

(See page 56)

**Part
one**

**Part
two/three**

**Part
four**

**Part
five**

Q1 None of them. Polyuria and polydipsia may be the initial symptoms of all these illnesses (although it is a very rare presentation in most of them). They all need to be ruled out, although (e) and (f) are by far the most likely diagnoses.

Q2 (e) Up to 40% of patients taking lithium develop nephrogenic diabetes insipidus.¹

Q3 (a), (b), (c), (d), and (e). All are within the scope of general practice, and their results will narrow the differential diagnosis to one or two choices.

Q4 (a), (b), and (c). You have already ruled out diabetes and renal disease, and the lack of response of the urine osmolality to water deprivation rules out primary polydipsia (usually a diagnosis associated with psychiatric illness). You are left with primary diabetes insipidus and pituitary tumour as the main causes of Jerome's polyuria and polydipsia.

Q5 (a), (b), (c), (d), and (e). Only 30% of cases of diabetes insipidus are classified as '*idiopathic central diabetes insipidus*' so you must rule out potentially lethal causes. A low antidiuretic hormone level (found in Jerome's case) confirmed diabetes insipidus. Normal scans and levels of pituitary hormones ruled out tumours as causes, and autoantibody screening (for arginine vasopressin antibodies) was also negative.

Happily these results meant that Jerome had idiopathic diabetes insipidus that responded very well to intranasal vasopressin 10 micrograms daily. He is now back to his normal healthy self.

Reference

Grunfeld JP, Rossier BC. Lithium nephrotoxicity revisited. *Nat Rev Nephrol* 2009; 5: 270–6.

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