Enuresis is an area with huge potential for management in the community, write Yvonne Ryan and Nick van der Spek

Table 1: Causes of enuresis

- Urinary tract infection
- Constipation – causes voiding dysfunction
- Obstructive sleep apnoea
- Neurological problem in the spinal cord, eg. spina bifida with neurogenic bladder
- Emotional disturbance, eg. ADHD, child abuse
- Diabetes mellitus/insipidus
- Nocturnal seizures
- Anatomical defects, eg. ectopic ureter, urinary tract obstruction
sleep apnoea. A hair tuft on the sacrum may reveal spina bifida occulta. The first investigation is a urine dipstick to outline occult infection and proteinuria. Blood pressure should also be checked. Ultrasound of the renal tract is not recommended routinely except when a pathological cause is suspected or a voiding diary reveals voiding dysfunction.

**Therapeutic approach**

The therapeutic approach is defined by the age/maturity of the child. Many of these mechanisms require cooperation from the child and a heavy investment of the parent’s time. Education of the parents and child about enuresis using ‘the three systems’ approach is important.

The ‘three systems’ approach is a model used to explain visually to the parents and child about the three main causes of enuresis:
- Monosymptomatic enuresis due to arousal difficulties
- Monosymptomatic enuresis due to reflex leaking of urine (nocturnal polyuria)
- Non-monosymptomatic enuresis due to bladder or bowel dysfunction (lower urinary tract symptoms)

**General advice**

First try to minimise the embarrassment/anxiety of the child. Encourage parents to share their enuresis experience with the child. Positivity and motivation are key. Have the child look into the mirror each morning and repeat the positive affirmation ‘I am the boss of my bladder’. The child needs to feel empowered and not helpless or punished. This is the basis of the use of star and reward charts where activity to help with continence (such as filling out the diary and changing bedclothes) and not just dry nights are rewarded. The best reward for the child is for the parent to spend dedicated time with them; for example play a football game at the weekend.

Children should be instructed to drink liberally during the day (aim for >50% of daily intake before 12pm), but not to drink excessively with the evening meal and in the evening. The child should be toileted every night before bed. Commonsense modifications may be needed for children who participate in sports in the evening times. No child should go to bed thirsty and fluid restriction or lifting during the night is not a useful strategy to achieve long-term dryness. (See Table 2 for a list of Dos and Don’ts for parents). The parent can find general advice on the website www.bedwetting.ie

**Under sevens**

Children under the age of seven can be reassured that this is a very common problem and most can expect to be dry by seven years of age. Spontaneous cure rates are 14% a year. Star and reward charts may be helpful in this age group. The parents need particular support and advice as this can be a frustrating time for them, with significant sleep disturbance and expense.

**Over sevens**

Once aged seven, monosymptomatic children who remain problematic can be referred for a trial of an enuresis alarm system. This is a simple mechanism that causes an alarm to sound when the child wets. The aim is to gradually train the child to wake up when the bladder is full or to hold on through the night. Alarms are normally available through local community services/enuresis clinics, which may be run by a public health nurse in conjunction with a paediatrician.

Desmopressin is an antidiuretic hormone analogue and is commonly prescribed for enuresis. It reduces wetness in 70% of children (40% totally dry, 30% drier than before) and is convenient and easy to use. It is costly however, and usually results in relapse when discontinued. It can be helpful to reduce wetting in the short term or for ‘emergency’ situations such as a family holiday or sleepovers. The usual dose of desmopressin is 120 micrograms sublingually at bedtime. There is a risk of hyponatraemia with this medication.

Oxybutynin can be useful if the patient has symptoms of bladder instability. Tricyclic antidepressants are not indicated.

Table 2: DOs and DON’Ts for parents

**DO:**
- Remember that bedwetting is neither the child’s fault nor your fault as the parent. Patience, love and encouragement will go a long way to resolving the problem for everyone in the family
- Encourage your child to drink throughout the day. It is important that they recognise the feeling of a full bladder
- Avoid fizzy drinks and drinks containing caffeine or tartrazine (eg. blackcurrant drinks) at bedtime. These cause more urine to be produced and can irritate the bladder
- Ensure your child has plenty of fruit, vegetables, cereal and fluids in order to avoid constipation (this can irritate the bladder and is a common cause of wetting)
- Ensure your child goes to the toilet before going to bed
- Leave the light on for easy access to the toilet
- Encourage your child to come out of nappies but make sure the mattress and bedding is adequately protected
- Allow the child to help with changing the bed and nightclothes. It helps if they are actively involved in overcoming the problem
- Make sure that the child has a bath or shower each morning to remove the smell of stale urine to avoid teasing or torment at school

**DON’T:**
- Get cross with your child
- Use waking the child as a long-term strategy to overcome bed-wetting

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Useful websites
www.nice.org.uk - see guideline on nocturnal enuresis.
www.eric.org.uk - a UK based childhood continence charity, lots of downloadable information and resources including the charts, appropriate for children, parents and professionals.

References