INTRODUCTION

It is estimated that between 10% and 15% of all children over 5 years of age wet themselves accidentally. Whilst the vast majority of these children will cure themselves with time, about 2% have an anatomical anomaly which needs correcting. Even in the functional cases treatment modalities exist to relieve symptoms and help keep the child dry.

Definitions:

Enuresis is defined as accidental wetting in children over 5 years of age. Primary enuresis occurs in children who have never been dry for a significant period of time. Secondary enuresis on the other hand occurs when the child starts wetting after a period of dryness of 6 months or more. Nocturnal - or night-time - enuresis is the commonest form and is 3 times commoner in boys. Daytime enuresis can occur alone, or together with nocturnal enuresis.

Causes:

The vast majority of children with enuresis have a functional anomaly. The commonest form of this is detrusor instability. The bladder wall in these cases has a tendency for spontaneous contraction resulting in urgency and wetting if the child does not go to the toilet at once.

Recent findings have shown that many children with nocturnal enuresis have a relative lack of vasopressin secretion at night. Vasopressin, which decreases the volume of urine by allowing increased tubular reabsorption, is normally secreted in larger quantities at night. In some children with nocturnal enuresis, this night-time increase in the production of vasopressin is absent.

It has also been postulated that there may be a genetic basis for enuresis. In fact in many cases of primary enuresis there is a strong family history. The risk of a child having enuresis is over 70% if both parents were enuretic in childhood, 40% if one parent had enuresis and only 10% if neither parent was wet as a child.

In about 2% of enuretics there is an underlying anatomical basis for the wetting. This could vary from spinal problems leading to a neuropathic bladder, to posterior urethral valves, to an ectopic ureter. In other cases urological anomalies lead to urinary tract infections which in turn cause the enuresis.

Management:

An important part of the management of enuresis is to exclude an underlying anatomical problem. It is also wise to exclude less common conditions such as childhood diabetes and diabetes insipidus. This usually involves testing the urine for infection, as well as for glucose and sodium. An ultrasound scan of the renal tract is indicated if there is suspicion of an ectopic ureter (this is often part of a duplex system) or if there is a proven urinary tract infection. An ectopic ureter is diagnosed as the source of enuresis by performing the Methylene Blue Test. This involves filling the bladder with the dye and placing a pad in the child’s underpants. If the resultant wetness is colourless then the urine must be coming from outside the bladder, i.e. from an ectopic ureter.

In cases of long standing enuresis or suspected spinal problems, urodynamic studies are essential to look for signs of a neuropathic bladder.

Treatment:

In most cases treatment is expectant once an anatomical abnormality has been excluded. Indeed spontaneous resolution occurs at the rate of 15% per annum.

However for those children, or families, to whom wetting is becoming distressing and stressful, one should advise pharmacological treatment to relieve symptoms until the child cures himself with time. Thus for daytime enuretics Oxybutanin is often effective in decreasing the frequency of accidents. For nocturnal enuretics, intranasal Desmopressin will help in about 70% of cases.

Bed wetting alarms and bladder training programmes have been advocated as being successful by many but are often impractical and time consuming.

Of course if an anatomical problem is discovered this must be treated in its own right.

Conclusion:

Enuresis is a common condition in childhood. Because many parents of enuretic children were wetters themselves, many families tend to take a philosophical attitude towards the problem and suffer in silence. The general practitioner has a role in advising these families that treatment for keeping these children dry exists and is readily available.
REFERENCES


FIRST ANNOUNCEMENT

As infectious diseases threaten to become the major medical challenge of the new millennium, it is vital that health care professionals are brought up-to-date with the latest developments in the prevention, control and treatment of infections in both hospital and community settings.

This conference will include a morning plenary session with three state-of-the-art lectures. A choice of concurrent symposia on nosocomial infections, infection control and community infections will be held in the afternoon. Topics include MRSA, antibiotic resistance sensible antibiotic prescribing, treatment algorithms for community infections, needlestick injuries.

Two world renowned experts from the Hospital Infection Division of the Public Health Laboratory (UK).

Dr. Barry Cookson & Ms. Linda Taylor will participate at this one-day session.

You are cordially invited to participate in what certainly will be a multidisciplinary educational experience not to be missed.

FIRST MALTESE CONFERENCE ON INFECTION CONTROL & ANTIBIOTIC THERAPY

ORGANISED BY THE INFECTION CONTROL UNIT ST. LUKE'S HOSPITAL

IN COLLABORATION WITH C.M.E. COMMITTEE AND THE MALTA COLLEGE OF FAMILY DOCTORS

Saturday 6th November 1999
New Dolmen Hotel, Bugibba

Further details can be obtained from the organisers
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