Editorial Comment

Re: Family compliance with the use of alarm devices in the treatment of monosymptomatic nocturnal enuresis

Childhood enuresis is one of the most distressing medical and social conditions that could a child and his/her parents can face. The prevalence of nocturnal enuresis was suggested to be between 15-22% of boys and 7-15% of girls at 7 years of age.[1,2] Moreover, 7 out of 100 children wetting bed at age 7 will take this condition into adulthood. It is extremely important to remember that treatment is unnecessary in younger childen in whom spontaneously cure is likely.[3] Initial conservative therapeutic approaches should be considered first. Explaining the situation and treatment options to the child and parents are important. A strong motivation is a must and success depends not only to child's compliance but also the parents should have a high compliance. EAU guideline suggests alarm treatment to be the best option for arousal disorder (LE:1, GR:A).[3] However, family compliance problems were suggested to be the most important issue and a limitation of this modality.[3] In this article, Oğuz et al, [4] pointed to an important aspect of alarm treatment in monosymptomatic nocturnal enuresis. This effort should be congragulated since they examined the family compliance with alarm device in the treatment of this condition. The results revealed that almost a quarter of parents who were suggested to use the device declined to start treatment with this option. Moreover, 46% of families never purchased the device, and only 19 families were eligible for evaluation. Enuretics who did not use the device were reported the limitations as follows: decreased bedwetting episodes, unable to pay additionally, had negative feedback from neighbours, disturbing noise, child rejection and very frequent breakdown of the device. The reluctancy of the parent which is the crucial factor examining family compliance was present in only 3 parents. Thus, it limits the interpretation of results. Similarly, authors did also acknowledged that the study is in retrospective nature and they could include only 19 families since majority of the parents did not comply with the treatment which restricted the number of participants. It would have been more informative and guide better if the authors examined social background of the families, compliance with respect to age, the literal status of parents, school year of child, house environment and some other demographic parameters. These need to be clarified in large scale prospective studies. Nevertheless, as authors stated this is the first study in Turkey that will guide physicians in choosing proper treatment alternatives according to the child's and parents' compliances to the alarm device.

Rahmi Onur
Department of Urology, Fırat University Faculty of Medicine, Elazığ, Turkey

References

1. Butler RJ, Golding J, Heron J. Nocturnal nuresis: a survey of parental coping strategies at 7 ½ years. Child: Care, Health and Development 2005;31:659-67. [CrossRef]
2. Verhulst FC, Van der Lee JH, Akkerhuis GW, Sanders-Woudstra JAR, Timmer FC, Donkhorst ID. The prevalence of nocturnal enuresis: do DSM III criteria need to be changed? J Child Psychology Psychiatry 1985;26:989-93. [CrossRef]
3. Tekgül S, Riedmiller H, Dogan HS, Hoebeke P, Kocvara R, Nijman R, et al. Monosymptomatic Enuresis: EAU Guidelines, Pediatric Urology 2013:47-9.
4. Oğuz U, Sarıkaya S, Özyuvalı E, Şenocak Ç, Halis F, Çiftci M, et al. Family compliance with the use of alarm devices in the treatment of monosymptomatic nocturnal enuresis. Turkish J Urol 2014;40:52-5.

Submitted:
14.02.2014

Accepted:
20.02.2014

Correspondence:
Rahmi Onur
Department of Urology, Fırat University Faculty of Medicine, Elazığ, Turkey
Phone: +90 424 212 85 25
E-mail: rahmionur@yahoo.com

Available online at
www.turkishjournalofurology.com