GUEST EDITORIAL

Nocturnal enuresis: A call for advocacy

Significant progress has been made since the 1960s, when enuresis was classified as a 'psychophysiological symptom of psychopathology' by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders*, 2nd edition (DSM-II).[1] Contemporary evidence suggests that the aetiology is complex and involves a combination of physiological, psychological, genetic and environmental components. Although epidemiological studies have consistently reported high prevalence rates, this condition is often underdiagnosed and undertreated, as only half of the patients seek medical care.[2,3] Failure to seek care can be driven by the patient's sense of embarrassment, or the carer's misconception that enuresis is incurable or that the child will eventually 'grow out of it'.[4] In a developing country, where most of the population has limited education, these situations are particularly prevalent. Many individuals in this setting lack a comprehensive understanding of the condition and mistakenly view it exclusively as a behavioural problem. Children often share beds with other people, including adults, and anger, frustration and disgust are just some emotions directed against the child by others in their ignorance. Children are often subjected to punishment or public humiliation following episodes of enuresis, with the intention of teaching them a lesson.[5] Such children become isolated, lack self-esteem, and have poor academic and occupational performance. When medical help is intentionally sought for the patient, urotherapy, alarms and medication are expensive, making compliance and treatment success a challenge in developing countries.

New statistical methods applied to longitudinal population studies[6-8] have shed important light on certain aspects of enuresis. Under the age of 10 years, bedwetting less than every night is common, with a tendency to improve and resolve spontaneously. However, nightly wetting is uncommon at any age (1% of children at 7.5 years of age), and is associated with a low spontaneous resolution rate and underlying bladder dysfunction. A child bedwetting nightly after 10 years of age almost invariably has compromised nocturnal bladder capacity, most commonly due to bladder overactivity, but also other bladder dysfunction. The presence of bladder dysfunction is a poor prognostic feature for spontaneous resolution and is not always apparent from the history. Bladder outlet obstruction can also be missed in boys, and careful questioning about the urinary stream is important. In addition, secondary-onset enuresis in the 6th/7th year of life is a recognised pattern and often remains persistent. It was traditionally associated with emotional/behavioural triggers, but it is mirrored in daytime urinary incontinence trajectories,[7] so it is more likely to be caused by the onset of bladder dysfunction. Finally, if a child has monosymptomatic nocturnal enuresis at 9.5 years of age, their odds ratio for enuresis at 14 years of age is 3.5, and 23 in the case of non-monosymptomatic nocturnal enuresis.[8] There is therefore no guarantee that the older child with bedwetting will 'grow out of it', and skilled assessment and directed management are warranted in this group.

In view of the high prevalence of enuresis, its psychological impact, adverse effects on quality of life for both the child and the family, and long-term consequences in adulthood, this issue of CME presents the South African guidelines on primary monosymptomatic enuresis (PMNE). Deficiencies in undergraduate and postgraduate training have resulted in lack of confidence on the part of doctors in managing urinary incontinence in children.[9] Clinicians typically lack the necessary expertise to detect psychopathology during a brief 10 - 20-minute consultation. Furthermore, they do not have the time or specific techniques to encourage parents and children to comply with therapy effectively.[10] We hope that this resource will be invaluable to healthcare practitioners at all levels of care. Enuresis is not the child's fault, and healthcare practitioners need to empower themselves and advocate for the child who has this problem, while appreciating the burden that may be placed on the parents and family.

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