maintenance of confidentiality (CoC); financial support for uncovered services (SA); and provider education (QS). Some challenges we have encountered include: provision of specialty, not primary, care (CC); no-show rate of high-risk youth (PC); lack of internal mental health providers with transgender expertise (CoC); insurance coverage issues (CoC, AS); long wait time for new patient visits (AS); and mental health comorbidities (QS).
Conclusions: Providing services to transgender youth within an academic hospital setting is logistically possible, economically feasible, and can deliver a high quality of care. Organizing this service implementation using PCMH principles ensures that multiple domains of quality are being addressed. Laying the groundwork to serve this very rewarding patient population involves provider training and needs assessment of clinical capabilities.
Sources of Support: None.

106.

TRENDS IN DISORDERED EATING BY SEXUAL ORIENTATION IN WESTERN CANADA

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Purpose: Health disparities between sexual minority (SM) adolescents and heterosexual adolescents have been identified for risky behaviors such as substance use and risky sexual practice. Yet, few studies have looked at disordered eating (e.g., binge-eating and self-induced vomiting) which may cause serious health consequences. SM youth may be at higher risk for disordered eating, in part because of stress and trauma experiences. Additionally, prevalence of disordered eating within the same sexual orientation group may change over time, as seen in general adolescent samples. We thus examined (a) trends in disordered eating within each orientation group and (b) disparities between SM and heterosexual adolescents in western Canada.
Methods: Data were from the British Columbia Adolescent Health Survey of 1998, 2003, and 2008, a province-wide, school-based, cluster-stratified random survey of students in grades 7-12. We included students from school districts participating in at least 2 of 3 survey years (weighted N's $>$ 210,000), with 91% heterosexual (HET), 7% mostly heterosexual (MH), 3% lesbian, gay, and bisexual (LGB). Measures included binge eating (twice a month or more) and vomiting on purpose after eating (at least one time for boys; twice a month or more for girls).Trends in prevalence across survey years were tested by contingency tables with z tests. Age-adjusted odds ratios assessed differences in disordered eating between SM groups and HET groups in each year. All analyses were stratified by gender and adjusted for complex sampling.
Results: Binge-eating rates declined between 1998 and 2008 among HET boys (8.4% to 6.4%) and HET girls (14.5% to 12.9%) and between 2003 and 2008 among MH girls (23.7% to 19.3%). Among LGB boys, the rates declined from 30.2% in 1998 to 14.8% in 2003, then increased (but not significantly) to 24.2% in 2008. A significant decrease in vomiting was found among HET boys (from 3.8% in 1998 to 2.5% in 2008). Among LGB boys, the rates declined from 19.4% in 1998 to 4.5% in 2003, followed by an increase to 18.5% in 2008. LGB girls had increasing rates from 9.3% in 2003 to 16.2% in 2008. MH boys and MH girls had 1.5-2 times odds of binge eating and vomiting compared to their HET peers. Orientation differences between LGB and HET were narrower in 2003 than in 1998 (AOR of binge eating for boys 4.7 to 2.1; for girls 2.6 to 1.8; AOR of vomiting for boys 6.3 to 2.1; for girls 4.1 to 3.8), followed by a widening gap in 2008 (AOR of binge eating for boys 4.5; for girls 2.4; AOR of vomiting for boys 9.3; for girls 6.4).
Conclusions: A declining trend in disordered eating was observed for heterosexual youth and a V-shaped trend for LGB youth. Sexual minority youth were at higher risk across all years. Findings suggest the need to continue monitoring trends by orientation and explore factors that may influence the trends.
Sources of Support: Grants #CPP86374 & #MOP 119472, Canadian Institutes for Health Research; McCreary Centre Society's BC Adolescent Health Survey.

107.

UK AND IRISH SURVEILLANCE STUDY OF GENDER IDENTITY DISORDER (GID) IN CHILDREN AND ADOLESCENTS

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Purpose: The incidence of childhood/adolescent Gender Identity Disorder (GID) is unknown. GID is an important condition where gender identity differs from biological sex. It is associated with significant distress, particularly with puberty, with much controversy internationally over the optimal timing of hormonal treatment. We examine the incidence and clinical presentation in UK and Irish children and adolescents.
Methods: STUDY POPULATION: Children and adolescents aged 4-15.9 years in the UK and Republic of Ireland. DESIGN: Joint British Paediatric Surveillance Unit (BPSU) and Child and Adolescent Psychiatry Surveillance System (CAPSS) study. New cases of GID reported by clinicians over a 19-month reporting period (01-Nov-2011 to 01-June-2013) are validated against the authoritative DSM-IV-TR (2000). Exclusions include disorders of sexual differentiation and major psychosis. PRIMARY OUTCOME: Incidence of childhood/adolescent GID, calculated by dividing the number of validated cases by the base population of children and adolescents aged 4-15.9 years. Sources of denominator data: UK Office of National Statistics and the Central Statistics Office in Ireland. STATISTICAL ANALYSIS: Descriptive statistics and comparisons using two-sample t-tests or Mann-Whitney U tests for continuous data and Chi-squared or Fisher's exact tests for categorical data.
Results: Preliminary descriptive data from the first 15 months' surveillance (n = 138 cases, 69 males) indicate that similar numbers of males and females are affected by this condition. Early estimates suggest UK and Irish incidences of 1:80,000 and $<$ 1:200,000 respectively. There is a lag of several years between median [interquartile range] onset of symptoms (7y [4-12y]) and presentation to Paediatricians or Psychiatrists (14.5y [11.9-15.2y]), with most cases presenting at 14 or 15 years. Only a quarter of all cases (n = 35) were less than 12 years old at reporting, but 50% of cases reported by Paediatricians. There are high levels of psychiatric co-morbidity at presentation, with at least one other mental health diagnosis in 45%, and two or more other diagnoses in adolescents aged 12 years and over.
Conclusions: We present the first ever population-level data on the incidence, clinical features and presentation of childhood/adolescent GID. These data will inform clinical management, including the highly controversial debate around early pubertal suppression in this group.