The Pathway To The True Diagnosis

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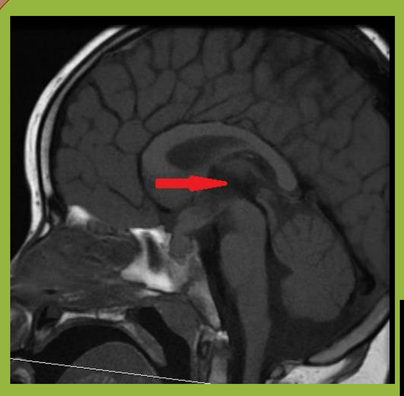
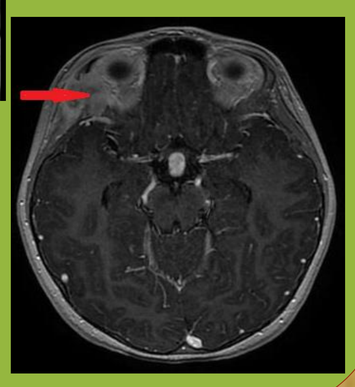
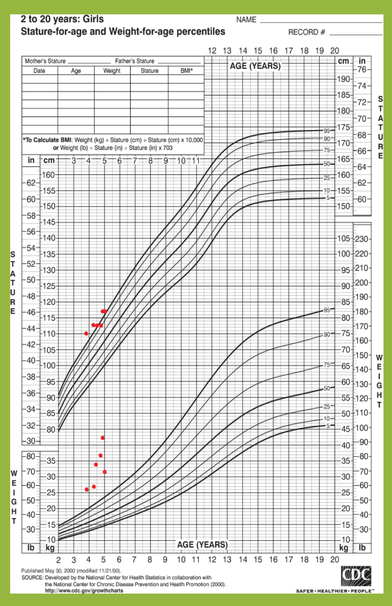
History:
- A 3 year old girl
- **Acute Interstitial Nephritis**
- Polydipsia accompanied by day-time and night-time polyuria
- Enuresis that developed 2 weeks before admission
- During the last year increased appetite and escalating weight gain
- SDS_h+ 3.5, SDS_{we} + 2, SDS_{BMI} + 3







Investigations:
- 24-hour diuresis > 5-6 l
- Urine specific gravity < 1005
- Urine specific gravity with test with Minirin > 1015

Diagnosis
- *Central Diabetes Insipidus (CDI)*

More investigations:
- Ophtalmoscopy: bilateral macular edema
- Hormonal evaluation: Prolactin 778; 449 U/l (<530 U/l)

MRI
- Supraselar mass with a second mass in the right orbit, accompanied with lytic lesion of the zygomatic bone. The radiological diagnosis was “Pituitary tumor”.

Differential diagnosis
- *Tumors with multiple sites development*
- *Lesions of the facial bones or anterior/middle cranial fossae with a concurrent intracranial mass*
- CDI
- *Langerhans Cell Histiocitosis (LCH)*

More investigations:
- *The histological result from pituitary surgery revealed **Eosinophilic granuloma.***

Diagnosis:
- *This confirmed the diagnosis LCH*

Management:
- The patient started chemotherapy according to the established current protocol and Minirin 4 x 1/2 t.

Follow up:
- Since the start of Dexamethasone, the initially weight continues to increase. Since the stop of Dexa she lost 11 kg.
- She continues on the current protocol and Minirin 4 x ¼ t.

The frequent initial presentation of intracranial benign and malignant tumors to the Pediatric Endocrinologist requires step-wise multidisciplinary approach for ensuring better outcome.

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