ENURESIS: OUTCOME OF TREATMENT

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SYNOPSIS

A clinical study of 40 patients with enuresis seen at the Child Psychiatric Clinic in 1982-84 showed that 39 patients were referred by medical practitioners. The sex ratio showed more boys with enuresis. 29 patients were from age groups 7—9 and 12—13. 33 patients had primary enuresis and 18 had a family history of bedwetting. 19 were last-born children. Medication was used to treat 16 patients and another 15 were treated using Star Charts. The improvement rate was 58%.

INTRODUCTION

In the DSM-III (1), enuresis is defined as repeated involuntary voiding of urine during the day or at night. It occurs at least twice a month for children between the ages of 5 and 6 and once a month for older children.

Enuresis is referred to as "primary" if the child has never become dry and as "secondary" if he has been dry for a period of at least one year.

A patient may wet by night (nocturnal enuresis) or by day (diurnal enuresis) or both. In clinical practice, nocturnal enuresis forms the bulk of the referrals. The majority prove to be due to developmental delay. Primary enuresis tends to run in families.

PATIENTS AND METHOD

This is a retrospective study of 40 consecutive patients with enuresis referred in 1982 to 1984 and seen by the author at the Child Psychiatric Clinic.

Besides the psychiatric interview, all patients had a physical examination and a urinalysis.

The data were collected from the clinical case sheets.

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RESULTS

The characteristics of this group of 40 patients are presented as follows:

a. Sex ratio

22 boys and 18 girls.

b. Age distribution

Boys, age ranged from 7-13 years, average 10 years 2 months.
Girls, age ranged from 4-16 years, average 10 years 7 months.

c. Ordinal position

1st child:	10 patients
Middle child:	7
Last child:	19
Only child:	4
	40

d. Types of enuresis

Primary enuresis 33 patients (including 1 with nocturnal and diurnal enuresis and 1 with soiling).
Secondary enuresis 7 patients (including one with nocturnal and diurnal enuresis).

e. Family history of enuresis

12 patients had a parent or sib with history of enuresis and another 6 had other relatives with history of enuresis.

f. Sources of referral

By Outpatient Clinics	15 patients
School Clinic, (Institute of Health)	9
Private Medical Practitioners	7
General Hospitals	7
Child Psychiatric Clinic	1
Ministry of Education	1
	40 patients

TREATMENT

After the history-taking, physical examination and urinalysis, the diagnosis and treatment plan were discussed with the parents and the patients.

As part of the treatment programme, the patient was asked to pass urine before going to bed each night. He should try not to drink too much water before bed-time.

All patients were started on the "Star Chart" for 2 to 4 weeks. A star sticker was pasted daily on the chart on those nights he was dry. The parents were to praise him for the dry nights. At the Clinic, he was also praised by the doctor for keeping the bed dry.

The improvement criterion was taken as no more than 2 wet nights per month.

When there was no improvement on the Star Chart, medication with Tablet Imipramine 25 mg at night was used. 3 patients had their dosage increased to 50 mg and 1 had a change of medication to Tablet Amitriptyline. None of them complained of side-effects.

The treatment regime was distributed as follows:

No. of patients on medication:	16
No. of patients on Star Chart:	15
No. of patients seen for consultation only:	8
No. of patient referred to paediatrican for urinary tract infection	1
	40

Duration of treatment varied from 4 weeks to 18 months (average 17 weeks) for those on medication and from 4 weeks to 6 months (average 12 weeks) for those on Star Charts.

A total of 31 patients were taken on for treatment. The outcome of treatment was as follows:

No. of patients improved on medication:	12
No. of patients improved on Star Chart:	11
No. of patients with no improvement on medication:	4
No. of patients with no improvement on Star Chart:	4
	31

Short-term improvement rate was 74% (23 out of 31 patients). However, 5 patients (4 of them had primary enuresis and 4 out of these 5 were aged more than 10 years) on medication relapsed when medication was stopped, thus giving an improvement rate of 58% (18 out of 31 patients).

DISCUSSION

In 1983, Lim (2) reported the results of treating 5 children with primary nocturnal enuresis in Singapore using a responsibility-reinforcement approach. The cure criterion was based on 14 consecutive dry nights irrespective of period of therapy. The cure rate was 60%.

In the present study, regarding the characteristics of this group of 40 patients, it is interesting to note that 15 patients came from the age group 7-9 years and another 14 from the age group 12 and 13 years. Some parents seemed tolerant of the children's condition and sought treatment late, although there were some who were worried if the enuresis was symptomatic of kidney disease. Bedwetting was kept a family secret. 18 patients had a family history of enuresis.

The diagnostic types of enuresis conform to textbook description that primary enuresis forms the majority of referrals. The sources of referral indicate that parents in Singapore recognise enuresis as a medical condition.

Regarding treatment, it is important to exclude organic causes of enuresis especially in teenagers. Not all cases of enuresis need to be referred to a child psychiatrist. Most can very well be treated by medical practitioners and paediatricians. Cases in which a psychiatric referral is indicated include the following:

1. The enuresis is associated with behaviour or emotional problems.
2. The enuresis is an expression of strained parent-child relationship or ineffective parenting eg. punitive, rejecting parents, overprotection and infantilization of the child and
3. No improvement to supportive and medical treatment and the parents and/or the patients are very distressed.

Some parents are rather shy to report to doctors that their children are still bed-wetting. It may be helpful if doctors routinely inquire if a child-patient over the age of 5 years has bed-wetting. Prevalence studies in other countries report that about 10% of children still wet their beds at age 5 years. A tell-tale sign is a child who smells of urine or has rashes on the buttocks or the thighs.

REFERENCES

1. The American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders 3rd Ed. Washington: 1980.
2. Lim C L: Enuresis in Children. Sing Med J 1983; 24: 363-6.