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Long Term Outcomes of Straight Ileoanal Anastomoses Converted to Ileal Pouch Anal Anastomoses

Marianna Maspero[1], Olga Lavryk[1], Taha Qazi[1], Benjamin Cohen[1], Jessica Philpott[1], Jean Paul Achkar[1], Jeremy Lipman[2], Hermann Kessler[1], Holubar Stefan[2], Scott Steele[2], Tracy Hull[2]
[1]Cleveland Clinic Foundation, Cleveland, Ohio, United States; [2]Digestive Disease and Surgery Institute, Cleveland Clinic Foundation, Cleveland, Ohio, United States.

Background: While ileal pouch anal anastomosis (IPAA) is the most common and recommended way to restore intestinal continuity after total proctocolectomy, straight ileoanal anastomoses (SIAA) are still selectively performed around the world. In case of SIAA failure, conversion to IPAA is possible, but reports on its outcomes are scarce.
Methods: We retrospectively analyzed our prospectively-collected database on pelvic pouches, and identified patients where SIAA was converted to an IPAA. Our aim was to report long-term outcomes and quality of life.
Results: Twenty-three patients were included (14 females). All patients underwent SIAA at an outside hospital. The median age was 15 years (IQR 12.5-17) at the index operation, and 19 years (16.5–24) at conversion to IPAA. The patients had their SIAA performed between 1980 and 2017. The indication to SIAA was ulcerative colitis in 17 (74%) cases, indeterminate colitis in 2 (9%) cases, and familial adenomatous polyposis in 4 (17%) cases. The median interval between IAA and IPAA was 4 years (3-6). The indication to conversion to IPAA was incontinence/poor quality of life in 12 (52%) cases, sepsis in 8 (35%) cases (4 fistulas, 3 anastomotic leaks, 1 concomitant fistula and anastomotic leak), anastomotic stricture in 2 (9%) cases, and prolapse in one (4%) case. Thirteen (56%) patients received a J pouch, while 8 (35%) underwent an S pouch, and 2 (9%) a W pouch. Twenty (87%) patients had a handsewn anastomosis. All patients were diverted at IPAA construction. Three (13%) patients never had stoma closure, due to patient wishes, failed healing of vaginal fistula, and pelvic sepsis, respectively. After a median follow-up of 109 months (28-170), pouch failure occurred in 5 additional patients. Pouch survival for patients who achieved stoma closure was 82% at 5 years and 75% at 10 years. Information on quality of life was available for 15 (65%) patients (3 with pouch failure). The median number of bowel movements per day was 8.5. The median quality of life was 8/10 (8-9), quality of health 8/10 (7-8), and quality of energy 7/10 (6-10). The median satisfaction with surgery was 9.5/10 (8-10): all patients would recommend surgery to someone else, while only one patient reported they would not undergo conversion to IPAA again.
Conclusion(s): Conversion of SIAA to IPAA leads to acceptable long-term outcomes and good quality of life, and can safely be offered to patients with complications of SIAA.

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Outcomes of Crohn's Disease in Patients After Renal Transplant

Marianny Sulbaran, Jami Kinnucan, Michael Picco, Francis Farraye, Jana Hashash
[1]Mayo Clinic in Florida, Jacksonville, Florida, United States.

Background: Data regarding the course of inflammatory bowel disease (IBD) in patients after renal transplant is scarce. The aim of this study was to evaluate outcomes of Crohn's disease (CD) in patients who have undergone renal transplant.
Methods: This is a retrospective study to evaluate patients with CD and renal transplant who were followed at our institution between January 2016 and August 2022. Patients with less than 6 months follow-up after kidney transplant were excluded from the analysis. Variables analyzed were CD age of onset, Montreal classification, year of the renal transplant, CD location, history of surgical intervention related to CD, immunosuppressive drugs used post-transplant for the renal graft and for management of CD, as well as CD activity post-transplant based on clinical and endoscopic criteria. Descriptive statistics were used to analyze data.
Results: A total of 93 patients were identified on initial search with 37 (62% male) meeting inclusion criteria. The mean age of patients was 58.8 years (range: 27–84 years) with a mean disease duration of 24.4 years (range: 1-70). The age at CD diagnosis was 32.4, range 9-69. Among these, 15 (55.6%) were A2, 8 (29.6%) were A3, and 4 (14.8%) were A1. The diagnosis of CD preceded the renal transplant in 33 (89.2%) of the patients. Disease location was ileal or ileo-colonic in 27 (73.0%), colonic CD in 7 (18.9%) with 1 patient (2.7%) having perianal disease with ileocolonic involvement. The location of CD was not available in 3 patients. Twenty patients (54.1%) were in clinical remission after renal transplant on chronic immunosuppressive therapy for their renal transplant, 14 (37.8%) had active disease and in 3 (8.1%) there was insufficient data. Among the 20 patients that were in clinical remission, 13 (65%) were not receiving any biologic for CD treatment. Twenty-five (67.6%) patients were on a combination of 3 post-transplant medications, typically tacrolimus, mycophenolic acid, and prednisone. Twelve (32.4%) patients were on 2 of these medications for their renal transplant. Twenty-6 (70.3%) patients had previous abdominal surgery related to CD. Eighteen (48.6%) patients were off medical therapy for their CD after renal transplant. Among those on biologic therapy for CD post renal transplant, 7 were on infliximab, 6 on vedolizumab and 3 on ustekinumab.
Conclusion(s): The diagnosis of Crohn's disease frequently preceded renal transplant. In this cohort, almost half of patients on chronic renal transplant immunosuppressive therapy did not require additional biologic agents for management of their Crohn's disease. When needed, addition of biologic therapy to patients' post-renal immunosuppression should be considered in collaboration with the transplant team.

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Comparison of Clinical Characteristics Between Young IBD and Non-IBD Patients With Adenomatous Colon Polyps

Mario El Hayek[1], Fadi Mourad[1], Kassem Barada[1], Fadi Francis[1], Gaelle Haddad[2], Jana Hashash[2]
[1]American University of Beirut Medical Center, Beirut, Lebanon; [2]Mayo Clinic in Florida, Jacksonville, Florida, United States.

Background: Patients with inflammatory bowel disease (IBD) are at an increased risk for colorectal cancer. Studies addressing pre-malignant colon polyps in young patients with IBD are relatively limited. In this study, we aim at describing the clinical characteristics of young patients with IBD (< 50 years of age) who were found to have adenomatous polyps on colonoscopy. We also sought to compare their clinical characteristics to those of the young non-IBD patients who had a colonic adenoma.
Methods: This was a retrospective chart review of a gastroenterology database at a tertiary care center to identify all patients younger than 50 years of age who had adenomatous polyps on colonoscopy performed between 2008 and 2021. Patient demographics, indication for colonoscopy, as well as number, size, location, and pathology of polyps were recorded for all patients. Timing and findings on follow-up colonoscopies were also collected.
Results: A total of 633 patients were included in the study, of who 23 (3.7%) had a diagnosis of IBD: 12 (52%) had Crohn's disease, 10 (44%) had ulcerative colitis and 1 patient had undetermined IBD. The mean age of the IBD cohort was 39.6 ± 8 years, 65% were males, 48% were smokers, and they had a mean BMI of 27.5 ± 5. Indications for colonoscopy in this group were IBD follow-up (52%), abdominal pain (17%), rectal bleeding (17%), diarrhea (4%) and ileal thickening on CT scan (4%). Adenomatous polyp location among the IBD patients was: 4% in the cecum, 39% in the ascending colon, 13% in the transverse colon, 57% in the left colon (descending/sigmoid colon), and 26% in the rectum. Twenty of the 23 (87%) patients had tubular adenomas, one had a tubulovillous adenoma and 2 had sessile serrated adenomas. Ten (43%) patients had a follow-up colonoscopy after a mean time of 2.5 years with 4/10 developing recurrent adenomas. Four (17%) patients had a third colonoscopy, and one of these patients developed another tubular adenoma. A comparison of all these characteristics including demographics, indications for colonoscopy, location and pathology of polyps as well as timing and findings on colonoscopy follow-up was conducted between the IBD group and the 610 young (<50 year old) patients with no IBD. All variables were not statistically significant between the 2 groups except for the mean age at first colonoscopy which was lower in the IBD group (42.95 ± 6 years in the general population; p = 0.008) and the number of patients who underwent a second follow-up colonoscopy which was higher in the IBD group (6% in the general population; p = 0.034).
Conclusion(s): Patients < 50 years of age with IBD who had colonic adenomas are mostly males and overweight, similar to patients with no IBD. When compared to the non-IBD cohort, those with IBD are younger at diagnosis with colon adenomas, tend to have a more vigilent surveillance, and have similar clinical/polyp characteristics.

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The Significance of the Concentration of Antibodies to Infliximab When Alternating the Original Drug Infliximab and Its Biosimilar

Mariya Zvyaglova[1], Oleg Knyazev[1], Anna Kagramanova[1], Albina Lishchinskaya[1], Tatyana Shkurko[2]
[1]Moscow Clinical Scientific Center named after A. S. Loginov, Moscow, Russia; [2]Research Institute of Health Organization and Medical Management, Moscow, Russia.

Background: Biosimilars are analogues of biopharmaceutical drugs, with a close, but not identical, parent molecule. Biosimilars offer greater access to affordable treatment for inflammatory bowel disease, while being comparable in efficacy and safety to brand-name products. However, switching from original genetically engineered biological drugs (GEBD) to biosimilars requires study and analysis. We aimed to determine the concentration of antibodies to infliximab in patients with UC receiving infliximab by one trade name (TN) and when alternating infliximab and its biosimilars and to determine the frequency of loss of response during the year of observation.
Methods: In the Department of inflammatory bowel diseases of the A. S. Loginov Moscow Clinical Scientific Center of the Moscow Healthcare Department, were observed 38 patients with IBD, who regularly received the original drug infliximab (IFL) -group 1 (n = 20), group 2 a group of patients (n = 18) alternated the original drug infliximab and its biosimilar. The level of antibodies to IFL in the blood serum before the next scheduled administration of the drug 10 months after inclusion in the study by enzyme immunoassay using the Shikari Quantitative Determination of Infliximab (Q-INFLIXI) and Shikari Quantitative Determination of Antibodies to Infliximab (Q-ATI) kits (Matriks Biotek). The loss of response was assessed by clinical, laboratory and instrumental data. Comparative analysis was carried out by the method of 4-field tables using non-parametric statistical tests.
Results: Of the 20 patients with UC of the 1st group, 3 (15.0%) had antibodies to IFL, on average, its concentration was 8.5 ± 2.2 ng/ml (normal values <5 ng/ml). Of the 18 patients of the 2nd group 10 (55.5%) antibodies to IFL were detected, on average - 187.9 ± 38.2 ng/ml. (OR - 0.141; 95% CI 0.030-0.658; x2 - 6.923, P = 0.023). During the year of observation among patients of the 1st group receiving the original IFL, the loss of response occurred in 2 (10.0%) patients with UC. Of the patients of the 2nd group, the loss of response occurred in 8 (10.0%) (RR - 0.139; 95% CI 0.025 - 0.785; x2 - 5.797; p = 0.017).
Conclusion(s): The concentration of antibodies to infliximab is higher in patients with UC when alternating IFL and its biosimilars than in patients with UC who regularly receive IFL by one TN. The frequency of loss of response when alternating infliximab and its biosimilars is significantly higher in patients with UC who regularly receive the drug for one TN.

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A Case Series of Treatment of Proctitis With Rectal Tacrolimus in Pediatric Inflammatory Bowel Disease

Mark Baniqued[1], Ayesha Fatima[2]
[1]Oakland University William Beaumont, Rochester Hills, Michigan, United States; [2]Beaumont Health Pediatrics, Royal Oak, Michigan, United States.

Background: Inflammatory bowel disease (IBD) is comprised of Ulcerative Colitis (UC) and Crohn's Disease (CD). Patients with disease limited to the rectum (inflammation that extends no more than