LOOK AT POSSIBLE MEDICAL CAUSES FOR ENURESIS AND KNOW ABOUT INVESTIGATIONS AND POSSIBLE ORTHODOX TREATMENT INVOLVED. LOOK AT 6-8 REMEDIES WITH PARTICULAR ASSOCIATION WITH THIS CONDITION.

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ENURESIS

'The unconscious or involuntary passage of urine.' (Blacks, 1992. p199)

'Enuresis is a term which is reserved for incontinence in children. It is the involuntary passing of urine at night when asleep. The existence of incontinence during the day suggests a kidney or bladder condition. It is mainly a disorder found in boys and affects 10% of boys aged 4-11 years. There are estimated to be 500,000 cases in Britain between the age of 6 and 16. As a group they also have signs of decreased muscle tone, co-ordination problems and EEG abnormalities. It is considered to be a sleep disorder and so is treated by the antidepressant imipramine. This is an attempt to alter depth of sleep and has little effect. There is the added danger of poisoning by overdose.

'Less harmful are behavioural methods such as an alarm bell. This is connected to a mat under the sheet so that the bell sounds if the child wets the bed. Intranasal desmopressin, antidiuretic hormone, is used in some cases although the manipulation of pituitary hormones to treat bed-wetting seems excessive. Enuresis is notoriously difficult to treat and is frequently related to psychological factors. It may be necessary to address the family as a whole as well as the individual child.' (Gascoigne, 1995. p179)

NOCTURNAL ENURESIS

'The involuntary passage of urine during sleep. It is a condition predominantly of childhood. In a small minority of cases it is due to some organic cause such as infection of the genito-urinary tract, but in the vast majority of cases it is due to inadequate or improper training of the child or psychological ill-health. Traditionally it is said to be associated with threadworms, but there is little, if any, evidence to support this tradition.

'Before deciding that a child is suffering from nocturnal enuresis, it is necessary to remember that the age at which a child achieves full control of bladder function varies considerably. Such control is usually achieved in the second year, but more commonly in the third year of life, and there are some children who do not normally achieve such control until the fourth, or even fifth, year.

'It is a difficult condition to cure in the absence of an organic cause. If there should be an organic cause, treatment consists of its eradication. In the absence of such a cause, treatment consists essentially of reassurance and firm but kindly and understanding training. In quite a number of cases the use of a buzzer alarm which wakens the child should he start passing water is helpful provided that it is backed up by psychological support from the parents and the family doctor.' (Blacks, 1992. p412)

'Nocturnal enuresis is a normal occurrence in young children but persists in as many as 5% by 10 years of age. In the absence of urinary-tract infection simple measures such as bladder training or the use of an alarm system may be successful. Drug therapy is not appropriate for children under 7 years of age and should be reserved for when alternative measures have failed preferably on a short-term basis to cover periods away from home. The possible side-effects and the toxicity of these drugs if taken in overdose should be borne in mind when they are prescribed.

'Desmopressin, an analogue of vasopressin [antidiuretic hormone, ADH], is used for nocturnal enuresis; particular care is needed to avoid fluid overload and treatment should not be continued for longer than 3 months without stopping for a week for full re-assessment.

'Tricyclics such as amitriptyline, imipramine, and less often nortriptyline are also used but behaviour disturbances may occur and relapse is common after withdrawal. Treatment should not normally exceed 3 months unless a full physical examination (including ECG) is given and the child is fully re-assessed.' (British National Formulary, no 33 (March 1997) p351)

ORGANIC CAUSES OF BLADDER DYSFUNCTION

Urinary incontinence is often a symptom resulting from confusion and immobility experienced in acute illness. Other chronic causes may relate to damage to the cerebral cortex (cerebrovascular disease, Alzheimer's, Parkinson's), spinal cord damage (MS, trauma or tumour), or damage to afferent parasympathetic fibres (diabetic autonomic neuropathy). Local causes include pressure on the bladder from fæcal impaction, stress incontinence due to pelvic floor weakness in women, prostatic obstruction, and post-menopausal atrophic changes in the vagina, urethral and trigonal mucosa. Other causes include drugs such as diuretics, poor mobility, anxiety or attention-seeking behaviour.

Important considerations are duration and timing of incontinence, associated urinary symptoms and drug treatment. Examination of abdomen, central nervous system, rectum, perineum, vulva and vagina are necessary to determine existence of any organic cause. Urine cultures are taken. Pelvic ultrasound may identify chronic urinary retention; catheterisation and cystometrography provides information about dynamic filling pressures within the bladder. Cystoscopy and cinefluoroscopy may be used where the diagnosis is otherwise unclear.

PATTERNS OF NEUROGENIC BLADDER DYSFUNCTION

Atonic bladder

Cause: Damage to sacral segments of conus medullaris
Damage to sacral roots/nerves and pelvic nerves

Results: Loss of detrusor contraction
Difficulty initiating micturation
Distension of bladder, overflow incontinence

Hypertonic bladder

Cause: Spinal cord damage involving pyramidal tracts above conus medullaris
Frontal lobe lesions

Results: Urgency and urge incontinence
Bladder/sphincter incoordination
Incomplete bladder emptying

Cortical lesions

Post-central — loss of awareness of bladder fullness, incontinence
Pre-central — difficulty initiating micturation
Frontal — inappropriate micturation, loss of social control (Edwards et al, 1995. p1030)

TREATMENT OF URINARY INCONTINENCE

'The mainstay of treatment is toilet training in which patients are encouraged to anticipate episodes of incontinence by regular emptying of their bladder. Practical measures such as modifying the dose of a diuretic or facilitating access to the lavatory may also be effective.' (Edwards et al, 1995. p1121) Physical obstructive causes (fæcal impaction, prostatitis) are generally treated by removal of the obstruction. Bladder relaxants such as oxybutinin are used in cases featuring hypertonic bladder. Oestrogen creams are used in atrophic vaginitis. Exercises and possibly reconstructive surgery are the treatments for pelvic floor weakness. If all preventative and management treatment fails, catheters and incontinence pads are used. (See also extract from BNF under Nocturnal Enuresis above.)

BELL & PAD TRAINING

'This is used in the treatment of enuresis. A special pad is placed under the patient's bed-sheet. It contains an electric circuit which is completed when wetted by urine, thereby sounding an alarm bell which wakes the patient. Micturation is interrupted and the patient gets up to complete emptying his or her bladder. After repeated training the patient learns to respond to sensations of bladder distension and wakens before micturation occurs.' (Edwards et al, 1995. p984)

ESOTERIC VIEW

In an attempt to understand the 'meaning' of nocturnal enuresis from a more esoteric point of view, I looked at several publications which are usually quite helpful in coming to an understanding of the dynamics involved. Few of them dealt with the problem directly. Dethlefson does so, but perhaps reveals more about himself than the condition in the process. 'Illness and death are regularly used to submit the world to extortion … it is quite easy to detect the theme of 'symptoms as expressions of power' in the particular case of bed-wetting. If a child spends all day under such strong pressures (whether from parents of from school) that it can neither let go nor express its own needs, nocturnal bed-wetting solves several problems at once: it provides the chance to let go in response to the pressures being experienced, and at the same time it offers the child the opportunity to condemn its otherwise all-powerful parents to utter helplessness. By way of this particular symptom, in fact, the child is able to return in safely disguised form all the pressure that it is put under during the day. At the same time we should not overlook the link between bed-wetting and crying. Both of them serve to unload and release inner pressures by way of 'letting go'. We could thus describe bed-wetting as a kind of 'lower level crying'. (Dethlefson & Dahlke, 1990. p180-181) I find, as with many other areas he covers, that while there appears to be some element of truth in his analysis, its judgmental tones are obstructive and it does not seem to reflect the whole picture.

Page does not mention the problem specifically, but deals with the diathesis in her chapter on base chakra imbalances: the polarity between control and insecurity manifested by individuals who have not fully inhabited their bodies or committed themselves to life on earth. The lack of sufficient soul pressure in the area of the base chakra leads to problems — 'Whether the insecurity is consciously revealed or not, when there is poor control on matter by spirit, diseases emerge which relate to undisciplined energy in the base chakra. These include panic attacks with palpitations, hyperventilation, frequency of micturation (passing water), regular trips to the toilet to open the bowels and muscle spasms. The physical body is out of control.' (Page, 1994. p119-120)

The anthroposophists have a similar slant though from a different model. The kidney is regarded as the organ which impregnates food substances absorbed by the body with astral forces, connecting with the astral body and its supporting element, air. Urine secretion varies with atmospheric (air) pressure and also in response to stress, bodily reactions of which are moderated through the function of the adrenal glands — flight or fright responses effect urine release.

REMEDIES

The following are remedies listed in the Complete Repertory under *Bladder, Urination, involuntary*, together with *Bladder, Urination, involuntary, night, incontinence in bed*, plus remedies listed in various materia medica and articles (in sans serif font) associated with enuresis. Where these latter remedies do not appear in the Complete in the rubrics above, the publications containing the reference(s) to the remedies are listed (see Bibliography).

Abrom-aug (G)
Acet-ac
Acon
Aeth
Agar
Ail
Alet
Allox
Aloe (B)
Alum
Alum-sil
Alumn
Am-b (B)
Am-c
Am-val (B,BI)
Amyg-am
Anac
Anan
Ant-c
Ant-t
Antipyrin (C,H)
Apis
Apoc
Arg
Arg-nit
Arist-cl
Arn
Ars
Ars-i
Ars-s-f
Atro
Aur
Aur-ar
Aur-m
Aur-s
Bapt
Bar-acet
Bar-c
Bar-i
Bar-m
Bar-s
Bell
Benz-ac
Berb (B)
Bor (Br)
Bov (IHA)
Brach (C)
Bry
Bufo
Cact
Calc
Calc-i
Calc-o-t
Calc-p
Calc-sil
Calen (HP)
Camph
Cann-i
Cann-s
Canth
Caps (K,Z)
Carb-an
Carb-v
Carbn-s
Carc
Cast (K,Z)
Caust
Cedr
Cere-s (A,C)
Cham
Chen-a
Chen-v (C,H)
Chin
Chin-ar
Chlol
Chlorpr (J)
Cic
Cimic (B)
Cimx
Cina
Cob-n
Coca
Cocc
Coc-c (C)
Colch
Coloc (K,Z)
Con
Crot-c
Crot-h
Cub
Cupr
Cyn-d (CC)
Dam
Daph (A)
Dig
Dol (H)
DPT (M)
Dros
Dulc
Dys-co
Echi
Equis
Ergot (J)
Ery-a
Euphr (Ha)
Eup-per
Eup-pur
Ferr
Ferr-ar
Ferr-i
Ferr-m (C,H)
Ferr-p
Fl-ac
Gaert
Gels
Glon (D)
Graph
Grat
Guare
Hell
Hep
Hydr
Hydr-ac
Hydrang
Hyos
Hyper (MA)
Hypoth (J)
Ign
Iod
Jug-r
Kali-ar
Kali-bi (Ca)
Kali-br
Kali-c
Kali-i (Bu,C,H,Kn)
Kali-m
Kali-n
Kali-p
Kali-sil
Kreos
Lac-c
Lac-d
Lach
Lath
Laur
Led
Lina
Lup
Lyc
Lycpr
Lyss (J)
M-aust
Mag-c
Mag-m
Mag-p
Mag-s
Mand
Mang (C)
Med
Merc
Merc-c
Mill
Morg
Mosch
Mur-ac
Nat-ar
Nat-c
Nat-m
Nat-p
Nat-sil
Nat-s
Nit-ac
Nitro-o (C)
Nux-m
Nux-v
Ol-j
Olnd
Op
Ovi-g-p (C,IHA)
Ox-ac
Petr
Phos
Ph-ac
Phys
Physal
Pic-ac
Pip-m (BI)
Pitu-gl (BI)
Pitu-p (J)
Pix
Plan
Plat-m (Hn)
Plb
Podo
Psor
Puls
Pyrog
Quas
Rad-br
Rat
Rauw (J)
Rheum
Rhus-a
Rhus-t
Rumx
Russ (C)
Ruta
Sabal
Sang
Sanic
Sant
Sapin (C)
Sapo
Saroth (J)
Sars
Scroph-n (C)
Sec
Sel
Senec-j (C)
Seneg
Sep
Sil
Solid
Spig
Spong
Squil
Staph
Stram
Stront-br (C)
Stront-c (C)
Stry (B,C,HI,Hu)
Sulfonam (J)
Sul-i
Sulph
Syc-co
Syph (Bo,HR,J,P)
Tab
Tarax
Tarent
Ter
Thal
Thuj
Thyr
Til (A,C)
Trinic
Tritic
Tub
Uran-n
Urt-u
Ust
Uva
Verat
Verat-v (HI)
Verb
Vern-a (G)
Vespa
Vib
Viol-o
Viol-t
Visc
Zinc
Zinc-p

MAJOR REMEDIES

BENZOIC ACID

Affinities: URINARY ORGANS (kidneys, bladder), JOINTS. *Heart.* Bowels. Left side. Left side then right. Right side then left.

Mind: Dwells upon disagreeable occurrences, unpleasant things. 'If he saw anyone who was deformed it made him shudder.' (Vermeulen, 1996. p136) Hurry followed by fear. Sensitive to noise. Frequent omission of words in writing. Desires to be carried. Children will not be laid down.

Generals: Alternating states. Inflammatory states of tongue, throat, tonsils, stomach and rheumatic manifestations. 'It is always characteristic of benzoic acid when the pains wander from one place to another when they vanish from the joints and extremities, then involve internal organs and reversely when the symptoms reappear in the joints with the improvement of the cardiac complaints, and when the urine periodically alters in regard to its amount, colour, specific gravity and odour in relation to the general symptoms of sleep, psyche, headache, and the urine is striking through its odour.' (Leeser, 1935. p690)

Urine: Urine of a very repulsive odour, of a changeable colour. Strong hot dark brown urine; foul, ammoniacal or odour of horse's urine, immediately on voiding. Enuresis nocturna with penetrating urinous odour. Sheets usually stained brown.

CAUSTICUM

Affinities: NERVES (*motor, sensory*). MUSCLES (BLADDER, LARYNX, limbs). *Respiration*. Skin. Right side; face. Left side.

Mind: Weeping from sympathy with others. Suffer with others. Ailments from grief. Internal suffering (kept in). Suffer from injustice in society. Immovable points of view. Indifference to dictates of conscience. Fear something will happen. Sensitive to authority. Fear of dark. Stammering. Anarchistic. Idealistic.

Generals: Chilly, < cold air, cold dry weather. > wet weather, bathing. Burning pains, rawness, soreness. Local paralytic affections. Sensation as if muscles and tendons too short. Gradual paralysis on all levels. > sips of cold water. Craves smoked food.

Urine: 'Involuntary urination, particularly in children. This may take place either at night when they are asleep or in the day while awake. In nocturnal enuresis, the emission of urine takes place during the first part of the night, after they have hardly fallen asleep. At times this takes place even before they have slept and it comes on so easily that they are hardly conscious of it. All sensations are wanting, and they only make certain of it by feeling with their hands and finding themselves in a pool of urine. Then again, due to paralysis of the sphincter muscles, we have involuntary urination while coughing, sneezing and blowing the nose.' (Choudhuri)

EQUISETUM HYEMALE

Affinities: GENITO-URINARY TRACT. Right side.

Mind: Disposed to frown. Angry. Dreams of crowds. Abnormalities that remain because he has made a habit of it (eg biting nails).

Generals: Disturbed sleep due to tiresome dreams. Worse at close of urination.

Urine: Aching, full, tender bladder not relieved by urination. Constant desire to urinate; passes large quantities of clear, light-coloured urine without relief. Nocturnal enuresis, especially in first

sleep, with irritable bladder. Dribbling of urine. Urine cloudy with great amount of mucous on standing. Excessive burning in urethra while urinating. Haematuria. 'This remedy is sometimes successful in cases which are not relieved by Cantharis … there are larger quantities of urine discharged than with Canth, which has characteristically very small amounts, but often repeated, even but a few drops at a time. Equisetum, like Chimaphila, sometimes shows excess of mucous, and it is also very useful in enuresis' (Nash, 1913. p422)

KREOSOTUM

Affinities: MUCOUS MEMBRANES (DIGESTIVE TRACT; *gums;* stomach; *abdomen; female genitals;* uterus). BLOOD. *Teeth.* LEFT SIDE.

Mind: Fear of coition, fear and dreams of rape. Many problems around menstrual period. Every emotion attended with throbbing. Sadness and weeping from music.

Generals: Excitement, restlessness, headache around menstrual period. Chilly. Corrosive, hot, foul discharges. Ailments from too rapid growth. Profuse haemorrhages from small wounds. Difficult dentition. Child screams the whole night; won't sleep unless caressed and fondled all the time.

Urine: 'It is one of our grand remedies for incontinence of urine. The urging is so great that the patient cannot get out of bed at night quick enough. The urine is chestnut brown, fœtid, alkaline and deposits a white sediment. It is a first class remedy for nocturnal enuresis of children. They wet the bed during the first sleep from which they are roused with difficulty. They frequently dream that they are passing urine in the proper place, but they wake up, also, to find out that it has been done in the most incompatible manner and in the most improper place.' (Choudhuri) 'Nocturnal enuresis from too profound sleep. Child cannot be awakened when taken up.' (Clarke, 1900. Vol II p178)

LAC CANINUM

Affinities: NERVES. THROAT. *Female organs. Breasts.* ALTERNATING SIDES.

Mind: Great lack of self confidence. Forsaken feeling. Self contempt (delusions, dirty, falling to pieces, being looked at, loathing of oneself, fear of failure). Hypersensitive amounting to hysteria. Forgetful and absent-minded. Aggression (cursing, malicious, rudeness, rage, hateful, scolding at slightest provocation). Many fears from strong imagination. Constant desire to wash hands. Aetiology disturbance in mother-child relationship. Sensation as if floating in air.

Generals: Warm-blooded. Alternating sides. Desire for pungent things (pepper, mustard) and salt. > cold applications. Ravenous appetite. Glistening, shining parts (throat, chancres, ulcers).

Urine: 'Nocturnal enuresis especially in those children who have grown up to adolescence and kept this habit. I have learned to always refer to Lac Caninum in those cases and see if I could not get other corroborative symptoms. It is amazing how many of them you can get, and what fine work the remedy does.' (Dixon, Homeopathic Recorder) 'Nocturnal enuresis (specific). Bladder seems full after urination.' (Phatak) 'Urine bright coloured. Slight difficulty in urinating, but at times very profuse and light-coloured. Desire to urinate often, with difficulty. Urine unusually frequent and dark. Constant and urgent inclination to urinate in large quantities, though not at all thirsty; urine highly coloured; next day the same urgent inclination, but urine was scanty, very turbid, and left a reddish sediment.' (Swan)

PLANTAGO MAJOR

Affinities: NERVES. Teeth, ears, spleen. Emmissions. Worms. Wounds.

Mind: Irritable, morose disposition. Great mental prostration, < mental exertion, causing rapid respiration and anxiety. Restlessness, pacing back and forwards. Intolerant of contradiction. Dullness > walking in open air. Hurry, desire to do several things at once. Undertakes many things, perseveres in nothing.

Generals: Considerable clinical reputation in earache, toothache, enuresis. Neuralgia of ears, teeth, face. Sudden boring pains < right side. Sharp darting pains in left side. Shifting pains. Restlessness especially of lower extremities. < sitting, > moving about. Frequent attacks of sudden sneezing with profuse watery bland coryza. Tongue white coated, breath putrid. Eructations tasting of sulphur. Thirst. Grinding of teeth during sleep. Weariness and prostration with desire to yawn and stretch. Abdominal colic > eating.

Urine: Profuse flow. Nocturnal enuresis, especially where lax condition of sphincter vesicae. Frequent emission of large quantities of pale urine, hot, scalding. Profuse, colourless urine, depositing white sediment < midnight to morning. ‘It is especially applicable to the nocturnal enuresis of children, particularly when depending on laxity of sphincter vesicae. In most of these cases the children secrete a large quantity of pale, watery urine, and though great pains are taken to have the bladder thoroughly emptied before retiring, yet the pressure on the weak sphincter will cause its escape before morning. It is of no use when enuresis is due to paralysis of the sphincter.’ (Choudhuri)

TUBERCULINUM

Affinities: LUNGS. *Mind. Head* — occiput. *Glands*. Larynx. Blood. Right side.

Mind: Need for change, desire to travel. Maliciousness, destructive when change frustrated. Compulsive, ritualistic, superstitious. Irritability on waking. Fear of dogs, cats. Precocious children. Romantic longing.

Generals: < before storm, cold damp weather, closed room. > open air, dry warm weather. Strong craving for smoked foods, fat, cold milk. Ravenous hunger at night. Profuse perspiration at night from slight exertion. Tendency to take cold. Marked disposition to respiratory ailments. Grinding of teeth during sleep. Constantly changing symptoms. Dark hair along spine in children. Rolling head to get to sleep. With every little ailment whines and complains.

Urine: Urine stops and starts, intermittent flow. ‘The remedy Tuberculinum is the best friend that parents of a bed wetter can have. This remedy has cured more children of the embarrassing, socially stigmatising disorder than any other remedy in the materia medica. The problem may be lifelong or only have begun after an acute illness such as an upper respiratory infection or a fever: a statement such as “After receiving the treatment for the illness, he began to have bed-wetting spells,” is a common tip-off to Tuberculinum. The bed-wetting may occur at any time from the first sleep of the evening to the deep sleep of the early morning; or more typically, several times during the night, some urinating every hour. The urine has a very strong odour that can remain in the bedding long after the child quits the habit. It is common for parents to tell the doctor that they took the child to the bathroom to urinate during the night but that it accomplished nothing, as the child wet the bed later anyway. It can be difficult for parents to waken the child. They may pick the child up from bed, carry him to the bathroom, hold him over the toilet, and tell him to urinate. The child often remains asleep during this whole procedure, grinding his teeth or thrashing about, but will urinate profusely when bidden. For most children the cause of the problem is that they cannot rouse themselves from a deep sleep to get up and go to the bathroom. This is especially true with Tuberculinum, but it is not the only reason: there is a lack of inhibition that makes urinating in bed a meaningless event to the child. It is commonly found that after the remedy has acted the sleep is not as profound and the child will awaken if needed.’ (Herscu, 1991. p334)

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