Diabetes Insipidus: A Review

Moshe Shapiro and Jeffrey P. Weiss*

Department of Urology, SUNY Downstate College of Medicine, USA

Introduction

Inappropriate secretion or action of serum antidiuretic hormone (ADH) is termed Diabetes Insipidus (DI), characterized by polyuria and polydipsia (defined as 24 hour urine output in excess of 40 ml/kg) and polydipsia [1]. As opposed to Diabetes Mellitus, where the urine is hypertonic and sweet (mellitus means honey in Greek), DI is defined as having urine that is hypotonic and bland, in the setting of polyuria. There are various mechanisms of pathogenesis of DI, all leading to the same clinical manifestation. In cases where the disorder is due to inadequate secretion of ADH, the disorder is termed Central DI, whereas when the disease is a result of renal insensitivity to ADH, the disease is termed Nephrogenic DI [1]. In cases where polyuria is due to vast amounts of ingested fluids driven primarily by behavioral or thirst disorders, it is called Primary Polydipsia (PP). Pregnant women can metabolize ADH in an accelerated manner leading to Gestational DI [2]. Overall, there are 3 cases of DI per 100,000 in the general population [3]. With regard to some familial forms of nephrogenic DI, incidence varies and some regions with common ancestry have higher incidence than other in the general population [4].

ADH, also known as arginine vasopressin (AVP), is produced in the hypothalamic nuclei. It is a highly evolutionarily conserved nonapeptide, with a 6 amino acid ring and a 3 amino acid tail with L-arginine in the 8th position. Oxytocin is also produced in the hypothalamic nuclei, with a structure similar to ADH, but with leucine in the 8th position. Both ADH and oxytocin are produced in the magnocellular neurosecretory cells (MNC) of the hypothalamus, mainly in the supraoptic (SON) and paraventricular (PVN) nuclei. While each MNC was initially thought to produce either ADH or oxytocin alone, more recent evidence indicates that there can be some overlap of production [5]. ADH is created as a composite precursor molecule composed of ADH, neurophysin-II (NPII), which is ADH’s carrier protein, and copeptin- a glycopeptides [5,6]. Both NPII and ADH are produced from the same precursor mRNA. After passage through the golgi apparatus the prepropeptide complex is packaged into large dense core vesicles (LDCV) which exit from the trans golgi network. Inside the LDCV enzymatic processing of the precursor molecules takes place. This is facilitated by the LDCV’s mildly acidic (pH 5-6) internal environment. Additionally the acidic environment keeps the fully processed ADH nonapeptide bound to the NPII. After their production, the LDCVs are transported in an anterograde fashion, down the neuronal axon along microtubules at a rate near 140 mm/day. LDCV’s containing ADH is stored in the nerve terminals of the posterior pituitary, awaiting neurosecretion. When an action potential causes an influx of Ca²⁺, the LDCVs fuse to the nerve terminal, releasing their contents via exocytosis. At normal plasma pH, NPII dissociates from ADH [7]. The LDCVs are then recovered via endocytosis and undergo retrograde transport to the cell body, where they are either reused, or degraded by lysosomes [5]. MNC’s have an intrinsic capability to detect hyperosmolality [8,9]. Experimental studies have shown that this is a mechanically mediated capability. This is demonstrated by mechanical cell volume reduction of isolated MNCs in vitro, leading to increased depolarization of the cells [9,10]. This response to mechanical stretch is mediated via channels called transient receptor potential vanilloid 1 (TRPV1) channels. These TRPV1 channels, in response to MNC shrinkage due to hyperosmolality, allow activation of a cation current (Ca²⁺ and nonspecific monovalent cations), leading to increased action potential firing, resulting in ADH release [8-10]. Actin filaments are also required for the regulation of the TRPV1 channel activity, though the exact function is unknown [8,11,12]. Regulation of ADH secretion is both pre and post transcriptional. Pre transcriptionally, hyperosmolar conditions lead to ADH mRNA transcription, increased ADH mRNA quantity, with following ADH secretion [5]. Chronic osmotic stimulation leads to increased co expression of oxytocin and ADH in MNC’s [5]. When hyposmolar conditions prevail however, ADH secretion and transcription shut down. This is thought to be via a negative feedback under steroid control. During hyposmolar conditions, ADH secreting MNC’s express a glucocorticoid receptor which has experimentally indicated that ADH release is suppressed under the influence of glucocorticoids. Post-transcriptionally there are two means of gene control. First, under hypomotic conditions there is an increase in the length of the poly (A) tail of the ADH mRNA transcripts, probably increasing the life of the mRNA. The means by which the polyadenylation is regulated is unclear, however poly(A) length and mRNA abundance are not linked, and thus are separately regulated. In vitro studies have shown that different stimuli can increase the poly(A) tail length without increasing mRNA abundance and vice versa. The second means of post-transcriptional regulation of the ADH gene product is through axonal transport. During hyperosmolar states, ADH mRNA has been detected in the neurohypophysis. Interestingly, the mRNA found in the neurohypophysis has regular length poly(A) tails. This has led to disagreement about the origin of the neurohypophyseal mRNA. One theory about the origin of the mRNA is that it is transported down the axon, originating in the cell body. This theory itself leads to 2 possibilities regarding the purpose of this transport. 1. ADH mRNA acts as a signaling molecule, carrying a message up and down the axons and possibly even beyond. 2. mRNA transport is actually a waste disposal mechanism, disposing of the older, shorter poly(A) mRNAs away from the perikaryon, leaving fresher, more efficient mRNAs in their stead. The second theory regarding the origin of the neurohypophyseal ADH mRNA, is local synthesis. This is hypothesized because of the finding of ADH mRNA in a subset of pituicytes. If this is the case it would explain why the poly(A) tail are...
of a different length than the ADH mRNA poly(A) tails found in the cell body.

ADH acts on V$_2$ receptors in the kidney leading to increased water retention. This will be addressed in detail in later paragraphs. In addition to its effect on the kidneys, ADH acts on receptors found throughout the body called V$_2$ receptors, also known as V$_2_r$ receptors. The V$_2$ receptor, when activated by ADH activates a G$_{q/11}$ protein, leading to stimulation of phospholipases C, D, and A$_2$ and ultimately to increased intracellular [Ca$^{2+}$]. The V$_2$ receptor is found in the brain, liver, and smooth muscle of blood vessels. In smooth muscle, the increased [Ca$^{2+}$] leads to vasoconstriction, hence the alternate name of Vasopressin. V$_{1a}$ or V$_2$ receptors are found in multiple tissues including the brain, thymus, heart, lung, spleen, uterus breasts, and anterior pituitary corticotroph cells. The V$_2$ receptor, when activated also acts via phospholipase stimulation, leading to increased intracellular Ca$^{2+}$ concentrations. V$_2$ receptors can also cause vascular endothelial cell secretion of von Willebrand factor and factor VIII, at concentrations far above those necessary to induce changes at the level of the nephron [13].

Blood pressure and intravascular volume stimulation of ADH release are controlled by baroreceptors in the carotid sinus and the aortic arch. These receptors send afferent signals through cranial nerves IX and X to the brainstems' nuclei of the solitary tract. From the solitary nucleus, inhibitory signals are sent to the magnocellular neurons of the hypothalamic nuclei. Only in instances of extreme hypovolemia do baroreceptors increase ADH secretion, allowing for principally osmotic control of ADH secretion [5,14]. In cases of both severe hypovolemia and hyponatremia, the usual inhibition of ADH by osmoreceptors is overridden by the baroreceptor input and ADH is released despite the hyponatremia [14].

ADH’s role in osmolality control is exerted though its influence on the kidney. ADH causes the kidney to reabsorb water in the collecting ducts and connecting tubules, and decreases plasma osmolality. In the principal cells of the collecting ducts, there are AVP V$_2$ receptors on the basolateral membrane. When AVP/ADH binds to the AVPR2 receptor, a signal cascade is initiated [1]. The AVPR2 receptor is linked to a G$_{q/11}$ protein which activates adenyl cyclase, raising cAMP levels. Increased cAMP stimulates protein kinase A (PKA) to phosphorylate vesicles containing aquaporin-2. This phosphorylation allows for transport of the vesicle to the apical surface of the cell. These vesicles then insert into the membrane and allow for water’s passage from urine into the tubular cell and thence back into the blood through aquaporins (3 and 4) fixed in the cell membrane. This phosphorylation of vesicles is limited by phosphodiesterases. When AVP is not present, AQP-2 channels are retrieved via endocytosis. In the basolateral membrane of the cell, AQP-3 and AQP-4 channels allow for waters’ passage though the cell and into circulation [15-17]. Aquaporins are a family of water channels. Aquaporins 1, 3 and 4 are all expressed without any hormonal regulation, whereas AQP-2 is expressed in response to ADH. AQP-1, the first aquaporin to be discovered, is widely expressed not just in the kidneys, but also in red blood cells and in cellular vesicles and vacuoles. Its main function in the kidney is passive water reabsorption in the thin descending limb of the loop of Henle and proximal tubule, and is a major component of the countercurrent multiplier [18]. Prostaglandins also play a role. Centrally, PGE-2 infusion causes increased ADH secretion [19,20]. In the kidneys though, prostaglandin’s role is somewhat unclear. There is evidence showing that prostaglandin E$_2$ activates a G$_i$ protein, which prevents cAMP accumulation (the reverse of the action on cAMP occasioned by G$_i$ protein), decreasing AQP-2 insertion into the apical membrane and promoting diuresis [21,22]. This is a potential mechanism by which prostaglandin inhibitors such as nonsteroidal anti-inflammatory agents may cause fluid retention. Recent studies done in Madin-Darby canine kidney cells show that AQP-2 phosphorylation and apical insertion are increased by prostaglandin EP2 and EP4 receptors activation [23]. It has also been shown in rats that butaprost, an EP2 agonist can increase urinary concentration in rats with the V$2_r$ blocked. Further research is required to determine the exact nature of the role of prostaglandins in water balance.
to the MNCs of the SON and PVN, blunting their response to changes in osmolality. However during late phase sleep these inhibitory signals decrease, leading to heightened MNC sensitivity to changes in osmolality, and hence increased MNC firing and ADH secretion. ADH has been implicated as a contributing inhibitory signaler, released from the SCN to act at the MNCs. Thermal regulation also seems to play a part in ADH release. When core body temperature rises by even 1degree Celsius, due to non febrile causes, ADH secretion is boosted. This increase in ADH output is anticipatory of future water losses due to panting, sweating and the like, and occurs before any changes in osmolality occur. This thermally regulated ADH output is also assumed to be mediated via a heat sensitive variant of the TRPV1 channel [30].

Osmolality is also detected and influenced peripherally [31,32]. Signals from oropharynx, small intestine and liver all contribute to osmostasis [31,32]. In the liver, in contrast to central osmosensing, signaling is stimulated by hyposmolality, as opposed to the hyperosmolal stimulated increase in neuron firing found in the OVLT and MNCs. This is mediated by the osmosensitive TRPV4 channels which are activated hypothetically, increasing cell electrical activity under hypotonic conditions. These signals are transmitted to the thoracic dorsal root ganglia and possibly the nodose ganglia and are then carried further to the nucleus of the solitary tract of the brain to modulate osmostasis. It has also been demonstrated in humans that ADH secretion is suppressed by non osmotic influences such as oropharyngeal stimulation caused by drinking. In rats distension of the stomach, and [Na+] in the small intestine also influence [ADH], anticipatory of imminent osmolar change [32].

 Destruction of the osmosensitive areas in humans, leads to the inability to secrete ADH in response to increased osmolality as well as absent thirst mechanisms. However, in cases where only the magnocellular neurons that produce ADH are damaged, patients do not secrete ADH appropriately in response to dehydration, but still have intact thirst mechanisms. While amongst different people the plasma osmolality ranges from 280-295 mOsm/kg, in any one individual, the osmolality is very tightly controlled, with changes of even 1% osmolality causing immediate adjustment of the rate of ADH secretion from the posterior pituitary [33]. The relationship between plasma osmolality and ADH concentration is linear, even beyond normal physiological levels of osmolality, such as that seen with hypertonic saline infusion or with the dehydration of patients with nephrogenic diabetes insipidus (NDI) [33]. There is a linear relationship between ADH concentration and urine osmolality as well. However, urine osmolality plateaus once it reaches maximum concentration regardless of ADH levels, which can be elevated far beyond what is needed to maximally concentrate the urine. Normally BP and IVV are controlled by the renin–angiotensin–aldosterone system. While arterial baroreceptors which are located in the walls of the aortic arch and carotid sinuses also influence ADH secretion, a much greater deviation from baseline is needed for this to occur. To re-emphasize, a 1% deviation from plasma osmolality alters the rate of ADH secretion, while a deviation of 10-15% of BP or IVV is needed to change the rate of ADH secretion [14,33]. Angiotensin II (Ang II) has been shown to increase the osmosensory neuron’s sensitivity to changes in osmolality. Meaning, under Ang II’s influence osmosensory neurons will have a greater response per increase in osmolality than the same osmotic stimulus without Ang II present. This effect is due to Ang II increasing the mechanosensitivity in the osmosensory neurons. When Ang II signals an osmosensitive neuron, protein kinase C is activated via Gq/11. Protein activation of phospholipase C, which hydrolyzes PIP2 into inositol triphosphate and diacylglycerol [34]. Protein kinase C is then activated by diacylglycerol. This ultimately leads to increased F-actin density. As mentioned above, actin plays a definite, yet as of now an unclearly defined role, in osmosensory response to hyperosmotic stimuli [11,34].

Central Diabetes Insipidus (CDI)

Inadequate secretion of ADH leading to polyuria and secondary polydipsia is termed CDI. The dose response curve of ADH is sigmoidal in nature and is due to the kidneys inability to concentrate urine much beyond 1200mOsm/kg on one end of the curve, and the high sensitivity of the kidney to low concentrations of ADH on the other [35,36]. Therefore under dehydrated conditions the posterior pituitary is able to secrete more ADH than can effectively increase urine osmolality. Hence, a large decrease (80-90%) in ADH output is necessary for symptomatic polyuria to occur. Once this decrease takes place, urine osmolality drops to below 300 mOsm/kg, and polyuria becomes clinically evident, with urine production rising above 50ml/kg BW/day [37]. As the patient increases his or her urine output, plasma osmolality rises until the thirst threshold is reached. At this threshold, plasma osmolality is higher than normal and is maintained at the thirst threshold. ADH deficiency does not need to be complete for CDI to occur, only that the maximal ADH plasma level at the thirst threshold is insufficient to concentrate urine [38]. Symptomatically, though, the onset is abrupt once the threshold is reached. On MRI imaging in a normal person, the posterior pituitary has a high intensity T1-weighted signal, appearing as a bright spot in the sella turcica, best seen in sagittal views [3,39]. This bright spot represents stored ADH [40]. The absence of a bright spot is not necessarily diagnostic of CDI, since, in many cases, patients with NDI are lacking a bright spot as well. However, the presence of a bright spot on MRI can rule out CDI with 95% sensitivity [40]. In the few cases of CDI with a bright spot present, it is thought that this spot is due to oxtocin stored rather than ADH [41]. MRI is also useful in detecting infundibular thickening. When infundibular stalk thickening is detected, in the absence of a pituitary bright spot, there are a number of disorders that should be considered in the differential diagnosis: granulomatous disease, craniopharyngioma, metastases to the hypothalamus, TB and, rarely, lymphocytic infiltration of the infundibulum of the posterior pituitary. Hence when DI is present along with infundibular stalk thickening and an absent bright spot, it is necessary to rule out a systemic cause for DI [41].

There is a wide range of lesions, as well as inherited defects, which can cause CDI. Despite this, in the majority of cases, such diseases present without CDI [42]. In adults, CDI is mainly caused by primary brain tumors, head trauma or is of autoimmune/idiopathic/familial origin. In children, however, a larger percent of CDI (50%, as opposed to 30% in adults) is due to brain tumors (or their treatment), with 29-54% resulting from familial/idiopathic/autoimmune causes [3,43,44]. Histocytosis X is a significant cause of CDI in children (16%), however it is not a significant cause of new onset cases in adults [3]. Children are also more likely to have an infectious etiology than adults. Granulomatosis, sarcoidosis, alcohol, phenytoin and clonidine cause 5% of adult cases, as opposed to essentially none in children [3].

Familial CDI is usually of autosomal dominant (AD) inheritance. It is caused by mutations of prepro-AVP, also known as vasopressin-neurophysin II. Onset occurs in children older than one year of age.
age and develops as late as young adulthood [43,45,46]. There are over 40 known mutations of this gene. Most of the mutations are in the neurophysin portion of the prepro-AVP, leading to impaired trafficking and formation of disulfide bonds [3,47]. In the autosomal dominant form, there is still one normal copy of the gene producing ADH. However, with time, the accumulation of the misfolded proteins in the magnocellular neuron becomes toxic, leading to neural demise and CDI. However, magnocellular neurons need not die for CDI to occur. Rather, in some cases, due to the buildup and entrapment of the misfolded proteins, normal selective degradation of proteins can be overwhelmed. In its place, a non-selective degradation takes place, destroying both ADH proper and misfolded protein alike [48,49].

Autosomal recessive (AR) CDI is caused by a missense mutation, changing the position-7 proline to leucine. This creates a mutated product that has 30 times less binding activity of normal ADH [50,51]. Alternatively, autosomal recessive CDI can also be part of a constellation of disorders known as Wolfram syndrome. Wolfram syndrome or DIDMOAD (diabetes insipidus diabetes mellitus optic atrophy and deafness) is an autosomal recessive disorder caused by mutation of the WFS1 gene. The WFS1 gene encodes for a transmembrane protein localized in the endoplasmic reticulum(ER) [52]. The WFS1 protein has been shown to play a key role in mouse pancreas beta cell response to stimuli, with eventual loss of beta cell mass, likely due to ER stress [53]. It is very possible that the CDI component of Wolfram syndrome is from impaired ER functioning that can either lead to ER stress and eventual cell neuronal death, or cause impaired response of the MNC’s to stimuli, or both. Both these forms of autosomal recessive CDI are rarer than the AD form. The AR form presents earlier than the AD type, usually within in the first year of life. CDI in Wolfram syndrome usually appears in the mid adolescent years [54]. Other etiologies of CDI are due to interruptions of secretion and/or destruction of the posterior pituitary and hypothalamic nuclei. Granulomatous disease, post-infectious processes, trauma, neoplasms, drugs (ethanol, phenytoin and others) and vascular injury all can disrupt ADH secretion, leading to CDI. Idiopathic CDI, which constitutes a sizable percentage of CDI, is now thought to be of autoimmune origin [43,44,55]. In some patients with CDI, a lymphocytic infiltration of the posterior pituitary has been suspected, and then confirmed by autopsy. The manner of infiltration was similar to previously documented anterior pituitary lymphocytic infiltration. As alluded to above, MRI can now help diagnose lymphocytic infundibuloneurohypophysitis through detection of a thickened stalk, or through enlargement of the posterior pituitary [56]. In some cases, both hypophysitis and infundibuloneurohypophysitis can coexist and present simultaneously. Additionally, evidence for an autoimmune origin of CDI is that in as many as 1/3 of patients with idiopathic CDI and 2/3 of patients with Langerhans histiocytosis, anti-ADH antibodies are detected, while patients with CDI caused by tumors have no anti-ADH antibodies. Further, patients with detected anti-ADH antibodies but no symptoms of CDI were either found to have partial CDI or had a high likelihood of developing CDI in the future: 3 of 5 such patients followed for 4 years developed CDI [56].

In patients with osmoreceptor dysfunction, a state similar to CDI can be present without polydipsia, and instead presents with severe dehydration and hyponatremia due to lack of thirst and decreased water intake [57,58]. Thirst is both regulated directly via the osmoreceptor mechanism discussed above, as well as a result of angiotensin II’s effect on the thirst center [59]. Many of the same etiologies of CDI can cause osmoreceptor dysfunction, but these lesions are located more anteriorly in the hypothalamus. One cause of osmoreceptor dysfunction is anterior communicating cerebral artery aneurism repair, causing infarction of the osmoreceptor cells [60]. Regardless of the cause of the damage, when these cells are injured, there is a lack of thirst and usually, inadequate ADH secretion stimulated by hyperosmolality. With osmoreceptor dysfunction, absent thirst leads to moderate hyperosmolality, typically ranging from 300-340 mOsm/kg H₂O. Even in normal humans there appears to be a somewhat blunted thirst response in relation to levels of dehydration. This leads to the eventual elevated secretion of angiotensin II and has been implicated as a possible source of hypertension [59].

While patients with CDI usually have little if any hyperosmolality, patients with osmoreceptor dysfunction can present with severe even life threatening hyperosmolality [61]. ADH secretion due to hypovolemia or decreased BP however, can still be intact [62]. Since baroreceptor pathways are still intact, the ADH and subsequent renal response are still elicited when hypovolemia occurs. Therefore it is important to recognize osmoreceptor dysfunction, with absent thirst and hyperosmolality, despite seemingly normal urine concentrating capability [62].

In cases of surgical or traumatic origin there are several distinct patterns in which CDI can manifest. There may be abrupt onset of polyuria followed by spontaneous resolution within several days [63,64]. Occasionally the damage is severe enough to cause permanent CDI immediately past the injurious event. There is also a distinct triphasic presentation that can occur, characterized by an initial phase of polyuria, due to axonal shock and inhibited secretion of ADH, lasting from hours to days. The second phase, lasting 2-14 days, is the antidiuretic phase, caused by uncontrolled release of ADH from the damaged neurons. The third phase is again, polyuria. During the second phase it is important to not overhydrate patients, in order to prevent hyponatremia from the uncontrolled ADH release. Frequently, there can be isolated transient hyponatremia (phase 2) following transphenoidal surgery, with spontaneous resolution [64-66]. Regardless of the pattern of presentation, in post-surgical patients with serum sodium ≤145 mEq/l spontaneous resolution is the rule [67]. In post-surgical patients with serum sodium >145 mEq/l, permanent CDI is likely [67]. In cases of post-traumatic CDI as opposed to post-surgical CDI, once polyuria has persisted for a few weeks, CDI is likely to be permanent [68].

While CDI, or any type of DI for that matter, is usually not life threatening, there are certain circumstances where CDI can be lethal. Children, especially infants, do not have free access to fluid. This can cause severe hyponatremia, dehydration, and death. It is especially important to have a high index of suspicion because the symptoms of CDI in young children are non-specific [3]. Usually, CDI presents with poor feeding and failure to thrive. Because breast milk has such a low solute load, polyuria is often not noticed until later in life when solid food is introduced and solute delivery to the kidneys is increased [3]. When polyuria becomes evident, it is usually accompanied by hyponatremia, dehydration and fever. CDI can also present with constipation and small hard stools [3]. In the past, frequent dehydration and subsequent hyponatremia led to seizures and almost invariably caused mental retardation. However, with better and earlier recognition of the disease and more effective treatment, this is no longer the case [3,69]. Children with CDI, however, have hyperactivity
disorder as well as short-term memory problems, most probably due to frequent voiding and drinking [3]. CDI is also reported in 50-90% of patients with brain death [65].

Clinical presentation

CDI is characterized by polyuria, polydipsia, urinary frequency and nocturia. Polyuria is defined as 24-hour urine production in excess of 40 ml/kg [70]. Nocturia in CDI is caused by increased urine production overall while bladder capacity remains normal-high normal. CDI usually has a sudden onset, due to the fact that urine can be concentrated up until 80-90% of ADH secreting cell are destroyed, after which urine can no longer be effectively concentrated and CDI becomes apparent [35,36]. Patients with CDI usually present with high-normal plasma osmolality, though in pediatric patients or in patients with absent thirst or no access to water, CDI can present with life threatening hyponatremia and severe dehydration. For unknown reasons, patients with CDI also report craving for ice water, and that ice water quenches their thirst better [3,71]. Patients with CDI, for unidentified reasons, also have decreased bone density. It is postulated that diminished ADH, and hence a decreased effect on prostaglandins and bone production, is a possible reason for the osteopenia associated with CDI [72].

Nephrogenic Diabetes Insipidus (NDI)

Congenital NDI, characterized by insensitivity of the kidneys to ADH, occurs rarely in the general population. For example, X linked NDI with some observational studies showing incidence of 8.8 cases per million live male births [4]. In more specific areas with residents of common ancestry, rates of NDI are even higher [4]. The vast majority of inherited cases of NDI are X-linked recessive, but there are both autosomal dominant and autosomal recessive variants as well. However, most NDI is not inherited, but rather results from either exogenous causes (e.g. lithium, demeclocycline) or renal disease [73,74]. In pediatric patients, NDI be a concomitant of obstructive uropathy [3,75]. Normally, ADH-induced signaling leads to the insertion of AQP2 into the apical membrane of the principal cells of the collecting duct. In X-linked disease, NDI is caused by mutations of the AVPR2 gene, leading to absent signaling for AQP2 insertion into the apical membrane. It is possible to clinically possible to detect mutations in the V2R and the AQP2 genes with genetic sequencing [76]. There are 5 classes of V1 receptor mutations leading to NDI [1,77]: (I) Abnormal mRNA that is untranslated or leads to aborted proteins (II) Translated proteins that are trapped in the endoplasmic reticulum (III) Proteins that are in the correct location but do not signal in response to ADH (IV) Proteins that are in the correct location but do not bind ADH (V) Proteins that are transported to improper organelles [77]. Close to half of X-linked NDI is due to class II mutations [77,78]. These class II mutations are resultant of a missense mutation. This mutation prevents the export of the functional V2 receptor to the basolateral membrane of the cell, and leaves the functional protein trapped in the endoplasmic reticulum. This prevents the receptor’s interaction with circulating ADH and subsequent insertion of AQP2 into the apical membrane. Female carriers are usually unaffected but can occasionally be symptomatic. Normally in females, inactivation of one of the X chromosomes occurs randomly in every cell, leading to a roughly equal amount of each of the chromosomes remaining active [79-81]. In symptomatic carriers, there usually is a correlation between a skewed X chromosome inactivation detected in leukocytes and symptomatic disease. In cases where the female patient is symptomatic but skewed X inactivation is not detected in leukocytes, it is possible that the disease is due to different X inactivation ratios between different tissues. Carriers can also have decreased urine concentration capability though asymptomatic, with no polyuria [79]. Autosomal NDI, both recessive and dominant, is caused by a variety of AQP2 mutations, similar to the case with X-linked CDI.

Lithium, widely used in therapy of bipolar disorder, is the commonest cause of acquired NDI. While lithium usually causes impaired urine concentration, only about 15% of patients taking lithium for >15 years develop full-blown NDI [74,82]. Lithium’s mechanism in causing NDI is unknown and a variety of mechanisms have been proposed - one of which is by decreasing cellular cAMP, causing decreased insertion of AQP2 into the apical membrane [83,84]. Other research shows that lithium’s action is likely not due to cAMP, but rather, to AQP2 transcription reduction and AQP2 mRNA degradation [85]. Another proposed method of decreased aquaporin 2 insertion is via lithium’s inhibition of glycoenc synthase kinase 3 (GSK-3), one of the regulatory enzymes of AQP2 and epithelial sodium channels (ENaC’s). When GSK-3 is inhibited, there is decreased cellular sensitivity to ADH, leading to decreased AQP2 insertion [86,87]. While lithium-induced impaired urine concentration is initially reversible, with time, the defect becomes permanent.

Hypokalemia and hypercalcemia are 2 metabolic etiologies of NDI, associated with decreased sensitivity to ADH. Hypercalcemia is another common cause of NDI [88]. The etiology of NDI with hypokalemia (plasma potassium <3.0 mEq/l) is incompletely understood, though it is postulated that, in addition to a decreased sensitivity to ADH, there is also decreased production of the countercurrent gradient via the Na-K-2Cl co-transporter in the thick ascending limb of Henle (TAL) [89]. Hypokalemia also can induce thirst leading to associated polyuria and polydipsia [90]. Hypercalcemia (plasma calcium >11 mg/dL) causes impaired countercurrent multiplier function in the nephron associated with decreased NaCl reabsorption in the TAL, in part, due to increased PGE2 production [91]. Hypercalcemia also may decrease AQP2 expression [92]. Both hypercalcemia and hypokalemia are reversible with correction of the imbalance; however, effects of chronic hypercalcemia are unknown [88].

Bilateral urinary tract obstruction is also another source of NDI. There are manifold etiologies leading to obstruction, including congenital origin, resulting from neoplastic processes, inflammatory reactions and others, all affecting the upper and lower urinary tract. These will not be discussed here and are beyond the scope of this paper. In bilateral ureteral obstruction, in addition to retained solutes, there is also significant volume expansion due to retained fluid. This increased fluid leads to increased BP and resulting secretion of atrial natriuretic peptide (ANP) [93]. Once obstruction occurs, there is an acute decrease in urine concentration capability. This is thought to be due to a variety of factors including decreased AQP expression, ischemic renal tubular damage and impaired ENaCs [94]. Increased PGE2 may play a role in the decreased AQP2 expression [95,96]. These defects, combined with decreased urinary concentrating capability, increased ANP, and the supernormal volume of fluid and solute, leads to diuresis [95]. In patients with significant obstruction, this impaired concentrating capability may remain long after the obstruction is removed [94-97]. It is postulated that defects in AQP1 expression are the cause of continued urinary obstruction-associated polyuria [94].
Since the osmoregulatory center of the brain is intact, such polyuria causes secondary polydipsia [98].

Broadly included in NDI are polygenic kidney disease, renal manifestations of Sjogren’s syndrome, and renal amyloidosis [99,100]. Bardet-Biedl syndrome, another cause of NDI, is a rare autosomal recessive disorder with obesity, mental retardation, retinopathy, polydactylty, male hypogonadism as well as polydipsia and polyuria [101]. In this syndrome there is an absent ADH receptor not on the basolateral side of the cells, but rather on the luminal side [101]. Bartter syndrome, an AR disease, is also characterized by polyuria and polydipsia; however, the impaired urinary concentration and resulting polydipsia come from impaired Na+ reabsorption in the TAL of Henle [102]. Bartter syndrome also leads to hypokalemia, which also leads to NDI, as described above.

Clinical presentation

In adults, NDI, as opposed to CDI, tends to present more gradually than CDI; as sensitivity to ADH decreases, polyuria increases [3]. Nocturia may be a presenting sign of NDI. During the night, there is normally maximally increased urine, due to lack of fluid intake. However, with NDI, this concentration does not happen and nocturia results. In contrast to the case for CDI, there has been no reported link between NDI, decreased bone density or craving for ice water [3]. Hereditary NDI usually presents in the first week of life [3,103]. One of the first signs of NDI in children is fever, accompanied by irritability, and constant crying [3,82]. Neonates will have vigorous sucking but will vomit soon after feeding, unless feeding is preceded by water [103]. These patients will also have signs of dehydration, such as constipation, hypotension, hypervolemia, hyperkalemia, and prerenal azotemia [3]. Hypertonic dehydration can lead to seizures and death [103]. Classically, mental retardation was considered a feature of hereditary NDI, but is now recognized to result from the frequent dehydrations and subsequent seizures [3,103]. With better recognition, mental retardation is rarely a complication of the disease. However, children with NDI frequently have short term memory and hyperactivity disorders, possibly related to frequent urination and fluid seeking, which interferes with normal ability to focus, cognitively [3]. Pediatric NDI often is accompanied by growth retardation due to decreased caloric intake, as well as lower urinary tract dilatation and obstruction, caused by increased urinary volume [3,104].

Gestational Diabetes Insipidus (GDI)

During pregnancy, the placenta produces cysteine aminopeptidase (vasopressinase), which metabolizes both oxytocin and ADH [2]. When cysteine aminopeptidase levels are greatly elevated, ADH is degraded beyond the capacity of the hypothalamic/pituitary axis to secrete it sufficiently to maintain proper urinary concentration [2]. This results in GDI, also known as "transient DI of pregnancy". Patients with GDI have decreased hepatic function, leading to decreased hepatic clearance of cysteine aminopeptidase [2]. In light of this, GDI is often associated with preeclampsia and the HELLP syndrome (hemolysis, elevated liver enzymes; low platelet count) [2]. In subsequent pregnancies, GDI is unlikely to return [2,105]. While increased urinary frequency and nocturia are normal during pregnancy, true polyuria is abnormal and deserves investigation.

Primary Polydipsia

Opposite in origin from the other forms of DI is primary polydipsia. Rather than having voluminous amount of dilute urine causing thirst and then ingestion of fluid as in DI, PP is characterized by the ingestion of vast amounts of fluid, most frequently water, causing hypotonic polyuria [106]. The patient ingests massive amounts of fluid, plasma osmolality decreases, and decreased secretion of ADH follows. Less circulating ADH results in reduced AQP2 expression and insertion. This causes a dilute polyuria. Eventually, the body sets this new, lower plasma osmolality as the threshold for ADH [107]. Frequent voluminous urination also causes medullary “washout,” (loss of the concentration gradient in the medulla), further impairing urine concentration capability [107]. Many cases of PP are manifestations of psychiatric disorders such as schizophrenia or obsessive compulsive disorder [108]. In extreme cases of PP the kidneys’ excretory capacity of around 20L/day can be surpassed, leading to a phenomenon called PIP syndrome (psychosis, intermittent hyponatremia, polydipsia) [109]. It is characterized by transient hyponatremia that corrects itself when the patient sleeps and fluid ingestion ceases. Polydipsia is extremely common in patients with chronic mental illness with around 25% of patients being affected. In schizophrenics < 50 years of age, hyponatremia is a significant cause of mortality. Dipsgenic polydipsia is a PP subvariety caused by a defect in the patient’s thirst center [106]. This can either be idiopathic, or, as a result of a structural lesion, similar in origin to the causes of CDI. PP may caused by drugs that cause dry mouth, a common side effect of many psychiatric medications. Primary polydipsia can be behavioral as well, due to recommendations to drink copious amounts, both for good reasons, such as recurrent nephrolithiasis, and for reasons based upon erroneous assumptions of the salubrious benefits of “hydration” [110,111].

Differential Diagnosis of Diabetes Insipidus

By definition, DI is characterized by polyuria with hypotonic urine. Therefore, before determining the variant of DI, it is prudent to verify that there is polyuria, and it is indeed hypotonic. For polyuria to be present, urine output needs to be in excess of 40ml/kg/24 hours [37,70,112]. In order to diagnose DI, urine osmolality should measure < 300 mOsm/kg. If urine is not hypertonic, then other etiologies of the polyuria should be investigated, e.g. diabetes mellitus (solute diuresis). Once the diagnosis of hypertonic polyuria is established, a history should be taken to characterize the polyuria. Onset of polyuria should be delineated as gradual or abrupt. The patient should be asked about craving for ice water [3,71]. While most cases of hereditary DI manifest at young ages, hereditary DI occasionally develops in adolescence; hence, family history can aid in diagnosis [3]. Generally speaking, DI is diagnosed by osmotically stimulating ADH secretion (e.g. by overnight fasting), and then measuring the response by either urine osmolality testing or direct measurement of plasma ADH levels. The gold standard is a dehydration test followed by plasma ADH levels, but ADH levels are difficult to measure commercially, and the indirect measurement of urine concentration is usually used first [3,113]. The relationship between plasma osmolality and urine osmolality is also helpful in establishing a diagnosis. Patients who are hyperosmolar do not have PP, so they can be tested for a response to DDAVP, a synthetic analogue of ADH. If the patient responds to DDAVP by concentrating their urine more than 800 mOsm/kg then CDI is the diagnosis. If DDAVP is administered and their urine osmolality remains below 2-300 mOsm/kg, NDI is present [3,112]. Patients with normal range plasma sodium and hypotonic polyuria should be worked up as follows: Serum and urine osmolality as well as serum ADH should be taken at baseline. Water should be restricted. Measure urine osmolality...
and volume with each voiding, stopping either when body weight decreases by 3%, urine osmolality levels off for 2 consecutive voids, or plasma Na⁺ reaches 145 mmol/L. Once plasma becomes hyperosmolar, treat with DDAVP and monitor urine osmolality for another 2 hours. If urine concentration increases by 50% or more, then CDI is the diagnosis. If DDAVP causes urine osmolality to increase by <10%, the patient has NDI. If urine osmolality reaches more than 750 mOsm, either CDI or PP is the diagnosis; the latter two may be distinguished by urine concentrating ability in response to dehydration which is normal in patients with PP [3,38]. MRI can aid in the diagnosis of DI; patients with the characteristic bright spot in the sella turcica are unlikely to have CDI (see above) [3,39,114]. Some difficulties may arise differentiating between NDI, CDI and PP, in that the latter may present with lower than expected concentration capacity, due to medullary washout caused by the massive amount of flow, leading to lack of a concentration gradient. NDI may present with residual sensitivity to ADH, or with secretion of ADH occurring at higher levels of plasma osmolality in patients with partial CDI. ADH assay, while helpful to differentiate between the two, is often inaccurate due to ADH's instability in the blood. Radioimmunoassays which detect copeptin, a stable molecule secreted with ADH may be helpful in quantification of serum ADH levels [113,115].

**Treatment of DI**

In general, the mainstay of treatment of DI is to correct current deficits and reduce future fluid loss. In most patients with intact thirst and mobility, there are only minor fluid deficits that may be immediately correctable. In patients who are unable to respond to thirst, such as infants, unconscious patients and patients with absent thirst, fluid deficits can be severe and need to be corrected slowly [116]. Correcting hypernatremia too quickly leads to water osmotically entering the brain, causing edema, seizures, and even death [116]. Hypernatremia should be corrected at a rate of no more than 0.5 mEq per hour [117].

**CDI**

The preferred replacement therapy for treating CDI is 1-desamino-8-D-arginine vasopressin, also known as DDAVP. It is similar to ADH but with the 8-position arginine a D-isomer (instead of L) and the terminal cysteine is deaminated. It is preferred to pitressin, a synthetic peptide identical to ADH, because DDAVP lacks the pressor effects of ADH, unlike pitressin [3,118]. DDAVP is useful in GDI, since DDAVP is resistant to placental vasopressinase [2,119]. DDAVP can be given as an intranasal spray, oral tablet or lyophilisate (melt) form [120]. A possible side effect is hyponatremia, brought on by continued ingestion of fluids despite the resolution of the polyuria, which can be avoided by allowing effects of the DDAVP to wear off before re-administering [121,122]. This is especially important while monitoring patients with post surgical CDI. By allowing the effects of DDAVP to dissipate before the next dose, the diuretic phase will not be missed and severe hyponatremia can be avoided [122]. Treatment of CDI in brain-dead organ donors has shown to improve both quality and quantity of organs harvested [65,123]. Continuous infusion of pitressin has been used in these donors [3,65,123]. Chlorpropamide also reduces polyuria by up to 75% by acting on the renal tubule to respond more effectively to residual ADH and is also thought to act by causing release of ADH [3,112,124,125]. Chlorpropamide is mainly used in patients with mild DI who need only modest reduction in urine output [124].

**NDI**

Patients with NDI respond to neither ADH nor DDAVP; hence, treatment of NDI differs from that of CDI. First and foremost, in cases of acquired NDI, it is essential to remove the offending agent i.e. lithium, whenever possible (which is not often). Additionally, adequate water must be given, especially in infants who cannot access water on their own [3]. A low sodium diet, combined with a thiazide diuretic, paradoxically aids in reducing polyuria by producing volume contraction [126,127]. This approach is thought to work by causing sodium loss, leading to reduced extracellular volume, decreased glomerular filtration rate, and increased proximal tubular sodium and water reabsorption [126]. Thiazides may also act on the inner medullary collecting duct to reabsorb water [126]. Thiazides may also increase AQP2 expression, in the setting of Li⁺ induced NDI [126,127]. Amiloride is used, as well, to cause volume contraction; it is especially helpful with Li⁺ induced NDI, because it prevents lithium entry into distal tubule cells [1,86]. Despite the contradictory evidence regarding prostaglandin’s effects on the kidney, prostaglandin synthase inhibitors, such as indomethacin, can limit diuresis. Hence while the precise mechanism for their action is unclear, prostanoladin synthase inhibitors increase cellular concentration of cAMP, leading to increased AQP-2 insertion into the apical membrane of the collecting duct and resulting higher urine concentration [128,129]. However, since these drugs can actually cause kidney injury and gastric problems with long-term use, they were classically used after other treatments have been tried [3,130,131]. Recent evidence shows a link between long-term thiazide therapy and renal cell carcinoma, especially in women. This may lead to increased treatment with prostaglandin synthase inhibitors and other therapies [131]. Thiazides and prostaglandin synthase inhibitors can also be used in CDI [132]. In contrast to CDI, treatment of NDI can only raise urine osmolality to plasma osmolality and no further [133]. DDAVP usually has no effect on patients with NDI but may be effective in patients with partial resistance to ADH; therefore, it is worthwhile to try a high dose of DDAVP [134]. Other potential treatments for NDI include possible rescue of trapped V₂ receptors stuck in the endoplasmic reticulum, as seen with class II mutations [78,135]. Rescue of these receptors via chemical compounds known as nonpeptide chaperones looks to be promising [78]. These nonpeptide chaperones stabilize the V₂ receptor trapped in the endoplasmic reticulum of the collecting duct cells. This stabilization allows the V₂ receptor to be exported to the golgi apparatus. There the receptors are glycosylated and inserted properly into the basolateral membrane. Another potential treatment of hereditary NDI being investigated is the use of phosphodiesterase (PDE) inhibitors, used to increase intracellular cAMP levels in the renal cells. Animal studies have showed that the PDE4 inhibitor rolipram and the PDE5 inhibitor sildenafil increase urine concentration [136,137].

**PP**

Fluid restriction is the preferred treatment of PP, however in patients with psychiatric polydipsia, adherence is suboptimal [138]. Clozapine has been shown to be effective in reducing water intake in schizophrenic patients. Despite this many clinicians will not use clozapine to treat PP unless there is significant hyponatremia, as clozapine has a significant side effect profile. However in cases of PIP clozapine is the standard treatment [138]. In fact clozapine is likely to be the reason for the apparent decrease in incidence of hyponatremia and polydipsia among psychiatric patients in recent years. Using
desmopressin or thiazides in PP can be lead to hyponatremia, and must be avoided. In patients with dypogenic polydipsia, alternatives to fluid intake, such as sour candies, gum or ice chips, may be useful.

Summary

DI is a disease of polydipsia and hypotonic polyuria caused by one of 4 etiologies: 1) Inadequate ADH secretion such as in CDI 2) Lack of response to ADH, as seen in NDI 3) Increased metabolism of ADH as occurs in GDI 4) Massive fluid ingestion as in psychogenic or dypogenic polydipsia. Both CDI and NDI can be inherited or acquired. CDI is usually acquired as a result of an idiopathic/autoimmune process, and inherited mostly as an autosomal dominant disease. NDI is usually acquired as a result of lithium toxicity and occasionally inherited as an X-linked recessive trait. GDI is thought to be related to decreased hepatic synthesis of ADH. CDI usually consists of correcting deficits and preventing further polyuria. CDI is treated effectively with DDAVP; milder cases benefit from therapy with desmopressin or thiazides in PP can be lead to hyponatremia, and must be avoided. In patients with dypogenic polydipsia, alternatives to fluid intake, such as sour candies, gum or ice chips, may be useful.

References


AQP1, -2, and -3 after ureteral obstruction is associated with a long-term urine-concentrating defect. Radiology 207: 79-83.


