



Figure 2 Treatment for primary monosymptomatic nocturnal enuresis

of 0.2 mg increasing to 0.6 mg daily may be given an hour before bedtime. This is now available in the country. Prolonged desmopressin bioactivity may increase the risk of water intoxication, a possible side effect of free water intake by the child when on desmopressin⁹.

While therapy is initiated, certain *guidelines* are recommended. The child is started on a low dose of the medication. Thereafter the dose is adjusted every two weeks to the maximum dose required to achieve dry nights. Therapy is continued for 3-6 months of dry nights and thereafter weaned over three to four weeks. In case of a relapse the same therapy is restarted or behavioral modification using an alarm device, is considered in conjunction. A structured withdrawal of therapy rather than tapering the dose of medications seems to improve the outcome¹⁰. This is achieved by administering therapy alternate day, followed by twice a week etc.

The various treatment modalities available are not used exclusive of each other and often a combination works best. Failure of one form of therapy should result in substitution or

addition of another. The three system model, suggesting desmopressin for low vasopressin release, oxybutinin along with bladder training for instability when suspected and the alarm to enhance arousability from sleep works well. A combination of one of these with motivational therapy is ideal. Comparative studies have shown that DDAVP has better short-term results, but the alarm has better long-term outcome. Hence, DDAVP is best used under special situations, e.g., if the child needs to remain dry when camping out or staying over at a friend's place. If long term efficacy, cost and safety are taken into consideration, the enuresis alarm comes out superior¹¹. In patients with enuresis and a voiding dysfunction DDAVP can enhance the effect of oxybutinin by reducing urinary output and bladder filling, thus reducing uninhibited bladder contractions. Reassurance and motivation of the child for involvement in the therapy and direct frequent contact with the therapist improves the outcome. An algorithmic representation for the treatment of primary monosymptomatic enuresis is depicted in Figure 2.

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