LANGERHANS CELL HISTIOCYTOSIS WITH ISOLATED CENTRAL DIABETES INSIPIDUS, LOW GRADE FEVER AND CELLER EROSION

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INTRODUCTION

The annual incidence of Langerhans cell histiocytosis (LCH) is 5 per million in admission with a diagnosis of isolated central diabetes insipidus (CDI) in children under the age of 15 (1).

AIM

The process leading to the diagnosis of LCH at presentation with isolated CDI, imaging findings, and the sellar erosion, will be discussed.

METHOD

Case presentation:
- A 4-year-5-month-old male patient was referred to our outpatient clinic with complaints of drinking too much water and urinating frequently for 2 months. Physical examination, complete blood count, and biochemical tests were normal.
- Other pituitary functions were found to be normal. In the follow-up of the patient, it was observed that his body temperature rose to 38-38.4°C in the evening once a day, and fell spontaneously and did not persist. On physical examination, any focus to explain the fever was not found. In laboratory tests, increases in acute phase reactants (WBC:14.89x10⁹/L, CRP:76.8 mg/L, Sedimentation:70 mm/hour) and anemia (Hb:10 g/dL, MCV:66.5 fL, RDW:16.3%) were observed.

RESULTS

- Water deprivation test was performed with a prediagnosis of diabetes insipidus in a patient with a urine density of 1001.
- After the test, the patient was diagnosed with diabetes insipids with serum osmolarity 303 mOsm/L and urine osmolarity as 121 mOsm/L. Urinary osmolarity increased by 330% after administration of 10 microgram of desmopressin acetate nasal spray solution.
- With these findings, the patient was diagnosed with CDI and desmopressin treatment was initiated.

CONCLUSIONS

Presence of isolated CDI with low-grade intermittent fever should be a warning for the diagnosis of LHH. But the patients with CDI should be evaluated in terms of LHH, the most known underlying cause, regardless of the presence of fever.

REFERENCES


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