SECTION ONE

For Parents and Carers

Bedwetting
Basic Facts for Parents and Carers

Bedwetting is known in medical terms as ***nocturnal enuresis*** (roughly meaning 'urinate in the night'), and sometimes is just referred to as *enuresis*.

How common is bedwetting?

Bedwetting is common in school age children. It affects:

- 1 in 5 children at 5 years.
- 1 in 10 children at 10 years.
- 1 in 30 to 100 teenagers at 15 to 17 years.

Effects of bedwetting on a child and family

It can be tempting to assume bedwetting is something a child will grow out of in time, or to minimise the problem to try to make the child feel better about it. This does little, however, to lessen its impact on a child's emotional, psychological and social development. There may be strong feelings of shame, guilt and failure, and a sense of being different to others. In some cases bullying and victimisation can result, both in the family and at school. Often bedwetters will avoid social activities that most children take for granted.

Bedwetting doesn't only affect the child concerned; it can be a burden and a source of disturbance, concern and frustration for the entire family. In addition to the emotional costs, there are the financial costs to parents/carers as well as time and effort in cleaning. It can lead to even the best intentioned parents becoming frustrated and intolerant, and relationships suffer.

Are there different types of bedwetting?

For many children, bedwetting is the only problem with wetting they have. This is called

mono-symptomatic enuresis
(meaning 'one symptom' bedwetting).

Some children have other symptoms, such as needing to wee as soon as they feel the urge (urgency), wetting while they're awake, needing to wee more often than usual, or others.

If any other bladder symptoms are present, this is called

non-mono-symptomatic enuresis
(meaning 'not one symptom', that is, more symptoms).

Your doctor will be careful to distinguish between these two, as treatment differs for the two conditions.

What causes bedwetting?

There are three main factors that cause bedwetting. These are:

- Difficulty arousing from sleep.
- Producing more urine during sleep than usual.

- Bladder factors, for instance:
  - A lack of the signal that stops bladder emptying during sleep,
  - A reduced amount the bladder can hold, or
  - Bladder overactivity, that is, the muscle that squeezes the bladder to empty it contracts when the bladder isn't full.

However, not all children have all three factors, and the contribution of each varies from one child to another.

Other factors include:

- Family history: bedwetting has long been recognised to cluster in families.
- Some children have snoring and sleep apnoea when they sleep which affects their ability to wake at night to pass urine.
- Children with developmental and other disabilities such as attention deficit/hyperactivity disorder and autistic spectrum disorder have higher rates of bedwetting.

Link with bowel problems

Constipation is common in children with bedwetting (about 25%), and can be a major factor causing the problem. Constipation and other bowel symptoms will need to be addressed by your doctor, and when these are effectively dealt with it is sometimes enough to resolve the bedwetting without further treatment.

How is bedwetting treated?

To begin, it is important to **establish regular drinking and urinating habits**. Drinking well and weeing regularly during the day is important. If the amount the bladder can hold and the urge to wee are causing problems for your child, they need to be treated before other treatment starts.

Treatment is also given for **constipation** or other bowel problems if present.

If the child has **other wetting symptoms** (if they have non-monosymptomatic type), those will be treated first, including any tests that might be needed such as a bladder ultrasound.

If bedwetting is still occurring, **alarm treatment** will generally be offered next (see the information on alarms). Alarm treatment takes longer than medication to get a result (3 to 6 months), but has a lower relapse rate than medication and no side effects on the child's body.

If bedwetting persists after 3 to 6 months of alarm treatment, medication may be considered.

Outlook for becoming dry

- About 1 in 7 children with bedwetting will stop wetting without any treatment or intervention each year.
- Without treatment some children will continue to experience bedwetting through to teenage years, and even to adulthood.
- Treatment helps the majority of children to significantly improve, and most to become dry at night much earlier.

Assessment for Bedwetting
Parent/Carer Information

What will the assessment of the child involve?

The aim of this assessment is to identify what is causing the child's bedwetting problem.

The parent/carer and the child will be interviewed by a health professional and asked lots of questions about the child's bladder, bowel function and bedwetting problem.

Many parents/carers won't know things about their child's bladder or bowel habits, as it isn't a general topic of conversations in most families. Sometimes there may be disagreement between the parent/carer and the child's answers, but remember that the child knows his/her body better than anyone. Some children won't have mentioned daytime problems; they don't see them as abnormal because it is normal for them.

The child's bedwetting problem may be caused by having a bladder that becomes overactive at night or the child may produce too much urine at night. Some children may have both problems. Most children who bed wet are unable to arouse to the sensation of a full bladder, regardless of the cause of the full bladder.

Every child and family deserves a thorough assessment of bedwetting, and this should be done in a sensitive manner. It is important to tell the health professional everything, including how the parent/carer and the child are coping with the wetting. The health professional will understand these issues.

General questions that will be asked are:

- At what age did the child develop daytime control of urine and faeces (wee and poo)?
- When did the child wean from nappies during the day?
- Has bedwetting been a lifelong problem for the child?
- Medical and surgical history (including medications as these can impact on wetting).
- What does the child eat and drink?

Health questions to check for causes of bedwetting and issues that may affect treatment, for example:

- Risk factors for bedwetting, such as sleep apnoea or constipation.
- Daytime bladder symptoms, such as urgency or frequency.
- Questions to determine whether the child's development has been normal.

Family questions are important to check for causes and the best treatments:

- What effect is bedwetting having on the child and family? (This may determine the treatments suitable for the child).
- How motivated is the child and other family members to treat this problem?
- Are there other family members who had/have wetting or kidney problems?

Physical assessment and other tests:

The health professional will need to exclude physical causes for the bedwetting.

They'll need to examine the child including the genital area, back and abdomen. They'll also test the child's urine with a dipstick to exclude infection and/or other diseases. If there's any reason why the child can't be examined please tell the health professional straight away.

What do the parent/carer and child need to do?

- Ask other family members if anyone had/has urinary or kidney problems.
- Observe the child for about two weeks before the appointment. Note if there is:
  - Urinary urgency or frequent visits to the toilet.
  - Ask the child to listen to their urine stream. Is it a steady stream or does it stop and start?
  - Record dry nights and wet nights. Also, keep a note if the child got up to go to the toilet at night.
  - Chart the child's bowel motions (poos), as constipation is a risk factor for bedwetting.
- Your health professional may also ask you to keep a 3-day frequency volume chart recording all drinks going into the body and all urine coming out of the body. This will include the amount the child is wetting and the number of times he/she gets up to go to the toilet at night. An appropriate chart and instructions will be given by the health professional treating the child.

What rights does a parent/carer or child have during an assessment?

It is the parent's/carer's right to enquire why the health professional needs to ask the questions and to ask about tests that the child may need, such as why the child need the tests, what is involved, what needs to be done for the tests, who will do them and what will the results mean for the child. The parent/carer has the right to refuse a physical examination for the child.

Bladder Management
Parent/Carer Information

What is normal?

Children should go to the toilet to pass urine between 5 - 7 times per day.

For the bladder to work properly, it needs to be relaxed while filling up with urine. Usually, the bladder only contracts (squeezes) when urine is passed. 30% of bedwetting children have overactive bladders at night, so their bladder is contracting even when they don't want it to. This might only happen at night, but for some children it happens in the daytime as well.

Aims of bladder management

- To reduce the episodes of urgency, caused by bladder overactivity or by holding on for too long.
- To normalise the bladder's holding capacity.

Symptoms of an overactive bladder

- Passing urine often during the day (frequency).
- A feeling of "busting" to go to the toilet (urgency).
- "Holding on" behaviour, like squatting or putting their hands on the genital area.
- Occasional daytime wetting.
- A lower than normal amount of urine they can hold in the bladder, for their age.
- Possibly more than one wet episode per night.

A child may experience symptoms of an overactive bladder because they are not drinking enough or because they are constipated. These should be addressed first. If they continue to experience symptoms of an overactive bladder despite drinking well and not being constipated, they need to be assessed by their doctor to see if they need additional treatment.

Important DOs and DON'Ts in bladder management

The child usually has to increase their fluid intake, most of which should be water.

- **Don't** leave all the drinking until after school.
- **Don't** drink large amounts 2 hours before bed.
- **Don't** have caffeine (found in cola, chocolate and fizzy drinks), as it can irritate the bladder and make the child feel busting and want to go to the toilet more often.
- **Do** wee regularly during the day, at least every two to three hours.
- **Do** encourage regular drinks, and reward what the child does.

What is timed voiding?

Timed voiding (weeing) can be used to change a child's bladder habits.

Some children don't go to the toilet often enough and need a schedule to prevent them overstretching their bladder. If your child needs this, your doctor or other health professional will help you work out a schedule for your child to follow.

Bowel Problems and Bedwetting

Constipation is common in children with bedwetting and can be a major factor causing the problem. Even if a child regularly passes bowel motions it is still possible that the bowel is filled with hard, impacted faeces, and this can interfere with the normal functions of the bladder.

What causes constipation?

The most common cause of constipation is regularly holding on when a child needs to pass a bowel motion. This might be because they don't like going to the toilet at school, may be embarrassed to go at a friend's house, lack of opportunity, or not wanting to stop what they're doing. Diet may play a part, with processed, low fibre diets more likely to contribute to constipation than fresh, high fibre diets. Stressful events can play a part, such as family upheaval, a new school or kindergarten, or illness. It might start after they've passed a hard or painful bowel movement, or if they have irritation around the anus. Inadequate fluid intake can lead to hard bowel motions, so it is very important for children to drink water regularly through the day.

What happens to the rectum?

When the bowel motions are held for too long, the rectum reabsorbs the water from them and they become harder and more difficult to pass, which can make a child more reluctant to pass a bowel motion the next time. The hard faeces build up and the rectum is stretched, with a loss of sensation so the child finds it harder to know when they need to pass a motion. Sometimes a child can pass regular bowel motions but hard faeces are still in the rectum and the rectum is still stretched.

What does constipation have to do with bedwetting?

When a child is constipated with a stretched rectum, it can press on the bladder and interfere with the amount of urine it can hold. It can also irritate the bladder, causing it to spasm or empty when it shouldn't. In some cases, when the constipation is treated and normal bowel function is re-established, bedwetting and other symptoms may resolve without the need for other treatment.

Bowel Management for Children

A child should have 4 or more bowel motions per week, which are soft and easy to pass.

How to help:

1. Bowel activity occurs about 20 minutes after each meal. The child should sit on the toilet and try for a bowel motion at that time. One of the most important times is after breakfast.
   - The feet should be well supported with a stool.
   - The child should sit and try for a few minutes but no more than 5 minutes.
   - Always ensure the child wipes his/her bottom properly.
2. Tell the child to never ignore the messages the bowel is sending to their brain, if they are able to go to a toilet. When they need to go, they should go.
3. Your doctor or nurse will be able to tell you if your child needs to take any medications to help with their bowel motions. The medications will make their bowel motions soft, more frequent and easier to pass. Make sure the child takes them as directed.
4. The child should drink about 5 or 6 glasses of fluid per day (water is the best option), depending on their age. Your health professional will inform you of the minimum amount, about 50 mL per kg per day.
5. The child should eat fibre in their diet. A variety of fruit, vegetables and cereals such as porridge are good options, aiming at 2-3 serves of fruit and 4-5 serves of vegetables daily.