codes as described in the literature (2). The primary outcome was the rate of all-cause readmission within 30 days of discharge. Secondary outcomes were reasons for readmission, readmission mortality rate, morbidity, and resource use (length of stay and total hospitalization costs and charges). Propensity score (PS) using the 1:1 nearest neighbor matching without replacement was utilized to adjust for confounders (3). Independent risk factors for readmission were identified using a Cox proportional hazards model (4). **RESULTS**: In total, 116,124 hospital admissions among adults with a primary diagnosis of STEMI were identified, of which 18.05% were diabetics. 1:1 PS matching was performed based on demographic (age, gender, hospital status, etc.) and clinical characteristics (Charlson comorbidity score. The 30-day rate of readmission among diabetics and non-diabetics with STEMI were 9.31% vs. 6.18% (p <0.001). The most common readmission for both groups was recurrent myocardial infarction. During the index admission for STEMI, the length of stay (LOS) among diabetics and non-diabetics patients were not statistically different (4.74 vs 4.58 days, p=0.12). However, the total hospital cost for the diabetic patients was statistically different ($27,027 vs $24,807, p <0.001). Most importantly, diabetics patients' in-hospital mortality rate during their index admission was significant higher (10.20% vs 5.92%, p <0.001). Amongst those readmitted, the LOS, total hospital cost, or in-hospital mortality among diabetics were not statistically different when compared to their counterparts during their readmission. Diabetes (HR 1.60, CI 1.27-2.02, p <0.001) was an independent predictor associated with higher risks of readmission. Other independent predictors associated with increased 30-day readmission include acute exacerbation of CHF, acute exacerbation of COPD, acute kidney injury, secondary diagnosis of pneumonia, history of COPD, history of ischemic stroke, history of atrial fibrillation & atrial flutter, history of chronic kidney disease, history of iron deficiency, and use of mechanical ventilator. **CONCLUSION**: In this study, diabetics patients admitted with STEMI have a higher 30 days of readmission rate, total hospital cost, and in-hospital mortality (p <0.001) than their non-diabetic counterparts.

Pediatric Endocrinology

PEDIATRIC PUBERTY, TRANSGENDER HEALTH, AND GENERAL ENDOCRINE

Clinical, Hormonal, Psychosexual Aspects, Gonadal Tumors and Genetic Background of an Androgen Insensitivity Syndrome Cohort

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Introduction: Androgen Insensitivity Syndrome (AIS) is the most common cause of Differences of Sexual Development (DSD) in 46, XY individuals. It is a X-linked genetic disease caused by allelic variants in the Androgen Receptor Gene (Xq11-12), leading to 3 different phenotypes: Complete (CAIS), Partial (PAIS) or Mild (MAIS). Methods: Patients with clinical suspicion of AIS (familial history, atypical genitalia, primary amenorrhea and/or inguinal hernia) performed hormonal serum measurements (LH, FSH, estradiol, testosterone) and molecular sequencing of the *AR*gene, including all exonic regions (8 exons) and the 5'UTR region. Psychosexual variables (gender identity, gender role and sexual orientation) were evaluated through questionnaires. Gender identity was also evaluated through projective psychological test (HTP test). A histopathological study and immunostainining of CD240 and OCT3/4 were carried out for all individuals submitted to gonadectomy.Results: This cohort is made up of 64 individuals: CAIS (n=26) and PAIS (n=38), from 46 different families (24 PAIS; 22 CAIS). Inguinal hernia was the first clinical presentation in 35% of CAIS. Among the PAIS, 20 (52%) were assigned as female at birth, while 18 (48%) as male. Among In the group of PAIS, external genitalia virilization (Sinnecker score) influenced sex assignment (p<0.01). Final height and weight were similar between PAIS and CAIS. Furthermore, gender identity at adulthood, gender role at childhood and sexual orientation were in agreement with sex assignment in virtually all cases of both PAIS and CAIS. No gender change was observed. Molecular diagnosis was obtained in 96% of CAIS and in 87% of PAIS. There were 10 novel AR allelic variants (4 in CAIS - 2 small deletions, 1 *missense*and 1 at splicing site and PAIS - 5 *missense*and 2 synonymous variants (both causing a new exonic splicing site leading to a short AR protein). LH ranged from 9 to 48 UI/L (mean 19), testosterone from 190 to 1500 ng/dL (mean 438), without phenotype differences. Seminoma was identified in 2 out 24 (8%) individuals with CAIS (at 19 and 20 years of age). This rate was higher taking into account only those who underwent gonadectomy after puberty (16 years old or later: 2 out 17 (12%). Among PAIS there were 2 cases of NICG (at 3 and 19 years of age) and none of seminoma. Conclusion: Hormonal levels did not enable us to differ PAIS and CAIS. Inguinal hernia is a common clinical presentation of AIS. External genitalia appearance in PAIS influenced sex assignment. The psychosexual development in AIS usually complies with sex assignment. No gender change was observed. There is a risk of seminoma in CAIS, especially after puberty, which is not low enough to be ignored.

Reproductive Endocrinology

TRANSGENDER MEDICINE AND RESEARCH

Cosmetic Injection of Silicone in a Transgender Person Leading to Granulomatous Disease with Hypercalcemia and Terminal Kidney Failure

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