**Diabetes Insipidus (DI) Following Traumatic Brain Injury**

Onset of dilute polyuria in the setting of TBI: **UOP > 300 ml/hour**

Other reasons for diuresis: Diuretics, large resuscitation, mannitol, hyperglycemia, cerebral salt wasting?

- Yes → **Address cause of polyuria**
- No → **Urine Specific Gravity < 1.005**
  - Hypernatremia greater than clinically desired than goal set by Trauma or Neurosurgery

- Yes → 
  1. Start DDAVP 0.5-2 mcg IV q12 hours (May increase frequency to q8 hours)
  2. Replace volume losses with balanced solution crystalloid if hypovolemic. (Ex. Plasmalyte, LR)
  3. If slow response to DDAVP, may consider correcting free water deficit with D5W/enteral fluids (At discretion of attending)

- No → Once sodium and urine output begin to correct to acceptable range, consider decreasing or discontinuing DDAVP and/or modify fluid replacement

**During therapy:** Check electrolytes at least q4 hours in the acute phase, follow urine specific gravity, strict I&Os, and be aware that sodium should **NOT** rise or fall > 1mEq/h
References


*Updated/Revisions:*
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