**Description of variables**

Data were extracted from the local IBD databases and hospital medical records, and were collected and managed using REDCap electronic data capture tools hosted at the Asociación Española de Gastroenterología (AEG; www.aegastro.es). The AEG is a non-profit Scientific and Medical Society focused on Gastroenterology, and it provided this service free of charge, with the sole aim of promoting independent investigator driven research. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources.

Variables were grouped in three time intervals: from CD diagnosis to index surgery, from index surgery to the beginning of rescue therapy with anti-TNF drugs, and from the beginning of anti-TNF until the end of follow-up, anti-TNF discontinuation, new intestinal resection, death or loss of follow-up (whichever occurred first).

Recorded baseline characteristics included date of birth, gender, smoking habit at diagnosis and time of surgery, date of CD diagnosis, disease location and behavior according to the Montreal classification, perianal disease and extraintestinal manifestations. Regarding disease-related treatments, we recorded the number of intestinal resections, exposure to immunosuppressants, exposure to anti-TNF prior to the last surgery, anti-TNF therapy within 6 months before surgery. In relation to the index surgery, we collected the type of primary prevention, if any, for endoscopic POR. Finally, we considered the index ileocolonoscopy as the last one showing endoscopic POR before starting anti-TNF therapy.

The number of bowel movements, the development of abdominal pain, and/or weight loss immediately after index surgery (within 3 months) were registered in the database in order to define clinical POR (see below). In addition, C-reactive protein levels >5 mg/L and fecal calprotectin >100 mg/kg were registered when measured within the time interval between the index surgery and the beginning of anti-TNF rescue therapy. The endoscopic findings (Rutgeerts score) of all ileocolonoscopies performed between index surgery and the beginning of anti-TNF rescue therapy were also registered.

Regarding anti-TNF rescue therapy, we collected the type of drug, treatment regimen (induction schedule or direct maintenance schedule), concomitant use of immunosuppressants (thiopurines or methotrexate) and dose-escalation or discontinuation. Magnetic resonance enterography (MRE) findings at the time of starting anti-TNF were recorded when available. The number of bowel movements, the development of abdominal pain, anemia, or weight loss, as well as C-reactive protein levels >5 mg/L and fecal calprotectin >100 mg/kg during follow-up and at last follow-up visit, were also collected. Finally, the last MRE and all the ileocolonoscopies performed after starting anti-TNF were registered. New surgical intestinal resections were also collected.

We also assessed the induction of clinical remission in patients with clinical POR at the beginning of anti-TNF therapy, as well as the development of clinical POR during anti-TNF therapy or within the 3 months after treatment discontinuation. For this purpose, and given that no clinical score has been validated to date for clinical POR and these patients may develop chronic diarrhea as a consequence of ileocolic resections (i.e. intestinal bacterial overgrowth, bile salt malabsorption), we defined *clinical POR* as the presence of 2 out of the following 3 criteria: weight loss, increase in stool frequency of at least 2 bowel movements/day, and new onset of abdominal pain at the last endoscopy or MR enterography.