in patients of the 1-st group, Clostridium difficile toxin A and B was detected in 3/23 (13.1%), in the second group - in 12/21 (57.1%) patients with UC (RR 0.23, 95% CI 0.075–0.7, χ2 = 9.5, P = 0.05), in the third - in 9/50 (18%) (RR 0.06, 95% CI 0.08–0.82, χ2 = 6.6, P ≈ 0.05).

CONCLUSIONS: The frequency of Clostridial infection in patients with ulcerative colitis receiving mesenchymal cells is significantly lower than in patients with ulcerative colitis receiving biological immunosuppressive preparations.

P100
Young Investigator
Study of endoscopic findings in children with chronic diarrhea attending Alexandria university children’s hospital
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BACKGROUND: Chronic diarrhea is a major problem worldwide with high morbidity and mortality.

METHODS: The medical records were reviewed for: clinical presentation, clinical examination, laboratory investigations and endoscopic findings.

RESULTS: Forty patients were included in the study. The mean age of the patients was 3 and half years. Patients from rural areas were more than from urban regions. Sixty-five percent of the patients were males and thirty-five percent were females. Mucoid diarrhea was the most common type of diarrhea. Failure to thrive was evident in abetalipoproteinemia and Crohn’s patients. Fecal calprotectin above 150 mg/kg is highly specific and sensitive for inflammatory bowel disease. Eosinophilic enterocolitis was the most common disease (57.5%) followed by celiac disease (15%) then ulcerative colitis (12.5%).

CONCLUSIONS: Management of patients with chronic diarrhea should be initiated and followed in a specialized Pediatric GIT unit since it requires experience and close clinical, endoscopic and pathological assessment.

P101
Incidence of peri-pregnancy flares among patients with Crohn’s disease
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BACKGROUND: Evidence informing providers and payers regarding the appropriate management of women with reproductive potential continues to grow and was primarily stimulated by the FDA’s Pregnancy and Lactation Labeling Rule. The objective of this analysis was to examine the unmet clinical needs of patients with Crohn’s disease (CD) during pregnancy.

METHODS: CD patients with pregnancies resulting in live births were identified in the MarketScan® database (1/2010-9/2016) using ICD-CM codes for CD-related symptoms: abdominal pain, blood in stool, diarrhea, fatigue, fever, loss of appetite, weight loss, rash; (2) CD-CM code for CD-related complication: abscess, anal fissure, bowel obstruction/stricture, fissure, fistula, gallstone, inflammation of the eye/mouth, kidney stone, liver disease, ulcers; (3) CD-related hospitalization/ER visit; (4) 60% increase in CD-related outpatient visits from BL (5) addition or potency increase of oral corticosteroid from BL; (6) addition or dose increase in biologic therapy from BL; and (7) addition of other CD indicated therapies from BL. An assumption was made that only a single flare could occur within 30 days.

RESULTS: 1,726 successful pregnancies among CD patients were identified. The mean age was 30.3 years, mean (SD) Deyo-Charlson comorbidity index was 0.1 (0.4), most patients had commercial PPO coverage (63.4%), and the most prevalent comorbid condition was infection (42.5%). There were no significant differences in BL characteristics between pregnancies with and without flares. Among the 1,726 pregnancies, there were a total of 5,074 flares (1,268 flares [25.0%] during the BL period, 2,227 flares [43.9%] during the pregnancy period, and 1,379 flares [31.1%] during the post-partum period). To account for differences in the duration of each peri-pregnancy period (baseline [6.0 months], pregnancy [9.2 months], postpartum [6 months]), average monthly flare rates were calculated. The rates were 211.3, 241.7, and 263.2 flares/month, respectively. For the BL pregnancy and post-partum periods. The most frequent clinical proxies for flares during the BL period were an increase in CD-related outpatient visits from BL (23.7%) and CD-related symptoms (23.9%). The most frequent clinical proxies for flares during both the pregnancy and postpartum periods were the addition or increase in dose of CD-indicated therapies (45.6% pregnancy period, 35.8% postpartum period) and CD-related complications (25.0% pregnancy period, 35.4% postpartum period).

CONCLUSION(S): The consistently high risk of flares during the peri-pregnancy period demonstrates the need for optimizing the management of CD. While sole reliance on claims data is a limitation in assessing poor CD control, the use of clinical proxies to explore national trends in CD disease control might help uncover unmet needs. Healthcare professionals should aim for disease control prior to pregnancy and have a treatment plan during and after pregnancy to optimize clinical outcomes and minimize CD-related complications for women.