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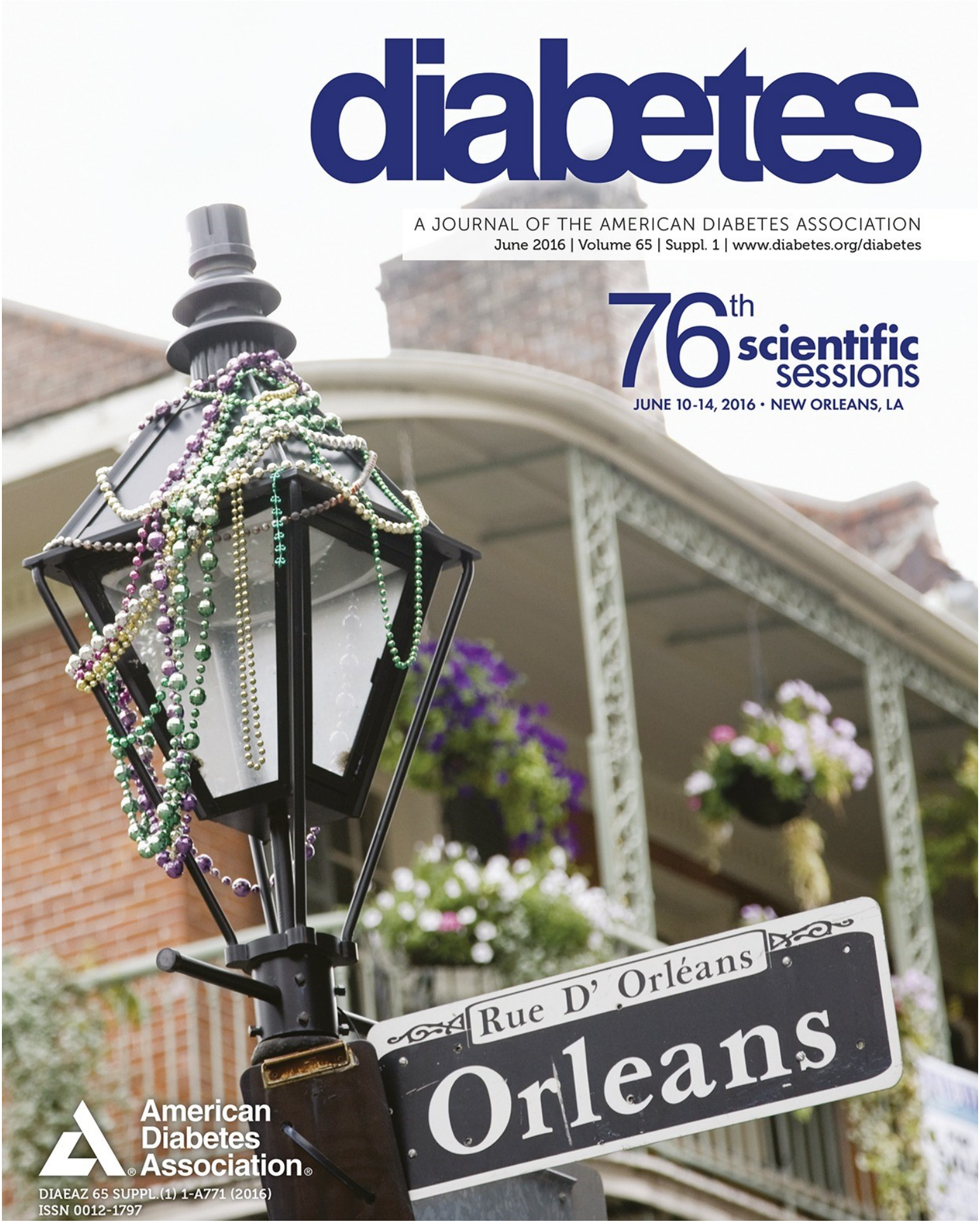

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returning for their second LP visit. We have seen 29 patients return for the second LP visit (phase 2 started Nov 2015).

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2324-PUB

Transition Referral Practices for Young Adults with Type 1 Diabetes: National Survey of Pediatric Endocrinologists

SHIVANI AGARWAL, KATHARINE C. GARVEY, JENNIFER RAYMOND, MARK SCHUTTA, *Philadelphia, PA, Boston, MA, Denver, CO*

Transfer from pediatric to adult care for young adults (YA) with type 1 diabetes (T1D) is a vulnerable time marked by gaps in care and deterioration of glycemic control. Standardized protocols for establishment of adult diabetes care are not available, and little is known about pediatric endocrinologist (PE) referral patterns in the United States. To characterize PE experiences, referral practices, and barriers to transitioning YA with T1D, we fielded a web-based survey to PEs in the American Medical Association Masterfile. We received 142/1020 completed surveys (response rate 14%) representing 32 states. The majority of PEs (age 44±10; yrs in practice 12±11) were female (66%) and worked in academic centers (75%). Half endorsed patient age as the main reason for initiating transfer while only 13% had a transition policy. The most frequently endorsed barriers to timely YA transfer included reluctance to end a long therapeutic relationship (75%), lack of guidance from a transition policy (46%), inability to identify an adult diabetes provider (AD) (45%) and concern about inadequate resources in adult care (45%). Many (~40%) PEs felt that ADs lacked training in YA T1D care and that mental health access was most lacking in adult care (63%). To facilitate YA transfer, PEs desired lists of ADs experienced in YA T1D care (79%); use of transition readiness tools (63%); and adoption of transition policies (54%). Survey responses did not differ by PE gender, age, yrs in practice, or practice setting (Fisher exact p≥0.05). Our results underscore key barriers to timely establishment of adult diabetes care for YA with T1D from the perspective of referring PEs including PE emotional attachment to YA patients, lack of transition policies, and perceived lack of AD T1D expertise and resources. These findings highlight potential targets for intervention such as provider continuing medical education, and widespread dissemination of transition policy and preparation tools to PEs.

2325-PUB

Pancreatitis in Children with Type 1 Diabetes

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Acute Pancreatitis (AP) and Diabetic Ketoacidosis (DKA) are known to coexist but the pathophysiology, prevalence and optimal diagnostic modality, are unknown. We compiled a small retrospective case series of 8 patients with type 1 diabetes (DM1) treated at the Children's Hospital of Philadelphia who presented with Amylase and/or Lipase >3x the upper limit of normal; either with and without coexisting DKA. AP was confirmed by imaging in 2/20 episodes, and in all cases recovery was imminent. Like previous studies, we show that lipasemia is less specific than amylasemia in defining AP during DKA. We report for the first time a linear relationship between lipase and amylase in the setting of DKA in children. Furthermore, our finding of unexplained pancreatitis in children with DM1, without DKA suggests that AP may cause or worsen DKA. Clinicians should use amylase to rule out AP during DKA.

Figure 1.

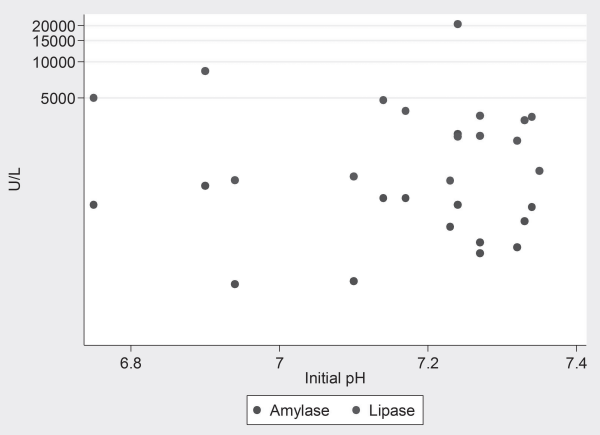
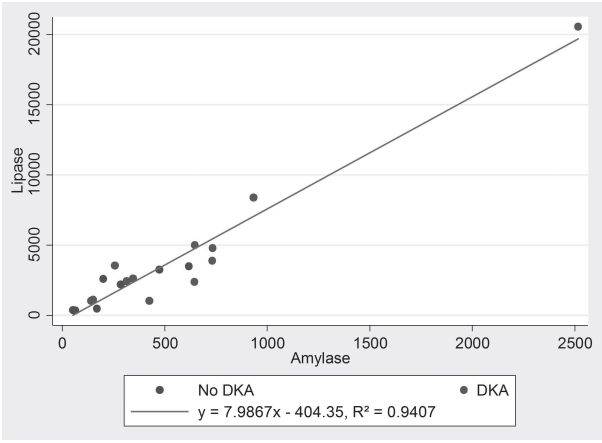


Figure 2.



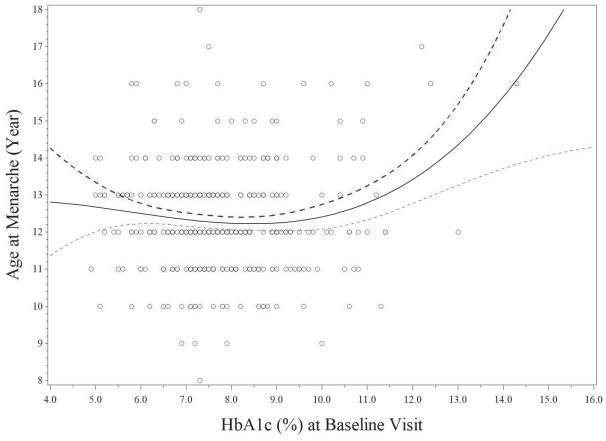
2326-PUB

Association of Glycemic Control, Body Mass Index, and Race with Age at Menarche in Girls with Type 1 Diabetes: SEARCH for Diabetes in Youth

HERMANN BORG, WEI LANG, RALPH B. D'AGOSTINO, JEAN M. LAWRENCE, CATHERINE PIHOKER, GRACE KIM, STEVEN L. YOUNG, PAUL WADWA, WILLIAM V. TAMBORLANE, ELIZABETH MAYER-DAVIS, *Chapel Hill, NC, Winston-Salem, NC, Pasadena, CA, Seattle, WA, Denver, CO, New Haven, CT*

Delayed age at menarche (AAM) in girls with type 1 diabetes (T1D) has been reported, yet its predictors remain elusive. Data from 401 girls (mean age 9.59 ± 2.69 yrs) diagnosed with T1D from 2002-2005 (T1D duration 9.75 ± 6.13 months) with a baseline visit prior to menarche and ≥1 follow-up visits, were used to examine the impact of baseline glycemic control (mean A1c 7.76 ± 1.36%), BMIz (mean 18.54 ± 3.41) and race (78% non-Hispanic white) on AAM. The unadjusted mean AAM for girls with poorly controlled T1D (A1c≥9.9%, n=28) was 12.9±2.1 yrs. There was a borderline difference (p=0.0435) between the AAM of this group and AAM of 12.4±1.4 yrs of optimally (A1c<7.5%, n=198) and AAM of 12.2±1.3 yrs of intermediately controlled (7.5%≤A1c<9.9%, n=174) groups. The Figure shows the scatter plot of A1c vs. AAM. Significant negative correlation between BMIz and AAM was shown (p<0.001). There was no significant difference in AAM by race. Multiple linear regression models were fitted to examine the impact of A1c, BMIz and race on AAM. A1c when adjusted for socioeconomic status, BMIz and T1D duration had significant linear and non-linear association with AAM (p<0.001). BMIz had significant independent effect on AAM (β=-0.55; p<0.0001). Race was not significantly associated with AAM. In conclusion, glycemic control and BMIz have independent opposite effects on AAM in girls with T1D.

Figure.



For author disclosure information, see page A696.

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