Among non-responders, obesity was present in 13.2% and overweight in 7.9% of patients. Among patients who responded to desmopressin treatment, comorbidity was present in 40.5% of patients. Among 38 non-responders, comorbidity was present in 21.1% of patients. The difference was not statistically significant in either of compared groups.

**CONCLUSION:**
The study did not prove statistically significant association between family history of enuresis, associated comorbidities or body mass index, and response to treatment with desmopressin.

**Keywords:** Monosymptomatic enuresis; Desmopressin; Attention deficit hyperactivity disorder; Body mass index; Family history

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Kopač M. Is Response to Enuresis Treatment with Desmopressin Influenced by Family History, Associated Comorbidities or Obesity?

**INTRODUCTION**

Enuresis is common in school age children. The occurrence of primary nocturnal enuresis was found to be 8.7% in the population of Slovenian 5-year olds which is comparable with data from other countries[1]. Monosymptomatic nocturnal enuresis is defined by the absence of any daytime voiding symptoms. Desmopressin is a vasopressin analogue and is the most widely used drug for treatment of monosymptomatic nocturnal enuresis with proven efficacy. It is considered as the first-line treatment, especially for children with enuresis in families who are not motivated enough to use the alarm therapy, who have recently unsuccessfully used the alarm or in those who are unlikely to use it correctly[2]. Several factors have been proposed to negatively influence clinical response to desmopressin treatment. One of them is constipation and it must be addressed before treatment[3-4]. The formulation of desmopressin also appears to influence the response to treatment: desmopressin melt (oral lyophilize formulation of desmopressin) has better response,
compared with tablet, in children with primary monosymptomatic nocturnal enuresis, mainly due to increased compliance\textsuperscript{[5,6]}.

**METHODS**

100 patients with monosymptomatic enuresis were evaluated in this retrospective study. Body mass index (BMI) was calculated in all of them. Children were defined as normal if their BMI was below 85th percentile (p), overweight if between 85th and 95th p and obese if their BMI was above 95th p. Family history data was available in 84 patients. All children, treated with desmopressin, received desmopressin melt oral formulation. The associations between response to enuresis treatment with desmopressin and family history of enuresis, body mass index and associated comorbidities (such as attention deficit hyperactivity disorder, mental disability, history of head trauma, difficult socioeconomic situation, language disorders and allergies) were analysed with $\chi^2$ (chi-square) statistical test, using computer programme Microsoft Excel statistical tests.

**RESULTS**

Family history was positive in 60% and negative in 44% of patients. Among 67 children, treated with desmopressin, family history of enuresis was positive in 58.8% of patients who responded to desmopressin treatment and in 54.5% of non-responders. The difference was not statistically significant ($p = 0.99$). Table 1 presents these data in more detail.

<table>
<thead>
<tr>
<th>Positive family history</th>
<th>Negative family history</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response to treatment</td>
<td>20</td>
<td>14</td>
</tr>
<tr>
<td>No response to treatment</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Sum</td>
<td>38</td>
<td>29</td>
</tr>
</tbody>
</table>

Obesity was present in 14.3%, overweight in 19% and normal weight in 66.7% of patients who responded to desmopressin treatment. Among non-responders, obesity was present in 13.2%, overweight in 7.9% and normal weight in 78.9% of patients. The difference was not statistically significant ($p = 0.90$). Table 2 presents these data in more detail.

Comorbidity was present in 40.5% of patients who responded to desmopressin treatment. Among non-responders, comorbidity was present in 21.1% of patients but the difference did not reach statistical significance ($p = 0.47$). Table 3 presents these data in more detail.

There were 72 patients with primary nocturnal enuresis and 7 with secondary nocturnal enuresis in the group of patients, treated with desmopressin. 52.7% of patients with primary nocturnal enuresis and 57.1% of patients with secondary nocturnal enuresis responded to desmopressin. The difference was not statistically significant ($p = 0.99$). Table 4 presents these data in more detail.

<table>
<thead>
<tr>
<th>Comorbidity present</th>
<th>Comorbidity absent</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response to treatment</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>No response to treatment</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Sum</td>
<td>25</td>
<td>55</td>
</tr>
</tbody>
</table>

The study also did not prove statistically significant difference in response to treatment with desmopressin between patients with primary and secondary nocturnal enuresis. The latter is defined as enuresis in a child that has previously been dry at night for 6 months or more after the age of 5 years\textsuperscript{[21]}. To the best of my knowledge, no previous studies have been conducted or published with the objective of determining the associations between above mentioned factors and response to enuresis treatment with desmopressin oral melt formulation in a single study. The role of family history was previously studied in terms of responsiveness to desmopressin therapy. It was found that 91% of enuretic children with a family history of enuresis showed a good response to desmopressin therapy while only 7% of enuretic children with no such history had a good response to this kind of treatment\textsuperscript{[31]}. There are some comorbidities, reported to be associated with poorer response rate, such as history of urinary tract infections, attention deficit hyperactivity disorder, psychological problems, autism spectrum disorder, mental and motor disability and sleep disturbances, manifested as snoring, waking up or restless legs\textsuperscript{[30]}. All proven or suspected organic comorbidities of the urinary tract, such as history of urinary tract infections or uropathy as well as patients with severe constipation, were excluded from this study. Therefore, only attention deficit hyperactivity disorder, psychological problems, autism spectrum disorder, mental and motor disability, sleep disturbances, history of head trauma, difficult socioeconomic situation, language disorders or allergies were considered as comorbidities. Another study investigated the correlation between body mass index and the efficacy of nocturnal enuresis and voiding dysfunction treatment in obese patients. It
revealed a reduced response to therapy in patients with a body mass index above the 85th percentile since patients with a normal body mass index had a lower nocturnal accident frequency than those above the 85th percentile after treatment. These findings are in contrast with the results of the present study suggesting the complex nature of enuresis pathogenesis. On the other hand, another study showed that language disorders (such as dyslexia or delayed language development) and testicular pathology could be comorbidities associated with persistence of nocturnal enuresis and treatment resistance. In addition, rate of remission in children with positive family history of enuresis was higher compared to children with negative family history but the difference was not statistically significant.

Further research on other possible predictors of response to enuresis treatment would be beneficial in order to adjust treatment to individual patients and improve its efficacy.

REFERENCES


