Case report

Wegener’s granulomatosis complicated by diabetes insipidus

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SUMMARY We report a case of Wegener’s granulomatosis complicated by cranial diabetes insipidus in which no evidence of local sinus erosion or intracranial granuloma was found. Unlike previously reported cases, the diabetes insipidus has not resolved despite successful treatment of the vasculitis. The patient is also unusual in that she had a prolonged 9-month prodromal period of seronegative polyarthritis before the appearance of typical systemic vasculitis and granuloma formation.

Diabetes insipidus is an uncommon complication of Wegener’s granulomatosis. It may be due either to erosion of granulation tissue from the sinuses into the hypothalamus or to intracranial granuloma formation. We report the case of a woman with Wegener’s granulomatosis who developed cranial diabetes insipidus and in whom no evidence of frank sinus destruction was found. The patient differs from the few previously reported cases in that the diabetes insipidus has persisted despite successful treatment of systemic disease.

Case report

A 47-year-old district nurse developed an inflammatory seronegative nonerosive polyarthritis, which was treated with nonsteroidal anti-inflammatory drugs. Three months after the onset of arthritis she had a prolonged episode of serous otitis media and deafness treated with antibiotics. The clinical and serological findings remained unchanged for 6 months. She then developed acute sinusitis requiring antral lavage, which was followed by a severe disabling exacerbation of her arthritis with widespread synovitis, necrotising cutaneous vasculitis, oral ulceration, episcleritis, pleuritic chest pain, polyuria, and polydypsia in excess of 4 litres per day. On admission to hospital no additional features were noted and ear, nose, and throat (ENT) examination was normal.

The haemoglobin concentration was 11.2 g/dl, with a normochromic normocytic film; the white cell count, differential, and platelet count were normal.

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Correspondence to Dr T. M. Chalmers.
insipidus associated toxic agents, granuloma. and cases markedly been merely considered Up the nervous granulomatosis, matoid symptoms. Churg-Strauss Discussion granulomatosis Wegener's Anterior pituitary Table 1

<table>
<thead>
<tr>
<th></th>
<th>Plasma osmolality (mosmol/kg)</th>
<th>Urine osmolality (mosmol/kg)</th>
<th>Urine volume (ml/h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desmopressin test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before 2 µg DDAVP</td>
<td>302</td>
<td>169</td>
<td>240</td>
</tr>
<tr>
<td>muscularly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 hours after</td>
<td>297</td>
<td>521</td>
<td>30</td>
</tr>
</tbody>
</table>

Anterior pituitary function tests

<table>
<thead>
<tr>
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<th>Plasma osmolality (mosmol/kg)</th>
<th>Urine osmolality (mosmol/kg)</th>
<th>Urine volume (ml/h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSH</td>
<td>1-1 IU/l</td>
<td>(&lt;5-7)</td>
<td></td>
</tr>
<tr>
<td>Serum T3</td>
<td>99 mmol/l</td>
<td>(45-145)</td>
<td></td>
</tr>
<tr>
<td>Prolactin</td>
<td>203 mU/l</td>
<td>(60-380)</td>
<td></td>
</tr>
<tr>
<td>FSH</td>
<td>56 IU/l</td>
<td>(&lt;26)</td>
<td>—Postmenopausal levels</td>
</tr>
<tr>
<td>LH</td>
<td>57 IU/l</td>
<td>(&lt;25)</td>
<td>—Postmenopausal levels</td>
</tr>
</tbody>
</table>

TSH = thyroid-stimulating hormone. T3 = tri-iodothyronine. FSH = follicle-stimulating hormone. LH = buteinising hormone.

Discussion

Wegener's granulomatosis is characterised by granulomatous lesions of the upper and lower respiratory tract, necrotising vasculitis, and glomerulonephritis, and the patient often presents with upper respiratory symptoms. It is to be distinguished on clinical and pathological grounds from lymphomatoid granulomatosis, polyarteritis nodosa, Churg-Strauss vasculitis, and lethal midline granuloma. Joint symptoms occur in up to 60% of cases and are usually mild, frank synovitis being rare. Up to 50% of cases also have involvement of the nervous system. Though the disease was formerly considered to be always fatal, the prognosis has been markedly improved by the introduction of cytotoxic agents, particularly cyclophosphamide.

Our patient illustrates 2 unusual features. Diabetes insipidus associated with Wegener's granulomatosis has previously been reported in only 4 patients. Although local extension of granuloma into the hypothalamus from the sinuses may be responsible, we could find no evidence of this on x-ray or CT scan of the skull, and there was no evidence of anterior pituitary dysfunction. The lesion was thus localised and probably due to vasculitis or to local granuloma formation. A previously reported case of diabetes insipidus complicating Wegener's granulomatosis responded well to cyclophosphamid therapy. The lack of response in our patient suggests that frank infarction had occurred.

A further unusual feature is the 9 months' history of preceding frank polyarthritis. Although polyarthritis can accompany Wegener's granulomatosis it is usually mild and does not precede the development of other symptoms by more than 3 months. The diagnostic criteria for rheumatoid arthritis do not specifically exclude Wegener's granulomatosis, and diagnostic confusion with rheumatoid arthritis may occur. This is clearly a problem in the early stages of the disease when classical features of Wegener's granulomatosis may be absent, and many patients have weakly positive tests for rheumatoid factor. Our case clearly underlines the diagnostic value of respiratory sinus mucosal biopsy even when the mucosa is macroscopically normal, and we believe that earlier biopsy of our patient could have provided the diagnosis before the onset of life-threatening systemic disease.

References

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