

Commentary

This article offers an interesting series of case reports purporting to link rapid maxillary expansion with increased nasal airway which in turn reduces nocturnal enuresis. The use of RME to increase nasal airflow is not uniformly agreed upon and the problem of measuring nasal airflow is itself controversial and complex. The link between nocturnal enuresis and nasal airflow inadequacies has not been experimentally established and so must be considered as experiential and descriptive. It is an interesting idea, but as the author suggests, why are only a small percentage of nasal airway deficient children affected with nocturnal enuresis? While the associations are tenuous, they make the article interesting.

A cause and effect relationship is certainly suggested by the fact that all 10 subjects in the sample ceased bedwetting after undergoing rapid maxillary expansion; and the fact that the 10 children reported represent the total number of nocturnally enuretic children referred to this

clinic in the past six years is honest sampling. Nevertheless, controls are needed to establish if other nocturnal enuresis patients could respond similarly, if sleep apnea patients have nocturnal enuresis, if the nasal airways of nocturnal enuresis patients differ from those of the general population, and if other possible associations exist among long face skeletal patterns, nasal respiration, sleep apnea and nocturnal enuresis.

The actual nasal airway increase is, agreed, limited by the rotation of the maxillary halves. Their center of rotation is commonly at the lower border of the orbit, as laterally separating the orbital floors is not desirable. Thus, the nasal width increase will be less than the dental increase by a factor of circumference and the radii length ($C = 2 \pi r$). The silver splint will probably not affect the line of force. The bottom line will be the airflow needed and the air passing through whatever space is provided.

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