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LETTER TO THE EDITORS

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Reply to the letter from K. Kano and O. Arisaka

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Sirs,

We thank Dr Kano and Dr Arisaka [1] for their interest in our study [2] and for sharing their experience in treating primary nocturnal enuresis (PNE) with long-term nasal desmopressin therapy. In comparison with our study [2] and two other studies [3, 4] of desmopressin therapy for 3 to 6 months, their study showed a lower non-response rate after 3 months and a higher cure rate after 12–24 months of nasal desmopressin therapy. In a review of long-term use of desmopressin for PNE, van Kerrebroeck also referred to several studies which indicated that desmopressin efficacy improved throughout the treatment period and that long-term desmopressin treatment might accelerate the cure rates [5]. The adjusted response rates after 3–42 months of treatment varied from 47–85%, while the cure rates at 0.5–84 months after cessation of treatment varied greatly from 7–71%. However, the results of different studies cannot be directly compared because of several reasons. The primary aim and the design of each study might be different, and this may affect the reported result. These differences occur in patient enrollment, which might recruit patients with different underlying causes and baseline wetting frequency (For instance 25% of the patients in the study reported by Kano and Arisaka [1] had failed imipramine therapy); the definition of responses, cures and relapses; the length and the completeness of the follow-up during and after treatment; and the reporting practices (intention-to-treat analysis versus those omitting dropouts, non-compliance or non-responders).

In our study we observed that the majority of the relapsers in the desmopressin group relapsed in the first 4 weeks after treatment, but there were still 25% of late relapsers in the next 8 weeks [2]. Hence, we would caution that the post-treatment follow-up period in any study, such as that of Kano and Arisaka [1], should be long enough to pick up potential late relapsers. With a relatively long treatment duration involving a group of patients with possible spontaneously improving enuresis, Kano and Arisaka could not clearly exclude the attributing effect of the normal development of dryness to the reported drug efficacy unless a control group had been included. Moreover, continuous family and medical support with behavioural modification may also contribute to a higher cure rate in a long-term study.

The primary objective of our study was to find out which treatment option is best—3-months' therapy with alarms, oral administration of desmopressin or combined treatment—for Chinese PNE children [2]. We observed that there was significant reduction in wetting frequency in all three treatment groups during treatment and 12 weeks after its cessation. There was no significant difference in the sustained responder rates (alarm 28.6%, desmopressin 21%, combined therapy 40.6%). Interestingly, both alarms and combined group continued to show gradual reduction of wetting frequency during the later half of the treatment, but the effectiveness of desmopressin seemed to plateau.

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