Nocturnal Enuresis as a Specific Compensatory Syndrome

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Abstract: The pathophysiological nature of the monosymptomatic primary nocturnal enuresis (PNE) in children is still the unresolved problem. The most hypotheses of pathogenesis of nocturnal enuresis are limited within anatomical, biochemical and physiological regulation of the urinary control. Based on our own observations as well as the data reported in the literature, we have concluded that in addition to described biological causes of this disorder, we should focus on the common clinical and developmental features observed in the majority of cases of the monosymptomatic primary nocturnal enuresis that could be united as “enuretic syndrome”. In attempt to move “outside of the box” of the urinary control we have put forward a hypothesis that enuresis is a specific compensatory syndrome which is self-developed by the child’s organism to “offset” the deviated sleep–wake mechanisms. This concept is based on the general “control system theory” and offers the explanations of the majority of symptoms. From the compensatory “offset” concept the treatment of PNE should be focused not on the suppression of the act of enuresis but on the stabilization of circadian sleep-wake mechanisms. Further investigations are needed to evaluate the validity of this concept.

Keywords: Enuresis, Bedwetting, Adaptation Syndrome, Compensatory Model, Etiology of Enuresis

1. Introduction

Enuresis, or “bedwetting” – is a disorder which is as old as the whole history of mankind. To quote a famous Glucklich’s conclusion: “bedwetting was with us since the dawn of civilization and, probably will be with us for a long time”. The word “enuresis” is derived from a Greek word (enourein) that means “to void urine”.

It is very difficult to find another disorder, which on the one hand has so clear clinical picture, has so much written about it, but, on the other hand, we do not have yet clear answers to physiological nature of PNE. Besides the forceful awakening or/and suppressing the symptom we do not have keys to the really control the child’s afflicted sleep and its deviations including PNE. We attempted to review of the literature and offer a new approach to resolve the theoretically intriguing and practically important puzzle of PNE. Because PNE is happening in sleep we focused on the relationships between PNE and circadian rhythm.

2. Methods

Because of significant heterogeneity of nocturnal voiding problems we concentrated only on the primary monosymptomatic sleep related nocturnal enuresis in children. We have conducted a review of the relevant literature related to the etiology of enuresis and studies of sleep patterns in enuretic children.

3. Definition and Classifications

Until 2006, there was no clear definition of enuresis that would delimit it from other types of urinary incontinence. This led to the fact that practitioners and researchers, using various literature, put different meanings to the concept of enuresis, which created confusion.

The definition of enuresis, accepted by most experts today and used in this article, was standardized by Nevéus et al. [1], on behalf of the International Children’s Continence Society (ICCS) in 2006 and updated by Austin et al. in 2014 [2].
Enuresis means intermittent incontinence while sleeping in children ≥ 5 years old. The terms (intermittent) nocturnal incontinence and enuresis are now synonymous. Thus, both, primary and secondary wetting episode that occurs during sleep is called enuresis in this article.

There exist primary and secondary enuresis [2]. We talk about primary enuresis when a child older than 5 years continues to wet bed during the sleep and there are no other diseases of the nervous, urogenital and endocrine systems detected [3]. It is estimated that 80% of children with nocturnal enuresis have this form. Secondary enuresis - is when child’s enuretic events are terminated, and after some time renewed again. It was thought that in children with secondary enuresis the conditioned reflex was elaborated, and then for various reasons got lost [4].

Enuresis is divided into monosymptomatic and non-monosymptomatic forms. Monosymptomatic enuresis is characterized by uncontrollable urination only during sleep (nocturnal sleep or naps). In children with monosymptomatic enuresis there should not be any other clinical manifestations, except episodes of incontinence during sleep and psychological problems (as a result of enuresis). Non-monosymptomatic enuresis differs from the monosymptomatic one by periodic urinary incontinence when a person is awake as well as multiple symptoms of other diseases, where we usually consider enuresis as a symptom of an underlying disease [1].

In this paper we study the isolated primary monosymptomatic enuresis, which is only in children who have never had a "dry period" from the moment of birth, enuretic events happen only while sleeping, without any signs of urinary incontinence when a child is awake and without any symptoms of other diseases. By "dry period" we mean the absence of urination in sleep minimum period of 6 months. (see Figure 1). [3]

Table 1. Hypotheses of the occurrence of enuresis.

<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th>Hypothesis</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1905</td>
<td>Freud, S.</td>
<td>Urinary eroticism [7]</td>
<td>“Enuresis as positive act of self comfort with relaxing warm urine”. Freud thought that urination was erotic and that wetting the bed was a frustrated sexual act.</td>
</tr>
<tr>
<td>1935</td>
<td>Malavazos, A. C.</td>
<td>Immaturity of the genitourinary organs [8]</td>
<td>Insufficient development of the genitourinary system might be the cause of enuresis in children.</td>
</tr>
<tr>
<td>1935</td>
<td>McGuinness, A. C.</td>
<td>Enuresis as an aggressive act in a submissive child [9]</td>
<td>“Sometimes enuresis is as aggressive act in a very submissive child. It may arise from such strong emotions as fear, hatred, jealousy and inferiority.”</td>
</tr>
<tr>
<td>1938</td>
<td>Mowrer, O. H. and Mowrer, W. M.</td>
<td>Psychogenic factors [10]</td>
<td>Since no physical abnormality or other biomarker has not yet been identified, enuresis was believed to be a psychogenic disease according to this hypothesis.</td>
</tr>
<tr>
<td>1938</td>
<td>Michaels, J. J. and Goodman, S. E.</td>
<td>Psychopathic theory [11]</td>
<td>Authors reported that electroencephalographic (EEG) abnormalities were common in children with behavioral disorders (neurotic, personality disorder, delinquency) and enuresis. Thus, enuresis is a biomarker for psychopathic development in children.</td>
</tr>
<tr>
<td>1940</td>
<td>Gill, S. E.</td>
<td>Toilet training [12]</td>
<td>Poor toilet training. Nowadays in U.S.A., the mean age initiating toilet training ranged from 25 to 27 months in 1980, and it increased to 36.8 ± 6.1 months in 2003.4 The reasons for late toilet training may be due to the introduction of disposable diapers, modern laundry facilities, and busy parents.</td>
</tr>
<tr>
<td>1945</td>
<td>Clark, G.</td>
<td>No theory possible [13]</td>
<td>‘The experimental evidence on the encephalic control of the bladder is so contradictory that a theoretical explanation is impossible.”</td>
</tr>
<tr>
<td>1947</td>
<td>Kugelmass, I. N.</td>
<td>Familial [14]</td>
<td>Approximately 50-75% of enuretic children have a close biological relative with the same problem (in 56% this is father, in 36% - mother, in 40% - brother or sister). If one of the parents suffered from enuresis, the probability of occurrence of this problem in the child is 40-50%, if both parents - 70-80%.</td>
</tr>
<tr>
<td>1950</td>
<td>William, S. Walsh, M. D.</td>
<td>Enuresis comes out of “enuretic dreams” [15]</td>
<td>The author suggests that in a dream the child may see running water, a urinal, etc., which suggests voiding, and this suggestion is carried out.</td>
</tr>
</tbody>
</table>
Neveus’ article provides the most comprehensive review available. Still, it is not clear as the author pointed out, how arousal threshold is related to “deep sleep” or to “detrusor overactivity”. Most importantly, it is still astonishing why so many children afflicted with enuresis, why so many boys, how and when to treat it and why does it disappear by itself?

Despite countless points of view, the overall picture of theories of enuresis reminds the story about blind men and an elephant: urologists look into a bladder overactivity, endocrinologists work with the hormonal level of child’s body, physiologists - with the general physical development, genetics are looking for the cause in the genome and so on, - all of them are right in their own way.

Working through a tremendous amount of information that was accumulated over the centuries, it is very easy to drown in the theories and hypotheses. However, there is one certain fact which is accepted by clinicians and researchers working with the mystery of enuresis. This fact is that enuresis always happens while a child is sleeping. This fact is a common denominator in all points of view and consolidates all the proposed hypotheses. That is why we shifted our further focus to the literature studying sleep patterns of enuretic children.

3.2. Sleep Patterns in Enuretic Children

In the recent decades, much attention was paid to the study of sleep in children with enuresis [25-42]. Researchers studied sleep architecture, sleep fragmentation, arousal threshold, sleep spindles, delta waves, periodic limb movements etc. In order to understand various aspects of sleep better, different methods and approaches were applied. Some of the most popular techniques used are: EEG (electroencephalography), polysomnographic methods, measurements of arousal thresholds with earphones, electrocardiographic recording of the heart rate variability (24-Hour Holter Recording), detection of night time awakenings by an actigraph, and so on.

While working on this article, we have picked out and examined studies of the sleep patterns in enuretic children, which were conducted by contemporary investigators during the recent 20-year period. The articles were retrieved from the archive database PubMed. We excluded questionnaire studies, considering the fact of subjectivity of this method. We therefore retained only those works, which were published based on the data collected by the specialized methods, where the level of human factor and subjective perception was much
lower (see methods mentioned above, for example). Below, in Table 2, we provide a list of the relevant works, together with a brief summary of the key findings.

**Table 2. Results of studies of sleep patterns in enuretic children, conducted during period from 1997 to 2017 years.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th>Subjects</th>
<th>Study</th>
<th>Results of study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>Wolfish, N. M. et al.</td>
<td>15</td>
<td>Arousal thresholds</td>
<td>In this investigation 39.7% of controls against 9.3% of enuretics are more likely to awake in the last third of the night (and less likely in the first third). Difficulty in awakening was inversely related to the number of enuretic episodes [25]. Arousal of subjects with primary monosymptomatic enuresis is usually similar to those of normal subjects. The measures cystometrogram was stable until the bladder got filled. Then the EEG pattern changed, however, enuresis occurred without patients awakening [26].</td>
</tr>
<tr>
<td>1998</td>
<td>Kawauci, A. et al.</td>
<td>19</td>
<td>Dysfunction of arousal</td>
<td>The number of voiding acts taking place during the stages 2, 3, and 4 of non-REM (rapid eye movement) sleep were 19 (51%), 7 (19%), and 10 (27%), respectively. Only one enuretic event (3%) occurred during REM sleep [27].</td>
</tr>
<tr>
<td>1999</td>
<td>Neveus, T. et al.</td>
<td>25</td>
<td>Relationships between bladder voiding and sleep</td>
<td>Enuretics were less likely to arouse during the night. Difficulty in awakening was inversely related to the number of enuretic episodes [28].</td>
</tr>
<tr>
<td>1999</td>
<td>Wolfish, N. M.</td>
<td>35</td>
<td>Arousal threshold</td>
<td>Enuretics showed a significant increase in the EEG delta power component during baseline sleep compared with controls, whereas no difference was encountered using a manual sleep score [29].</td>
</tr>
<tr>
<td>2000</td>
<td>Hunsballe, J. M.</td>
<td>11</td>
<td>EEG delta power component</td>
<td>The differences between the two groups (controls and enuretics) were statistically significant with regard to all parameters except NHR (night time mean heart rate). It was found that sympathetic nervous system hyperactivity was present in enuretic children [30]. Sleep of the enuretic children did not diverge to a large extent from that of the controls. The only significant differences were that the enuretic children had an increased number of sleep cycles. Tachycardia was often seen to precede the enuretic event. In some subjects a short EEG arousal was observed before micturition [31].</td>
</tr>
<tr>
<td>2001</td>
<td>Dundaröz, M. R. et al.</td>
<td>28</td>
<td>Relationship of autonomic nervous system to enuresis</td>
<td>SDNN (the standard deviation of all normal sinus R-R intervals over 24 hours), rMSSD (the root mean square of successive differences between normal sinus R-R intervals) and SDANN (standard deviation of all averaged normal sinus intervals for each 5-minute segment in 24-hour recording) increased in enuretics compared to healthy children. VLF (very low frequency component) and LF (low frequency component) decreased significantly compared to healthy children. The study has shown that parasympathetic nervous system is hyperactive in children with enuresis [32].</td>
</tr>
<tr>
<td>2002</td>
<td>Bader, G. et al.</td>
<td>21</td>
<td>Differences between the sleep of enuretic children and controls</td>
<td>Light non-REM sleep occurred significantly more frequently, and deep non-REM sleep and REM sleep occurred considerably less frequently in patients with enuresis than in controls. Cortical arousals occurred more frequently in patients with enuresis. It was found that children with enuresis have more light sleep associated with frequent cortical arousals but are unable to awaken completely [33].</td>
</tr>
<tr>
<td>2004</td>
<td>Unalacak, M. et al.</td>
<td>32</td>
<td>Cardiac autonomic regulation</td>
<td>Preliminary data show evidence of disrupted sleep architecture in children with a high incidence of PLMS (Periodic Limb Movements of Sleep) and increased cortical arousability leading to awakening, instead of classically accepted deep sleep [34]. Compromised sleep patterns were reflected in a higher number of actigraphic nighttime awakenings, the reduced percentages of motionless sleep, the higher number of reported nighttime awakening, and the increased sleep latency [35].</td>
</tr>
<tr>
<td>2008</td>
<td>Yeung, C. K. et al.</td>
<td>35</td>
<td>sleep patterns and cortical arousal in relation to bladder activity</td>
<td>Children with enuresis had a higher incidence of periodic limb movements associated with cortical arousals in their sleep [36].</td>
</tr>
<tr>
<td>2009</td>
<td>Dhandt, K. et al.</td>
<td>29</td>
<td>Sleep characteristics</td>
<td>The results of this study confirm both increased PLMS and increased sleep fragmentation. Enuresis was present in different sleep stages. In three children, we observed PLMS 5 min before the alarm signal was registered [37].</td>
</tr>
<tr>
<td>2010</td>
<td>Cohen-Zrubel, V. et al.</td>
<td>32</td>
<td>Sleep patterns</td>
<td>The mean apnea hypopnea index values were 0.96 ± 0.8 for the patient group and 0.46 ± 0.4 for the control group. The enuretic children reported significantly more subjective sleep disturbances than their healthy peers [42].</td>
</tr>
<tr>
<td>2011</td>
<td>Dhandt, K. et al.</td>
<td>67</td>
<td>Sleep fragmentation</td>
<td>SDNN (the standard deviation of all normal sinus R-R intervals over 24 hours), rMSSD (the root mean square of successive differences between normal sinus R-R intervals) and SDANN (standard deviation of all averaged normal sinus intervals for each 5-minute segment in 24-hour recording) increased in enuretics compared to healthy children. VLF (very low frequency component) and LF (low frequency component) decreased significantly compared to healthy children. The study has shown that parasympathetic nervous system is hyperactive in children with enuresis [32].</td>
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<td>2014</td>
<td>Dhandt, K. et al.</td>
<td>30</td>
<td>Sleep fragmentation and periodic limb movements</td>
<td>Light non-REM sleep occurred significantly more frequently, and deep non-REM sleep and REM sleep occurred considerably less frequently in patients with enuresis than in controls. Cortical arousals occurred more frequently in patients with enuresis. It was found that children with enuresis have more light sleep associated with frequent cortical arousals but are unable to awaken completely [33].</td>
</tr>
<tr>
<td>2015</td>
<td>Jönson Ring I. et al.</td>
<td>20</td>
<td>Sleep disordered breathing</td>
<td>Preliminary data show evidence of disrupted sleep architecture in children with a high incidence of PLMS (Periodic Limb Movements of Sleep) and increased cortical arousability leading to awakening, instead of classically accepted deep sleep [34]. Compromised sleep patterns were reflected in a higher number of actigraphic nighttime awakenings, the reduced percentages of motionless sleep, the higher number of reported nighttime awakening, and the increased sleep latency [35].</td>
</tr>
</tbody>
</table>

Table 2 allowed us to understand the questions which were investigated during the last 20 years, the methods used and techniques applied. These studies gave us the data essential for understanding patterns of sleep in enuretic children, as well as their similarities and differences with normal children.

Knowing the existing literature and based on our long clinical and polysomnographic experience (PSGs with improved registrations of the onset of the enuretic episodes) working with enuretic children, we came up with a list of specific features connected with enuresis. We have distinguished typical sleep disturbances and changes in the level of alertness. The most frequently patterns appeared in children with enuresis were highlighted into the “essential” and “associated” features of enuresis (see Table 3) [38-40].
4. Discussion

Enuresis conceals many secrets and paradoxes. The clear and simple symptom (sudden, spasm-like involuntary urination in sleep) contrasts with unclarity of the nature of it and controversial methods of treatment. Enuresis “defied” the traditional rule “each symptom should reflect a broken part in the body”. Centuries of intensive search for the organ ultimately responsible for involuntary urination in sleep did not lead anywhere. There is no organ or a system which was not blamed for this affliction, but was acquitted later. No underlying organic pathology was found to clearly explain bedwetting in sleep in the majority of cases. Despite the knowledge of many details of enuresis the main clinical and theoretical questions are still not answered:

1. Primary monosymptomatic enuresis is happening during sleeping but not when a child is awake. Why?
2. Is the process of urination during the sleeping similar to the process of urination when a child is awake or they are different and independent?
3. Both clinicians and parents know well that many treatments are initially helpful but only for a short time (therapeutic resistance). Why?
4. Why does enuresis spontaneously disappear (spontaneous “cure”)?
5. Is enuresis associated with other parasomnias epiphenomena or they have a common pathophysiology?

Treatments aiming at suppression of the urination in sleep removed symptoms without treating the enuresis itself, and gave only a short-time result. Awakenings by parents, alarm devices (that work “post factum”) cause further sleep disturbance, but not healing. Is enuresis so multifactorial and does it involve so many organs and systems that we could not talk about the nature of enuresis at all? We experienced shame when after a long unsuccessful treatment bedwetting disappeared spontaneously by itself. Therefore it is time to make a paradigm shift and revise general approaches to the paradoxes of enuresis.

We came up with a hypothesis of enuresis being a specific adaptation (compensatory) syndrome, actively produced by the body to stabilize the deviated sleep structure (deviations might be caused by any or all developmental, genetic, psychological and parenting factors).

Our hypothesis is based on the results of polysomnographic studies, which we conducted in our laboratory and on medical records of patients. Analyzing the obtained data, and comparing it with the results of other works, we noticed that bedwetting usually has some EEG and behavioral “forerunners” and after the episode “normalization of the followed sleep phase changes occurs” [38-40].

The explanation comes from comparing a normal hypnogram with a hypnogram of enuretic sleep. An example of a hypnogram typical for normal subjects (see Figure 2) has a successive and common algorithm. When a child falls asleep he/she generally reaches the deepest stage of sleep (stage 4) shortly (in about one hour). Afterwards, during the rest of the night the child shifts from the deep sleep stages to REM (seeing dreams) and back every 1.5-2 hours. This pattern is considered to be optimal and illustrates a healthy sleeping behavior, leading to full body recharging during the night and the maximum efficiency during the day-time.

If we look at the hypnogram of the enuretic sleep (see Figure 3), there is one very specific peculiarity. When an enuretic child falls asleep he/she reaches the deepest stages (3 and 4) within the same time-range as normal children. In contrast, the following sleep cycles are not regular. The child remains in sleep stages 3 and/or 4 for a long period of time (about 2 hours) or demonstrates chaotic changes in the hypnogram. The so-called “dead sleep” is often observed during the first 2 sleeping hours with rare breathing and very low heart rate. However, after the enuretic event takes place, the sleep cycle usually normalizes and the sleep pattern for the rest of the night stays similar to that of normal children.

In order to support our hypothesis, we demonstrate an example of the hypnogram measured in an enuretic child before and after treatment (see Figure 4). One can see that the patient with the primary monosymptomatic enuresis before treatment spent more than 3 hours in the deep stages of sleep at the initial stage of observation. Later an enuretic event took place, which however didn’t make the child wake up. The subsequent monitoring of sleeping cycle did not show any abnormalities in comparison with the normal behavior (except for a little discomfort caused by sleeping in a wet bed, we suppose). On the other hand, after several months dryness (recovery period) the hypnogram of the same child remained “normal” throughout the whole night.
Based on our hypothesis, we present explanations of generally known and accepted facts about enuresis in Table 4, which fit the logic of compensatory model of enuresis as a specific adaptation syndrome.

Enuresis is a disorder, means “out of order”. Conventional wisdom says that having a disorder is a bad thing. The advanced theory of adaptive chaos and the control system theory stated that mild disorders might have an adaptive, corrective and compensational in nature, serve to stabilize the organism as a whole, offset and contain “big disorders” [44]. Enuresis and other parasomnias might be examples of such compensatory, specific adaptive syndromes [38-40].

Table 4. Explanation of symptoms of enuresis by the compensatory model of enuresis as a specific adaptation syndrome (the “offset” syndrome).

<table>
<thead>
<tr>
<th>Facts</th>
<th>Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary urination in sleep</td>
<td>Enuresis could be a self-organizing adaptive mechanism to maintain or “switch” sleep stages</td>
</tr>
<tr>
<td>Normal capacity to hold urine during wakefulness</td>
<td>Because the urinary system “works” normally during the day</td>
</tr>
<tr>
<td>Enuretic act in sleep appears suddenly and with large volume</td>
<td>Daytime urination involved voluntary rhythmic contraction of pelvic muscles but in sleep enuresis is a sudden involuntory outburst of urine without contraction of pelvic muscles</td>
</tr>
<tr>
<td>The forcefully awakened child could urinate again as he/she falls asleep</td>
<td>Sleep was disturbed and enuretic act “normalizes” sleep architecture</td>
</tr>
<tr>
<td>Resistance to direct suppression</td>
<td>Enuresis is “needed” because it serves a specific function as a “switch” of sleep stages</td>
</tr>
<tr>
<td>Enuresis disappears spontaneously</td>
<td>When sleep mechanisms restored (“matured”) enuresis’s compensatory function is no longer “needed” and enuresis spontaneously disappeared (“cured”)</td>
</tr>
<tr>
<td>PNE gets worse</td>
<td>If the compensatory phase is not helpful, PNE became another “problem” for the organism and the second phase – more maladaptive “offset symptoms” appear.</td>
</tr>
<tr>
<td>Enuresis predominantly is seen in boys</td>
<td>Enuresis belongs to parasomnias - the group of circadian rhythm deviations. Almost all parasomnias are gender connected male/female ratio 3:1 as a developmental asymmetry.</td>
</tr>
<tr>
<td>Existing therapy do not cure enuresis</td>
<td>Therapeutic methods should be focused not on urinary system but on maturation or restoration of sleep-wake mechanisms.</td>
</tr>
</tbody>
</table>

5. Conclusion

In this study we have performed a thorough literature review of existed multiple theories of etiology of enuresis and results of studies performed during the last 20 years which investigated sleep patterns in enuretic children. Based on the found information and comparison with the results of our own studies, we came up with a hypothesis of enuresis being a specific adaptation syndrome which “offset” deviations of sleep-wake mechanisms and “normalizes” sleep function. When sleep mechanisms mature enuresis disappears (“cured”) by itself. If not – the second phase “deterioration”- occurred. If validated in the future large studies, the “offset” (specific compensatory) hypothesis might give a directions for an individual pathophysiologial therapy of this socially, emotionally and medically uncomfortable affliction.

To confirm that ‘the new is just a forgotten old’ let us recall what one of the Fathers of medicine – Avicenna – said in 1012 in his famous “Canon of Medical Science”: “Urinating in bed is frequently predisposed by deep sleep. When urine begins to flow, its inner nature and hidden will (resembling the will to
breathe) drives urine out before the child awakes. When children become stronger and more robust, their sleep is lighter and they stop urinating.” [45]

References


