



SDI Review Form 1.6

Journal Name:	International Journal of Medical and Pharmaceutical Case Reports
Manuscript Number:	Ms_IJMPCR_43679
Title of the Manuscript:	Dipsogenic Form of Primary Polydipsia in a Young Man and an Emerging Treatment Modality.
Type of the Article	Case study

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound. To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Compulsory REVISION comments	<p>The submitted manuscript is well written and the case adequately described. However, some concerns should be raised about some specific issues:</p> <ul style="list-style-type: none"> - As dipsogenic diabetes insipidus is a rare condition, it would be interesting to have the thirst scale obtained during dehydration test or during hypertonic saline infusion, as well as measurements of AVP or copeptin throughout the tests, and not only in basal condition. What were the limitations to perform hypertonic saline infusion test? - Although partial central DI usually attained maximal urinary osmolality below 600 mOsm/Kg, some patients concentrate urine above this value. Of note is the high levels of plasma osmolality after 4 h of dehydration, a value usually observed in patients with neurogenic DI, and rarely seen in controls or primary polydipsia. -The early age of initial polydipsia-polyuria also is of note. Indeed, psicogenic DI is rare in children. However, in familial neurohypophyseal autosomal dominant DI (FNDI) the deficiency of AVP is partial and may remain so for several years, with maintenance of T1 hyperintense signal of the neurohypophysis still present, with progression to severe DI years later. Additionally, in untreated children with DI, the constant need for water tend to induce a behaviour of thirst beyond sodium correction. Therefore, <i>AVPNPII</i> gene should be sequenced to exclude FNDI and a discussion of this particular DI aetiology should be added in the viewpoint of this particular case. - Why the authors made the choice for subcutaneous and not nasal or oral DDAVP? Subcutaneos DDAVP is not usually might have longer half-life, exposing the patient to water intoxication. 	<p>Limitations to hypertonic saline testing, sequencing for <i>AVPNPII</i> gene and other specialised test was due to inability of patient to afford further investigations during the course of his treatment, and this has been noted in the report.</p> <p>Discussion on adNFDI as a possible aetiology has been added to the report. The value of serum osmolality stated to be 316mOsm/kg after 4 hours of water deprivation test was an error, as the value of 297mOsm/kg was contained in the original laboratory report.</p> <p>The choice of subcutaneous desmopressin was because of its availability while managing the patient, as nasal and oral DDAVP were not available for use then.</p>
Minor REVISION comments		
Optional/General comments		