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TRANSIENT DIABETES INSIPIDUS: A COMPLICATION FOLLOWING TRANS-SPHENOIDAL SURGERY

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BACKGROUND
Central diabetes insipidus (DI) is one of the complications of trans-sphenoidal surgery caused by the damage of vasopressin-secreting neurons. While some patients develop permanent DI, most patients fully recover.

CASE
A 26-year-old female was referred to the endocrinology clinic for a suprasellar tumor. She presented with a chief complaint of hemianopsia two months prior to the admission. She also noted amenorrhea for about six months. Physical examination only showed bitemporal hemianopsia. She had normal free T4, TSH, LH, FSH, and cortisol levels. Brain MRI revealed cystic pituitary macroadenoma in the sellar-suprasellar region with optic chiasm compression. A day following transphenoidal surgery, she experienced polydipsia and polyuria. The patient was treated with desmopressin which improved symptoms in two days. After discontinuing desmopressin, her urine volume remained within normal limits.

DI as a complication of trans-sphenoidal surgery occurs in 18 to 30%, but the risk factors are not well established. It can be transient, permanent or triphasic, depending on the damage of vasopressin-secreting neurons. Postsurgical DI is diagnosed by excluding other forms of polyuria, such as excess intravenous fluids or mannitol administration. Key diagnostic clues are increased thirst, hypotonic polyuria and hypernatremia and/or hyperosmolality. Majority of cases are transient and resolve after two to three doses of desmopressin.

CONCLUSION
Urinary excretion and water balance following trans-sphenoidal surgery should be monitored closely. Increased diuresis might indicate postsurgical DI despite the amount of intravenous fluid administration.

PP-PN-13

AN UNUSUAL OCCURRENCE OF HYPOPITUITARISM IN MOSAIC TURNER SYNDROME: A CASE REPORT

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BACKGROUND
Turner syndrome (TS), the most common chromosomal anomaly in females, is characterized by short stature, hypergonadotropic hypogonadism and various congenital malformations. We report a case of concomitant multiple pituitary hormone deficiencies and gonadal dysgenesis.

CASE
An 18-year-old female was referred to our hospital for evaluation of short stature and primary amenorrhoea. Examination revealed severe short stature (height 131 cm, -4.2 SD), weight 27 kg with a BMI 15.7 kg/m^2, high arched palate, hypertelorism, increased facial naevi, camptodactyly with wide sandal gap. She had a female phenotype with female external genitalia and Tanner stage 1 for both breast and pubic hair development. Hormonal evaluation showed growth hormone (GH) deficiency and relative adrenal insufficiency after the clonidine and ACTH stimulation tests, respectively; low basal gonadotropin levels; low-normal prolactin levels; and intact thyroid axis. Abdominal ultrasonography showed pre-pubertal uterine and ovarian dimensions. Pituitary MRI revealed features suggestive of pituitary hypoplasia. Cytogenetic analysis pattern showed mosaic TS: mos 46,X,del(X)(q24)[17]/45,X[13]. The patient was diagnosed with concomitant hypopituitarism and mosaic TS. She was started on hydrocortisone and sex hormone replacement therapy, as financial constraints affected the decision on recombinant human GH therapy.

CONCLUSION
Mosaic TS with pituitary hormone deficiency is a very rare occurrence, probably the first case report from Indian literature. Combined gonadotropin, corticotropin and somatotropin deficiencies were previously not reported. In multiple pituitary hormone deficiencies, karyotyping should be performed even in presence of the slightest stigmata of TS.