**LETTERS TO THE EDITOR**

Desmopressin for bedwetting

SIR,—The article by Evans and Meadow cast further light on the ongoing controversy about the causes of nocturnal enuresis in children. 1 While some stress the importance of small bladder capacity 2 and others the importance of nocturnal polyuria caused by deficient arginine vasopressin (AVP) secretion, 3 many take the compromise of both factors playing their part. 4 In this paper, enuretics had higher nocturnal volumes (345 ml) and lower nocturnal urinary AVP concentrations (0.9) compared with non-responders (265 and 2.8 respectively). While these differences were insignificant for the small numbers of children involved (eight and 10 respectively) the authors rightly point out that there did appear to be ‘a trend towards desmopressin responsive enuretics having lower AVP concentrations and larger volumes of dilute urine at night’. It could well be that significant differences are found with larger numbers of children. It was also interesting that the age of desmopressin responders who appeared to produce more dilute urine was 12 compared with only 9 in the others. This supports our own feeling that the cause of nocturnal enuresis is more likely to be lack of nocturnal AVP secretion in older children and adults and smaller function bladder capacity in younger. A lot of the work addressed the lower nocturnal enuretics who are AVP deficient was done on older children and adults. 5 There was therefore no real support for Evans and Meadows suggestion that ‘It is possible that the diurnal variations in AVP are less well developed in younger children’. Recently we did a short study of nocturnal enuresis in 3 year olds to see if the enuretics produced more dilute urine overnight. At the routine medical on joining school, children were asked to bring along the first urine specimen of the day for measurement of osmolality. (This study was passed by our local ethics committee.) Fifty five children produced samples: 46 who were virtually dry and nine who wet the bed most nights. Mean (SD) osmolality of those who were dry was 801 (180) and of the enuretics 760 (264) mmol/kg (not significant). While it is possible that early morning osmolality may not be fully representative of total overnight urine production if the child has previously wet the bed, we feel this study does indicate that enuretics in young children is unlikely to be due to nocturnal polyuria. This type of developmental nocturnal enuresis is probably mainly due to low functional bladder capacity at night. In studies of nocturnal enuresis a firm distinction should be made between such children with developmental enuresis and older children and adults.

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Comparison of BCG vaccination at birth and at third month of life

SIR,—I read with interest the paper by Ildirim et al. 1 The authors recommend that practice be changed in which BCG is given to newborn infants, and that the vaccine be given at the end of the third month instead. I would be concerned that the uptake and continuation of BCG in those countries in which BCG is given to newborns will be lower. This would in turn result in a lower herd immunity, as well as a reduction in the number of deaths from TB per year. I would therefore prefer that BCG be given to all infants at birth, as this is the recommended strategy in those countries in which BCG is not given to newborn infants.


Dr Ildirim and colleagues comment:

We read with interest the letter of Dr Gorham and are pleased to learn that Dr Gorham accepts that immunisation is more effective at the end of the third month. We do not agree that the number of children coming for vaccination will be fewer at the third month. As more than half of deliveries are not pacified at 3 months of age will be considerably lower than when given in the neonatal period when the babies are in effect a ‘captive’ population. In the study reported, at the end of the first year 7% of those immunised in the neonatal period did not have a BCG scar as against 0.6% of those immunised at 3 months. We would suggest that even in this country, if BCG was planned to be given at 3 months the number of children not immunised would far exceed 7%, and that as a result the immunisation itself was more effective, the protection from tuberculosis itself will be less powerful. The risk of serious complications after immunisation (lymphadenopathy with fistulisation) was not significantly different between the groups.

It would, therefore, seem hasty to change any immunisation programme until further evaluation had taken place.

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Dr Gorham responds:

We agree that the number of children coming for vaccination will be fewer at the third month. As more than half of deliveries are not pacified at 3 months of age the herd immunity in developing countries, to reach the newborn for BCG vaccination will be more difficult in those countries. Instead every developing country has a vaccination programme (diphtheria, pertussis, tetanus, and polio) for children, starting in the second month of life. For children in those countries in which BCG is not given to newborns, it is more effective to immunise at 3 months.
Desmopressin for bedwetting.

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