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before GH replacement. Complete information on all MetS components were collected. MetS was defined according to the National Cholesterol Education Program's Adult Treatment Panel III (NCEP) and the International Diabetes Foundation (IDF). The prevalence of MetS was calculated, and associations were assessed between baseline variables and MetS.
Results
MetS was present in 14.9% (NCEP) and 31.8% (IDF) of our patients, lower than data from KIMS analysis (43.1%) and similar from the normal population (20–30%). The prevalences of MetS components (NCEP) were: waist circumference 26.5%, HDL 45%, triglycerides 47.8%, hyperglycaemia 4.3% and hypertension (14%). No childhood-onset patient fulfilled the definition of MetS, while 23.3% of adult-onset patients were diagnosed. The prevalence was higher in women (25 vs 5.8%, non-statistically significant). Mean age and GHD duration before GH replacement were similar among MetS and no-MetS patients; MetS patients had higher glycaemia ($P=0.005$), triglycerides ($P<0.001$), waist circumference ($P<0.001$), lower HDL-cholesterol BMI ($P=0.001$), and were shorter ($P=0.034$) than no-MetS patients.
Conclusion
The prevalence of MetS in our GHD patients were lower than KIMS study. That could be influenced by a lower age in our patients (13 years younger). However, we should diagnose and treat MetS components as they could contribute to the increased risk of cardiovascular morbidity and mortality found in GHD patients.
Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research project.
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P1515

Familial central diabetes insipidus with extremely high water intake

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Water intake in central diabetes insipidus (CDI) usually falls in range of 3–20 l a day. Intake of more than 20 l is regarded as physiologically unnecessarily even in the absence of antidiuretic hormone. We describe a family with 8 members suffering from autosomal recessive form of CDI due to mutation C105Y (codon numeration is given for preprovasopressin) in AVP gene. In all family members disease had presented in neonatal period or early childhood. It is remarkable that without desmopressin the water intake/output ranges from 30 to 34 l a day and is up to 3–4 l on 0.8 mg of oral desmopressin.
Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research project.
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P1516

Visceral adiposity index is associated with insulin sensitivity and adipocytokine levels in newly diagnosed acromegalic patients

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Background
The Visceral Adiposity Index (VAI) has been suggested as a new gender-specific marker of visceral adipose dysfunction, strongly associated with insulin sensitivity in patients with cardio-metabolic risk.
Aim
To test VAI in active acromegaly for the assessment of disease-associated metabolic risk evaluating its association with hormonal data, adipocytokine levels, insulin sensitivity and secretion parameters in a cohort of 27 subjects (15 M, 12 F, mean age 54.9 years).
Methods
Glucose, HbA1c, nadir and AUC of GH during OGTT, AUC of C-peptide (CP) during a mixed-meal tolerance test (MMTT), M value during an euglycemic hyperinsulinemic clamp, leptin, adiponectin, TNF-α, IL-6 were evaluated in newly diagnosed patients grouped into those with normal (Group A, No 15; 55.5%) and high VAI (Group B, No 12; 44.5%).
Results
VAI value was positively correlated with age of patients ($P=0.048$), basal, nadir and AUC of GH ($P=0.001$, 0.007 and 0.002, respectively), IGF1 ($P=0.001$), TNF-α ($P=0.010$) and negatively with adiponectin ($P<0.001$). Group B showed 1) significantly higher levels of basal GH ($P=0.018$), AUCGH ($P=0.047$), IGF1 ($P=0.047$) and AUCCP ($P=0.018$); 2) significantly lower M value ($P<0.001$) and adiponectin levels ($P<0.001$); 3) higher prevalence of systolic blood pressure ($P=0.006$) and impaired glucose tolerance ($P=0.001$).
Conclusions
In active acromegaly, VAI appears to be independently associated with hormonal parameters, insulin sensitivity and secretion indexes, adiponectin and TNF-α levels. Therefore, VAI could be used as a new easy tool in daily clinical practice for the assessment of metabolic risk associated with active acromegaly.
Declaration of interest
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	Acromegalic patients with normal VAI (Group A) No 15 (55.5%)	Acromegalic patients with high VAI (Group B) No 12 (44.5%)	P
Basal GH (μg/l)	3.3 (1.20–9.70)	32 (3.10–36)	0.018
Nadir GH (μg/l)	5.50 (2–8.80)	19 (2.10–35)	0.082
AUCGH	763 (345–997)	3700 (525–4230)	0.047
IGF1 (ULN)	1.61 (1.03–2.16)	2.40 (1.40–3.50)	0.047
Fasting glucose (mmol/l)	6.16 (5.58–6.49)	5.94 (4.72–6.33)	0.082
M value (CLAMP)	3.30 (3.14–4)	1.65 (1.42–2.70)	<0.001
AUCCP (MMTT)	351 (279–421)	769 (331–821)	0.018
HbA1c (%)	5.8 (5.45–5.90)	5.70 (5.10–6.70)	0.392
Leptin (ng/ml)	4.80 (2.80–18.45)	6.10 (2.40–9.60)	0.865
Adiponectin (μg/ml)	10.50 (9.10–15.95)	4 (3.40–7.20)	<0.001
TNF-α (ng/ml)	1.30 (1.05–3.05)	3.30 (1.10–4)	0.082
IL-6 (pg/ml)	1.72 (1.35–2.07)	1.48 (1.06–1.80)	0.252

P1517

Isolated diabetes insipidus happened during premenopause solution ten years after

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Pathologies of pituitary gland are often revealed by diabetes insipidus. Etiologies are, in first, tumors, inflammatory and granulomatosis diseases after, but stay idiopathic in 24% of French study, 52% of Italian study and 33% of Tunisian study.
Case report
Mrs A., 53 years old, consults in 1998 because polyuria–polydipsia, without diabetes mellitus. She is hospitalized during 2 days and hydric restriction test shows the organic reality. The others neuro-endocrine explorations stay unproductive, without confirmation of appearance of menopause. The brain and hypophysis examination by CT scan is found normal. The MRI shows pituitary stalk "thick", but lightly…And, haematologic perturbation, or inflammatory syndrome, or osteo-arthritis pain, or cardiovascular or nephrologic perturbation don't exist, and treatment by MinirinR has permitted to get back stabilized health status. The next MRI controls, executed at 6 and 24 months later, are perfectly stable, and so is clinical status. During 2008, Mrs A., consults because undulant fever and asthenia. Physical examination permits to discover bilateral tibia pain, erythematous lesions on the neck and thorax. Cutaneous biopsy, myelogram and bone biopsy permit to obtain diagnosis of Erdheim Chester syndrome, it's to say non Langerhans histiocytosis which aims are cardiovascular system, central and peripherical nervous system and the bone.
The initial having few symptoms situation can explain the time for diagnosis establishment. Nevertheless, in the beginning of the story, it was not justified to propose chemotherapy and supervision stayed justified.
Declaration of interest
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