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When children do not achieve urinary continence

LEDER

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Bladder disorders can have lasting effects on patients' lives into adolescence and adulthood. But effective treatments are available.

For a number of years, there stood a small abstract painting on my desk. It showed a jumble of streaks and bright colours against a dark background. When I asked the eight-year-old who gave me the picture what it represented, she asked me to turn it over. On the back was a single word: Chaos. She had suffered from urinary incontinence her entire life, had received multiple treatments and was just about to undergo another surgical procedure.

I believe that the despair and chaos portrayed by that picture may well represent what many children of a certain age feel when they fail to achieve urinary continence like their peers. A problem of this nature can affect a person their entire life. It is therefore highly commendable that Anine Lie and colleagues have focused on paediatric urinary incontinence in this issue of the *Journal of the Norwegian Medical Association* (1). Two further articles on the topic will appear in later issues (2, 3). Lie and colleagues' article provides a good introduction on how to approach the problem, especially in first-line care. The same principles of assessment and early treatment can then be built upon in the specialist health service. A proper workup is the foundation of both primary care and more specialised treatment for children with neurogenic bladder disorder (2) and for those who require surgery (3).

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Unfortunately, it was not so long ago that the majority of these children received inadequate treatment, ranging from so-called folk remedies to being treated as pariahs. With a few honourable exceptions, it was not until the mid-1980s that the treatment of urinary tract disorders in children gained momentum (4). The realisation that children were not small adults and that the assessment and treatment of paediatric urological conditions required their own guidelines was very important. Another step in the right direction was the development of a training programme on the treatment of urological disorders, first in Gothenburg and then later at Bergen University College in Norway. An understanding of the mechanisms of micturition, and a pedagogical approach to solving urinary tract problems, was highly important.

The field has developed and in many ways matured over time. The evidence base for the assessment and treatment of neurogenic and non-neurogenic urinary tract disorders has been expanded and strengthened. The establishment of two important collaborative groups, the European Society for Paediatric Urology (ESPU) and the European Association of Urology (EAU), contributed greatly in this respect. The two groups now collaborate on guidelines. These are well-written, updated annually and readily available in both expanded and short form. They are therefore well worth having as a source of useful background information when treating children with urinary tract disorders (5).

We must hope that the articles lead ultimately to revised guidelines

Norwegian authorities and organisations have perhaps not been as good at following international developments in this area as one might wish. The chapter on urinary incontinence in *Pediatriveilederen* [Guidelines in Paediatrics] is from 2009 and would benefit from being updated (6), although citations to updated reference works are provided on the same page. The Norwegian Directorate of Health's priority-setting guidelines for paediatric urinary incontinence are from 2015 (7). There have been major developments in the field, and significant increases in understanding of the problems, since these guidelines were published. It is therefore excellent news that the *Journal of the Norwegian Medical Association* is publishing a series of articles on this topic, and we must hope that the articles lead ultimately to revised guidelines.

It must nevertheless be emphasised that even if guidelines draw upon the most robust evidence base and the best recommendations, it is not always certain that they will provide the best results for individual patients. Guidelines can never replace clinical experience and an effective collaboration with children and their parents when choosing tests and treatments. They must support this interaction. Remember that guidelines are not legal rights, but sound recommendations.

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