How to help families cope with bedwetting during childhood or adolescence

Nocturnal enuresis can have a severe impact on quality of life. A member of the NICE guideline development group outlines the latest advice on treatments

More than one fifth (21%) of children aged between 4-5 years wet the bed at least once a week. While the prevalence of bedwetting decreases with age, it still affects many children well into adolescence. An estimated 2.5 million 11-14 year olds suffer with bedwetting. The problem can have a severe impact on a child or young person’s behaviour, emotional wellbeing and social life. It can also be stressful for the parents or carers.

In October, the National Institute for Health and Clinical Excellence published its first clinical guideline on the assessment and management of this condition in children and young people under the age of 19.

ASSESSMENT AND INVESTIGATION

At the initial assessment, the guideline advises to ascertain the frequency and duration of the child’s bedwetting, if they also experience daytime wetting, and, if so, its frequency or urgency. This will help establish any cause – if daytime symptoms predominate, nurses should investigate these first.

The assessment also needs to consider factors such as constipation or soiling, learning disabilities, diabetes or psychosocial or educational issues. This will help determine whether bedwetting is symptomatic of an underlying condition, or a product of any other medical, emotional or physical factors.

During this assessment, nurses should consider whether a record of fluid intake, daytime symptoms, bedwetting and patterns of toilet use would be useful. They can ask the child, parent or carer to record this.

Nurses should advise families on how to reduce the impact of bedwetting before starting treatments, such as bed protection. Support should be tailored to the child’s and parent or carer’s circumstances and needs. It is important to find out how children feel about their bedwetting and what they hope to achieve from treatment. For example, short term dryness may be a priority because of sleepovers or holidays.

Nurses should encourage parents or carers to try a reward system for behaviour – for example drinking certain amounts of fluid during the day or using the toilet before bedtime – rather than only for dry nights. Parents should avoid removing rewards or punishing their child for bedwetting as this reinforces the idea that it is the child’s fault.

DECIDING ON TREATMENTS

Previously, assessment and treatments were only being considered appropriate for children aged over seven years. However, NICE recognises that assessment, support and management can have a positive effect on younger children’s self esteem.

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The guideline says children aged under seven should not be excluded from treatment on the basis of age. Treatment should be based on the severity and nature of the bedwetting, the needs of the child and their parent or carer and the nurse’s judgement.

Any abnormal patterns of toilet use, soiling and constipation, and excessive or insufficient fluid intake should be addressed before treatments are started.

ALARMS

If bedwetting has not responded to fluids advice, toilet use or a reward system, alarms can be offered as a first line treatment.

Alarms are an effective treatment, teaching the child to wake when they start to void. This often results in a waking to void or their sleeping through and remaining dry.

The type of alarm should be tailored to the child. Factors to consider include maturity, understanding what the alarm is for, hearing impairments and learning disabilities. An alarm should be offered unless the child or parents/carers consider it undesirable or it is inappropriate, particularly if:

- The child wets the bed only once or twice a week;
- The parents/carers are finding it difficult to cope with the burden of bedwetting;
- The parents/carers are expressing anger, negativity or blame towards the child.

Progress should be reviewed after four weeks. If there are improvements, treatment should be continued until there have been at least two weeks’ uninterrupted dry nights.

If, after three months the child is still bedwetting, the nurse should assess whether other treatments should be considered. Alarm treatment should only be continued if the bedwetting is still improving and the child and parents or carers want to continue.

Further treatment could be:

- Combination treatment with an alarm and desmopressin;
- Desmopressin alone if an alarm is not acceptable to the child or the parents or carers.

DESMOPRESSIN

Desmopressin can be used in the short or long term. It can also be used when:

- Rapid onset and/or short term improvement in bedwetting is the priority;
- An alarm is inappropriate or undesirable, including for those aged 5-7 years.

If the child has not achieved complete dryness after 1-2 weeks on desmopressin, nurses should consider increasing the dose. If there has been an improvement after four months, desmopressin should be continued for three months, then reviewed again.

Nurses should explain to the young person and parents/carers that wetting is prevented only on the night desmopressin is taken, so it is not a cure. Fluid should be restricted one hour before and eight hours after taking it.

The guideline is available for download at www.nice.org.uk/CG111

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