paediatric unit in a non-tertiary centre over a 3 year period, highlighting the challenges presented.

7 patients had a total of 12 in-patient stays on a general paediatric ward. Length of stay ranged from 6 to 84 days, mean 44 days, median 55 days. Initial presentations were all unscheduled episodes of care. Age at initial presentation ranged from 10 to 14 years. Restrictive type eating disorder was the working diagnosis initial presentation in 5 of 7 cases. All were managed according to the Junior MARSIPAN Guidelines (Royal College of Psychiatrists). In the 2 youngest patients, both 10 years, the diagnosis of an eating disorder was made after medical investigation of weight loss. 5 of 7 children required nasogastric re-feeding during their first admission. 4 of 7 required transfer to a tertiary unit specializing in eating disorder management. Only one of these four was successfully discharged home by 6 months, the others have required repeat admissions over 3 years. Diagnosis in all 7 was restrictive eating pattern, non-bulimic.

Medical complications included profound bradycardia and hypotension at presentation in 7/7 and re-feeding syndrome in 1/7. 2/7 manifested extreme behavioural challenge on a general paediatric ward. 1/7 self-harmed. 24 hour supervision including meal support was required by Health Care Assistants in 5/7. No adolescent/child segregation could be provided. There are no nursing staff with training in managing the child with an eating disorder on our ward. Paediatric dietetic support was available but no other specialist treatment was possible.

This cohort is small in number relative to the overall admissions to our unit. Prolonged and repeat admissions have significant implications for the limited budget of a small hospital. Total length of stay of 489 days cost 400,000 euro for basic care alone. This unscheduled care group also represents a considerable work load for general paediatricians.

Best practice management of Anorexia Nervosa prompts the need for a multi-disciplinary approach from a paediatrician, psychiatrist, psychologist, and speciality trained dietician and nursing staff. The increasing incidence and prevalence of eating disorders among older children and adolescents is an increasing burden of care for general paediatric units in Ireland compounded by an under-resourced community Child and Adolescent Mental Health service.

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TRANSGENDER YOUTH: WHAT PAEDIATRICIANS NEED TO KNOW

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10.1136/archdischild-2019-epa.752

An increase in referral rates of transgender youth to services has been observed on an international level (Chen et al 2016, Fuss et al 2015). There is a paucity of knowledge vis-a-vis paediatrician's experience and knowledge of caring for transgender youth. General paediatricians knowledge is limited, with training on provision of routine care, supporting transgender patients and their families and co-ordination of medical management recommended (Shires et al 2017). Paediatric endocrinologists may be involved in prescription of hormonal therapy in transgender youth, in accordance with the updated Clinical Practice Guideline by the Endocrine Society in 2017.

Gender identity and expression is best conceptualized as a spectrum, and not simply a binary concept. The term *transgender* can be considered an umbrella term, encompassing the broad spectrum of individuals who transiently or persistently identify with a gender different from their assigned sex at birth. An inversion of the sex ratio of referred adolescents has been observed, with a number of clinics reporting more youth assigned female at birth referred in recent years than youth assigned male at birth (Aitken et al 2015; Kaltiala-Heino et al 2015).

This presentation will include an overview for paediatricians. The gender spectrum, social and medical transitioning, common co-morbidities, current evidence-base & guidelines and practical management of gender variant youth in the paediatric setting will be covered.

Medical, neurodevelopmental and psychiatric co-morbidities will be highlighted. Gender Dysphoria and comorbidity with medical disorders, such as Klinefelter Syndrome, and neurodevelopmental disorders, such as Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), will be explored. The current literature reports high co-occurrence rates of Gender Dysphoria and ASD (Van Der Miesen et al 2016, Janssen et al 2016, Shumer et al 2016) and is the focus of much attention. Research in recent years highlights elevated rates of co-morbid mental health difficulties, self-harming behavior and suicidality among transgender youth (Chen et al 2016, Holt et al 2016, Kaltiala-Heino et al 2015, Olson et al 2015, Reisner et al 2015).

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CONVERSION DISORDER: DON'T BE MISTAKEN, DON'T BE MISLED

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10.1136/archdischild-2019-epa.753

Conversion disorder is the loss or alteration of voluntary motor, or sensory function in the absence of identifiable pathology. ¹ It is most prevalent in the 10–15 year old age group, female: male ratio, 2:1.

We present 5 cases: all female, 11–14 years, presenting with vague symptomatology and normal investigations. 3/5 had identifiable psychological stressors. They had a combined total of 15 presentations, 9 admission episodes, 40 in-patient bed days and 20 radiological investigations.

1/5 was diagnosed with a treatable neurological condition.

Case 1: EO, 11 years old, repeated presentations with generalised weakness, dizziness, headache and arthralgia. Patient's father had died tragically one year prior. Mother has fibromyalgia and functional neurological disorder.

Case 2: RM, 14 years old, multiple episodes of collapse, with apparent unconsciousness (up to 40 minutes) with repeated presentations to hospital. Postulated aetiologies included neurocardiac syncope and Postural Orthostatic Tachycardia Syndrome. There followed exclusion from school and multiple medical opinions.

Case 3: KO, 14 years old, presented following recurrent pre-syncope, collapse, and shaking episodes. Previously investigated for recurrent vomiting, with no aetiology found. Psychological stressors included disabled sibling, significant mental health disorders, both parents.