disease, as patients with predominantly bowel symptoms do not come our way.

It is hard to believe that simple closure of the fistula renders subsequent surgery significantly more difficult, for the procedure involves no mobilization of the bowel.

It is disappointing that a modest contribution, pointing out that in appropriate patients more radical surgery may not be necessary, should be described as a major (retrograde) change in policy. It is certainly not as retrograde as Professor Hughes' own recommendation that the fistula be left *in situ* and the symptoms treated with 'antibiotics as necessary'.

G F ABERCROMBIE
12 March 1984

Late results of optical urethrotomy

From Mr W G Hartfall, Mr D St J Collier and Mr J A Pain
Department of Surgery
Ipswich Hospital, Suffolk

Dear Sir, We read with interest the paper on this subject (February *Journal*, p 105). It is unfortunate that no information was presented as to how many patients remained free of their stricture symptoms following a single urethrotomy. Furthermore, it is unclear whether the average 2.13 procedures per patient in the group of 46 patients were performed before or during the 6-year follow-up period. If it was during this period, then presumably 41 patients (89%) [*sic*] who remained symptom-free underwent only one procedure and the remaining 5 patients must have undergone a total of 57 urethrotomies.

We have found that of 100 patients, 65 were cured by a single urethrotomy (mean follow up 28 months, range 14–40 months), and of the remainder a further 20 by a second urethrotomy. Also if symptoms recurred they did so within 3 months of urethrotomy in 82% and in only 4% more than 6 months after urethrotomy (Pain & Collier 1984).

We agree that optical urethrotomy is the treatment of choice for urethral strictures, and although this technique has only been available for 10 years it appears that the majority of patients can be cured by a single procedure (Matouschek 1978, van Dessel *et al.* 1982).

Yours faithfully
W G HARTFALL
D ST J COLLIER
J A PAIN
29 February 1984

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A copy of this letter was sent to Messrs Smith, Kaisary and Ball, whose reply follows:

Dear Sir, The number of urethrotomies required to relieve symptoms in the 46 patients was as follows:

No. of urethrotomies	*No. of patients*	*Total urethrotomies*
1	23	23
2	11	22
3	4	12
4	3	12
5	2	10
6	2	12
7	1	7
		98

All the urethrotomies were performed in the 6 years under review. This series represents the first group of stricture patients treated by visual urethrotomy in the UK. Inevitably with the improvement in technique the number of urethrotomies performed for each patient has diminished considerably.

It is gratifying to note that Hartfall *et al.* confirm our long established view of the success of optical urethrotomy.

Yours sincerely
PATRICK SMITH
AMIR V KAISARY
ANDREW J BALL
26 March 1984

Nocturnal enuresis: a familial condition

From Dr Marta Elian
Consultant Clinical Neurophysiologist
Oldchurch Hospital, Romford, Essex
Dr Ezra Elian and Dr Arieh Kaushansky
Department of Paediatrics
Hasharon Hospital, Petach-Tikvah, Israel

Dear Sir, We have read with interest and some astonishment the editorial by John Black on nocturnal enuresis (August 1983 *Journal*, p 632). He advises that history-taking should include details on 'emotional disturbances, social, economic, housing difficulties and school problems' to cover all aspects of the condition. The advantages of the currently fashionable methods of management were discussed, rightly emphasizing that 'there have been no exciting advances in the treatment' of nocturnal enuresis. Missing from the list of important contributory factors to this condition was the familial aspect of

the disorder. The neglected hereditary aspect of the condition deserves special mention.

We studied the genetic aspects of nocturnal enuresis as defined by Nelson (1964) and Barnett (1972) in 100 Israeli children (unpublished). The first group comprised 64 children from different regions of Israel who had been referred to one of the University Hospital outpatient clinics for a variety of unrelated conditions, excluding genitourinary problems. The history of nocturnal bed-wetting in this first group of children emerged while inquiring about their developmental milestones. Thirty-six healthy Kibbutz children comprised the second group. A detailed history was taken about the familial occurrence of the condition. The parents' ethnic origins were also recorded. Those who had no siblings above the age of four (19 probands) were eliminated from the analysis of the familial aspect. A positive family history of the first degree was found in 59 of the remaining 81 children, that is siblings and/or parents also affected. An incidence of 83.3% (75 families) was found when uncles and first cousins were also included. The familial incidence showed an essentially similar distribution in the various ethnic groups.

The large number of cases with a positive family history and the strikingly similar incidence in the various ethnic groups support the importance of heredity in enuresis. The concept of persisting bed-wetting being a developmental delay was put forward fifty years ago by Denny-Brown & Robertson (1933) and later by others (Gesell & Ilg 1943, Bakwin 1961, Harbour *et al.* 1963, Klackenberg 1981). The results of our study support the concept that enuresis is a function of maturation, similar to a delay in language functions or variation in the onset of menarche. It is a common familial deviation or idiosyncratic family pattern which resolves spontaneously.

A search for possible emotional causes of enuresis has failed to establish a well-defined behaviour pattern of children with enuresis. No significant correlation has been found between stressful life events or psychopathological symptoms. The minor psychological changes occasionally found may well be the effect and not the cause of the symptom. Drug therapy with a wide range of chemicals, conditioning by different alarm systems and psychotherapy have remained on the whole unsuccessful, especially when the success is weighed against a background of spontaneous cure (Bakwin 1961, Wagner *et al.* 1982, Lapouse & Monk 1959, Schachter & Cotte 1941, *Lancet* 1977).

In his editorial Dr Black recognizes the importance of lessening tension in parents and child. This can be achieved by explaining to parents and children the inborn nature of delayed bed-wetting, that the tendency is inherited from one or both parents and that it disappears with time.

Sincerely

MARTA ELIAN
EZRA ELIAN
ARIEH KAUSHANSKY

20 February 1984

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