CASE REPORT

Familial neurohypophyseal diabetes insipidus due to a novel mutation in the arginine vasopressin–neurophysin II gene

M de Fost 1, A S P van Trotsenburg 2, H M van Santen 2, E Endert 3, C van den Elzen 4, E J Kamsteeg 4, D F Swaab 5 and E Fliers 1

1Department of Endocrinology and Metabolism, Academic Medical Center, University of Amsterdam, Meibergdreef 9, Room F5-166, 1105 AZ Amsterdam, The Netherlands, 2Department of Pediatric Endocrinology, Academic Medical Center, Emma Children’s Hospital, University of Amsterdam, 1105 AZ Amsterdam, The Netherlands, 3Laboratory of Endocrinology and Radiochemistry, Department of Clinical Chemistry, Academic Medical Center, 1100 DD Amsterdam, The Netherlands, 4Department of Human Genetics, Radboud University Nijmegen Medical Center, 6500 HB Nijmegen, The Netherlands and 5Netherlands Institute for Neuroscience, An Institute of the Royal Netherlands Academy of Arts and Sciences, 1105 BA Amsterdam, The Netherlands

(Correspondence should be addressed to M de Fost; Email: m.defost@amc.uva.nl)

Abstract

Background: Familial neurohypophyseal (central) diabetes insipidus (DI) is caused by mutations in the arginine vasopressin–neurophysin II (AVP–NPII) gene. The majority of cases is inherited in an autosomal dominant way. In this study, we present the clinical features of a mother and her son with autosomal dominant neurohypophyseal DI caused by a novel mutation.

Case: A thirty-four-year-old woman and her three-year-old son were evaluated because of polyuria and polydipsia since the age of 1.5 years onwards. Both patients were subjected to a water deprivation test confirming the diagnosis of central DI. Magnetic resonance imaging of the brain of the mother showed a hypothalamus without apparent abnormalities and a relatively small neurohypophysis without a hyperintense signal. Mutation analysis showed a c.322G>T (p.?’p.Glu108X) in Exon 2 of the AVP–NPII gene in both mother and son.

Discussion: This study reports neurohypophyseal DI in a mother and her son due to a novel mutation in Exon 2 of the AVP–NPII gene. Clinical and pathophysiological aspects of this disease are shortly reviewed and discussed.

European Journal of Endocrinology 165 161–165

Introduction

Neurohypophyseal (central) diabetes insipidus (DI) is characterized by impaired secretion of the antidiuretic hormone arginine vasopressin (AVP) resulting in polyuria and polydipsia. Under normal circumstances, the precursor hormone prepro-AVP is produced by neurosecretory cells in the supraoptic and paraventricular nuclei of the human hypothalamus (1–3). During axonal transport to the pituitary gland, prepro-AVP is cleaved to AVP and finally stored in the posterior pituitary (neurohypophysis). When water deprivation causes the plasma osmolality to rise above 280–290 mOsmol/kg, AVP is released into the circulation. In the collecting ducts of the kidney AVP binds to the vasopressin type 2 (V2) receptor, inducing up-regulation of the aquaporin II channels. This results in increased water retention with a rise in urine osmolality to a maximum of 1000–1200 mOmol/kg and a restoration of plasma osmolality to within the reference range (4).

Familial neurohypophyseal DI accounts for ~5% of all cases of central DI (5) and is caused by mutations in the AVP–neurophysin II (AVP–NPII) gene on chromosome 20p13 (6). The majority of cases is inherited in an autosomal dominant way, while only two families with recessive types have been reported (7, 8).

In this study, we present the clinical features of two patients with neurohypophyseal DI, not related to the earlier described Dutch families with this disease (9, 10), caused by a novel mutation in the AVP–NPII gene.

Case

A thirty-four-year-old woman was evaluated in the outpatient clinic of Endocrinology of the Academic Medical Centre because of polyuria and polydipsia, which had started at the age of 1.5 years. She drank an average of 8–10 l of water per day and had adjusted her life in such a way that she always had access to drinking water. Her medical history was otherwise unremarkable. She had no symptoms of neurological or pituitary dysfunction, nor a history of head trauma. Her menstrual cycle was regular. Her family history was unremarkable.
After exclusion of diabetes mellitus in childhood, she had not considered her drinking behavior to reflect a disease, assuming it was a peculiar habit, until she read an article in a Dutch newspaper on families with DI and recognized the symptoms. In addition, she also noticed that the older of her two sons, then 3 years old, had developed progressive polyuria and polydipsia over a period of 1.5 years. For instance, despite frequent changing of diapers his bed was wet every night and upon awakening the first thing he would ask for was water, often drinking 1 l immediately. Parallel to his large water intake, his food intake was low and he had a relatively low weight compared with his height. She contacted our outpatient clinic with a request for endocrine evaluation.

The mother underwent a water deprivation test, determining plasma osmolality, sodium and AVP concentration as well as urine volume and osmolality every hour (Fig. 1). After 6 h plasma sodium and osmolality had increased to 154 mmol/l and 299 mOsm/kg respectively. During the test she continued to have inappropriately dilute urine with an osmolality of 119 mOsm/kg and a diuresis exceeding 400 ml/h. Her body weight had decreased by 5.4%.

Plasma AVP (as determined, after solid phase extraction, by commercial RIA (Euro-Vasopressin, Euro-Diagnostica AB, Malmö, Sweden); detection limit 1.0 pmol/l; total assay variation 10–15% at 7.8 respectively 2.5 pmol/l) was undetectable at all time points. After intravenous administration of 2 µg minrin (desmopressin, or DDAVP), diuresis decreased to 0 and 125 ml/h during the last 2 h of the test respectively. Magnetic resonance imaging of the brain showed a relatively small neurohypophysis without a hyperintense signal, and no apparent abnormalities of the adenohypophysis or hypothalamus (Fig. 2).

Mutation analysis showed a heterozygous c.322G>T mutation in Exon 2 of the AVP–NPII gene. Since position c.322 is the final base of Exon 2, it lies within the consensus donor splice site of intron 2. Splice site prediction programs indeed showed a marked decrease in the confidence scores of this site, ranging from a 30% decrease to complete abolishment of this splice site, depending on the used program. However, it is unclear how the splicing machinery will process the pre-mRNA and what the effect on the protein level would be, which results in the nomenclature p.? for the protein change. Abolishment of the intron 2 donor splice site would very likely not lead to nonsense-mediated decay of the mRNA, as the 50–55 nucleotide rule will apply (11). Instead, it will very likely lead to a read-through into intron 2. There is no putative stop codon in the 174 bp long intron 2, suggesting that the entire (in-frame) intron would be inserted into the mRNA leading to an insertion of 58 amino acids into the AVP protein. Alternatively, a cryptic donor splice site may be encountered, leading to a shorter (in-frame) insertion.

Figure 1 Results of the water deprivation test in the mother. The vertical dotted line represents the moment of desmopressin administration. (A) Plasma sodium and osmolality. The horizontal dotted line represents the upper limit of normal. (B) Urine volume and osmolality.

Figure 2 T1 midsagittal fat saturated MRI of the brain showing a relatively small and hypointense neurohypophysis.
or a frame shift of the protein leading to an alternative stop codon. Altogether, if splicing is affected, the first 107 amino acids of the AVP gene will be present, followed by a unknown C-terminus (p.?/Glu108X). If splicing of the mutant pre-mRNA is nevertheless not affected, the c.322G>T mutation causes to change codon 108 from encoding a glutamic acid into a premature termination codon (p.Glu108X). Since it was not experimentally tested whether splicing is (partially) affected, the effect on the protein level could be both, resulting in the description p.?/Glu108X. Either way, the c.322G>T mutation represents a pathogenic AVP–NPII mutation causing central DI.

Treatment with oral desmopressin 0.1 mg 2–3 times daily was started. The patient now has a diuresis of 2–3 l/day and reports an improvement of her daily life that is no longer dominated by ascertaining sufficient access to drinking water.

Awaiting the gene mutation analysis of the mother, a water deprivation test was planned for her son. On the day of the test, the child spontaneously skipped his usual 1 l of drinking water on awakening. At entering the endocrine unit at 0900 h he weighed 7% less than a gain of 2.2 kg.

Discussion

This study describes a mother and her son with neurohypophyseal DI due to a novel mutation in Exon 2 of the AVP–NPII gene. They presented with a history of polyuria and polydipsia starting at the age of 1.5 years. The diagnosis was confirmed by a water deprivation test and DNA analysis.

At present, 62 mutations leading to neurohypophyseal DI have been reported (GenBank accession number M11166). All of these occur in the AVP–NPII gene, which is composed of four moieties encoding a signal peptide, AVP, NPII, and a glycoprotein of unknown function called copeptin (12). The majority of mutations, including those of the present family, have been found in the part of the gene encoding NPII, which is an intracellular binding protein for AVP. Only a few mutations have been localized to the signal peptide or the AVP coding sequence, and none in the glycoprotein moiety. It is assumed that all known autosomal dominant mutations cause defective folding or dimerization of the precursor (13).

Under normal circumstances the AVP protein forms homodimers, most probably in the endoplasmic reticulum (14). Mutant AVP-C67X also binds to the wild-type AVP, and the heterodimers are retained in the endoplasmic reticulum (14–17). It has been hypothesized that the accumulated mutant AVP heterodimers are cytotoxic, causing gradual but progressive loss of viable neurosecretory neurons, finally leading to AVP deficiency. In fact, a loss of neurons in the supraoptic and paraventricular nuclei of the hypothalamus, in particular of the magnocellular neurons, has been shown in transgenic mice (16) as well as in brain autopsy studies in cases of familial neurohypophyseal DI (18–20). The mechanism of cytotoxicity of the accumulated mutant AVP could explain the dominant inheritance pattern, the onset after the first year of life and the progressive nature of neurohypophyseal DI. In line with this, radiological studies show a gradual loss of the bright spot in the posterior pituitary as neurohypophyseal DI patients age (21). As suggested earlier, the c.322G>T mutation is expected to result in an AVP mutant with a different C-terminus (starting at codon 108) and/or in a truncated protein (p.?/p.Glu108X). It is, therefore, very likely that the p.?/p.Glu108X mutants are also able to heterodimerize with wild-type AVP considering that the C67X mutant is able to bind with wild-type AVP, indicating that the binding site resides within the first 66 amino acids of the AVP protein. The dominant inheritance in this family would be consistent with this reasoning.

Apart from its peripheral effects, AVP exerts central effects as a neuromodulator or neurotransmitter, mediated by centrally projecting AVP containing neurons in the paraventricular nucleus and in a number of additional hypothalamic nuclei such as the suprachiasmatic nucleus, the bed nucleus of the stria terminalis, the anteromedial subnucleus of the basal nucleus, and the diagonal band of Broca (1). These projections form the anatomical basis for central effects of AVP on mental functions including learning, memory, and social behavior (22). At present, it is not completely clear whether and how much these functions are affected in patients with central DI. A study on neuropsychological function in 23 neurohypophyseal DI patients, who were compared with non-affected family members and unrelated volunteers, did show minor disturbances in memory retrieval and sustained attention (23). The reason, why in patients with central DI abnormalities in central brain functions appear relatively small, compared with the major disturbance in osmoregulation, is not clear. One explanation could be that fewer parvocellular AVP neurons are lost compared with the magnocellular neurons of the hypothalamo-hypophyseal system (22), as a result of higher production rates of AVP in
the latter (24). Alternatively, the plasticity of the developing brain may be high enough to compensate for the loss of one particular neuropeptide, whereas the specific antidiuretic effect in the kidney via the V2 receptor cannot be compensated for by another peptide hormone.

Of interest is that the mother had noted two distinct periods during which the symptoms had changed in a major way. During pregnancy the symptoms had been worse, probably due to increased vasopresinase activity by the placenta, leading to increased degradation of the already sparse AVP (25). On the contrary, during labor, she had noticed a dramatic improvement of her polyuria and polydipsia. It is tempting to speculate that this is related to the increase in plasma oxytocin during late pregnancy and labor from ~17 to 45 pmol/l, which is 50 times higher than AVP concentrations (26). The sequence of oxytocin differs from AVP by only 2 amino acids, explaining why oxytocin has a mild antidiuretic effect via the V2 receptor in the rat kidney (27).

Declaration of interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

Funding

This research did not receive any specific grant from any funding agency in the public, commercial or not-for-profit sector.

Acknowledgements

The authors thank Martine van Vessem for her skilled assistance during the water deprivation test.

References


3 Flies E, Swaab DF. Pool CW & Verwer RW. The vasopressin and oxytocin neurons in the human supraoptic and paraventricular nuclei; changes with aging and in senile dementia. Brain Research 1985 342 45–53. (doi:10.1016/0006-8993(85)91351-4)


5 Baylis PH & Cheetham T. Diabetes insipidus. Archives of Disease in Childhood 1998 78 84–89. (doi:10.1136/adc.79.1.84)


Received 7 April 2011
Accepted 15 April 2011