NOCTURNAL ENURESIS- CASE REPORT OF A 22 YEAR OLD FEMALE

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Nocturnal enuresis is a common condition that causes physiological distress to the patient. It is even an embarrassment for the whole family. Usually the family members bring patients to the hospital at a very young age. Due to lack of medical facilities and the stigma attached to visit a psychiatrist few people avoid this problem and think that it will be cured by itself. Nocturnal enuresis, commonly known as "Bed Wetting", is a condition in which patients experiences urinary incontinence (unintentional leakage of urine) which occurs in children ≥5 years of age.

Nocturnal enuresis is further subdivided into primary and secondary types. Primary type of nocturnal enuresis refers to the presence of bed wetting in a child ≥5 years old who has never attained a bladder control (≥6 months) of consistent nighttime dryness. Secondary type of enuresis on the other hand is the presence of bed wetting in a child ≥5 years old who has attained an asymptomatic period (≥6 months) of consistent nighttime dryness in the past. Studies show that it is most commonly triggered by an unusually stressful life event, significant enough to cause psychosocial regression.[1,2,3]

Enuresis or bed-wetting has very long history and it is know as an illness since centuries. The term enuresis is derived from a Greek word "enurein" which means to "void urine." In the past many sadistic treatments were also used to cure the disease. However the first effective treatment was the use of bell and pad method of conditioning which still is considered to be an effective and widely used treatment. This treatment is based on negative reinforcement technique where the bell rings when the patient passes urine, which awakes him.[4]

The first comprehensive data concerning the incidence came from Isle Of Wight study. They found that 15.2% of boys (7 years of age) were enuretic less than once a week, whereas 6.7% were wetting at least once a week or more. In girls 7years, the frequency was 12.2% for those wetting less once a week and 3.3% with a frequency of once a week.[4]

Since then many studies have been carried out to find more about the prevalence and etiology of this disorder but all the studies have only showed the risk factors associated with this disorder because it is has a multifactorial etiology.[5,6,7]

The exact mechanism behind this disorder remains to be unclear. Few probable hypotheses include excessive production of nocturnal urine, over activity of the bladder and a failure to awaken in response to bladder sensations. Various studies support each

mechanism, and no single theory is likely to explain bedwetting in all children. Increased nocturnal urine production in few children is based on abnormal nocturnal plasma vasopressin release.[8,9] Few children may have an "hyperactive bladder;" however, these children also have symptoms during the day time which includes urgency, frequency and incontinence. Yeung study suggest that bladder over activity is an important cause of therapy-resistant nocturnal enuresis.[10]

Latest theories suggest the role of the central nervous system in enuresis. Caretakers of patient who wet the bed often report that they have a very deep sleep. Patients with nocturnal enuresis may, however, have sleep disturbance as well. A recent study of children with bedwetting showed that the sleep was significantly more disrupted and there was excessive daytime sleepiness.[11] Sleep fragmentation may result in a loss of the physiologic inhibitory signals to the bladder seen in animal studies.[12] This may also be probable mechanism behind nocturnal enuresis in children with obstructive sleep apnea.[13]

According to DSM-IV-TR the prevalence rate is 7% in boys and 3% in girls at the age of 5. The prevalence drops to 3% in boys and 2% in girls at the age of 10 however 1% of children continue having this problem even beyond 10 yrs of age. Spontaneous remission rate is in between 5-10%.[4]

The wide prevalence of nocturnal enuresis gives us the responsibility to bring the awareness amongst the family member and explaining them to come out to see a specialist so that it can be treated at an early stage so that the patient doesn't suffers from the emotional stress which happens due to the disorder which can further result in other co-morbid psychiatric illness.

This case report is about a 22-year-old female Ms. R who came to the psychiatry OPD quite distressed. She was a little hesitant and embarrassed even to discuss her problem with a psychiatrist. Her primary complaints were bedwetting since childhood, which use to happen twice a week. She was experiencing this problem since childhood but never visited a doctor since she was hesitant in discussing this problem with a doctor and always thought that will be cured on its own. Due to unawareness about the treatment options available she never visited a doctor. She was about to get married in a year and could not take this stress and finally decided to visit a doctor for the first time. Along with bedwetting she also had complaints of low mood, low self-esteem, excessive negative view regarding her future, apprehension and a disturbed sleep since 3 months. On further probing into her history we got to know that since her childhood she never attained bladder control. She never visited a doctor due to apprehension and lack of family support her parents were never really bothered about this problem and use to blame her and scold her for not using the lavatory in the night and drinking too much of water throughout the day. They did not acknowledge it as an illness and attributed this problem to her faulty daily routine.

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Since three months other symptoms started as well. She started being too apprehensive at work place especially after having bed-wetting episodes the prior night

She had low self-confidence, preferred spending time alone and used to have a low mood most of the day. Mostly her mind was preoccupied by this problem, as she knew it would affect her future married life. With her increased thoughts her bedwetting also increased which led to frequent sleep disturbances.
Before starting the treatment all her routine blood investigations along with anti diuretic hormones level were done which were in normal limit. X-ray spine was also come to be normal, sonography was also normal. EEG reports were also normal. Family history was also not significant nobody in her family suffered from this problem. After ruling out the entire general medical condition and physiological effect of substance a diagnosis of nocturnal enuresis was established.

Patient was started on Imipramine 25 mg /day at night. She came for a follow up after 15 days and subsequently the dosage of Imipramine was increased to 50mgs/day since patient was showing good improvement.
After significant improvement in her mood features patient was ready to undergo psychological interventions. Along with the pharmacotherapy cognitive behavioral therapy was also initiated after gaining patient's trust and confidence. She started coming for a regular follow up. Interpersonal issues and family dynamics were assessed in order to initiate family therapy. After six months of pharmacotherapy and cognitive behavioral therapy, today she has completely recovered and since one month she is off medications. 21 years of illness took only 6 months of treatment and recovery on combined pharmacotherapy and cognitive behavioral therapy.

This case also highlights the role of awareness in caregivers in early treatment and recovery. Most often people prefer not going to a psychiatrist due to the stigma associated with being tagged as a psychiatric patient.

This case clearly shows that such a long illness took only six months of treatment and hence could have evaded co morbid conditions like anxiety and depression which is quite often associated if treatment was sort earlier. It also proves that a better outcome can be achieved by combination of pharmacotherapy and cognitive behavioral therapy than either of it alone. Thus proving that a holistic approach leads to a better outcome.

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