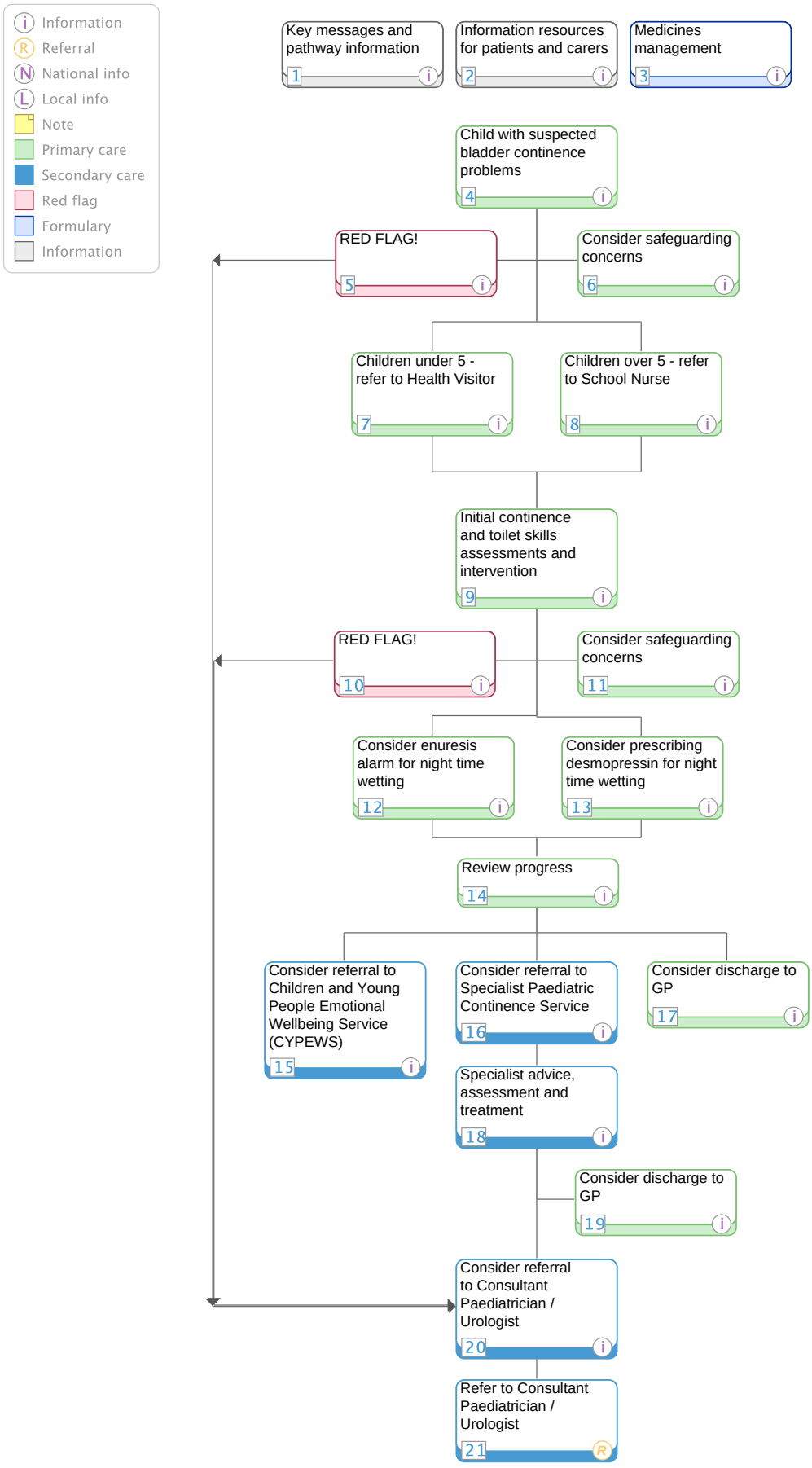
Enuresis - suspected

Draft Pathways - Gloucestershire > Child Development > Enuresis



Published: Valid until: Printed on: 31-May-2013

This care map is in development by . It is not yet approved for clinical use. A printed version of this document is not controlled so may not be up-to-date with the latest clinical information.

Enuresis - suspected

1 Key messages and pathway information

Quick info:

This pathway has been localised for use in Gloucestershire.

Key messages:

- Night time and daytime wetting is normal in children under 5, but parents may need reassurance which the Health Visitor can provide.
- Give advice to parents as per 'information resources for patients and carers' node.

Contributors:

- Dr Jeremy Welch, Children & Young People CCG Lead
- Helen Ford, Senior Commissioning Manager
- Christine Davies, Clinical Nurse Specialist
- Nevila Kallfa, Public Health Consultant
- Bridget Davies, School Nurse Lead
- Michael Richardson, Deputy Countywide Manager - Children & Young People Services
- Deborah Livingstone, Parent Carer Participation Worker

This pathway covers the management and treatment of children and young people with bladder problems.

Definition:

- Enuresis is the involuntary wetting in children older than age 5 years (after the age at which bladder control should have been mastered) with no congenital or acquired defects of the CNS
- Nocturnal enuresis (bedwetting) occurs at least twice a week
- Diurnal enuresis (day time wetting) occurs at least once per week
- Generally considered normal in younger children
- Primary wetting – child has never achieved sustained continence
- Secondary wetting – wetting occurs after the child has been dry at night or during the day for more than 6 months

Prevalence:

- Bedwetting is more prevalent in children than daytime wetting

Bedwetting occurs in:

- 15% of those age 5 years
- 5% of those age 10 years
- 2% of those age 15 years
- 1% of children continue to wet the bed into adulthood
- Male to female ratio is 2:1 age 13 years and younger, and is more common in girls after age 13.

Daytime wetting occurs in:

- 3% of girls and 2% of boys age 7 years
- 1% age 11 years upwards

Details:

- Less than 1% of primary incontinence has an organic cause, this is more common in secondary care incontinence.
- Night and daytime wetting is normal in children under 5.
- The spontaneous cure rate in bedwetting is 15% per year, independent of age.
- The distress and disability of bedwetting increases as the child gets older, and can affect self esteem, behaviour, scholastic achievement and later sexual activity.
- Reported rates of punishment are 20-30% with an increased risk in physical abuse.

Published: Valid until: Printed on: 31-May-2013

- Wetting can be caused by:
  - overactive bladder
  - insufficient bladder capacity
  - excessive output of urine during sleep
  - inability to wake from the sensation of a full bladder
  - anxiety / stress

NB: Bedwetting is usually monosymptomatic – other symptoms, eg daytime wetting or urinary tract infections (UTIs), may indicate an underlying pathology.

2 Information resources for patients and carers

Quick info:

Advice for parents:

- Do encourage the child to drink throughout the day. It is important that they recognise the feeling of a full bladder.
- Do ensure that the child has plenty of fruit, vegetables, cereal and fluids. This will help to avoid constipation which can contribute to wetting.
- Consistently prompt and use rewards systems to encourage children to use the toilet on their own.
- Encourage children to stay on the toilet until their bladder has emptied completely.
- Do stay calm, be prepared and try not to worry.
- Do remember, wetting is neither the child's fault, nor the parent's. Patience, love and encouragement will go a long way to resolving the problem for everyone in the family.
- Do avoid fizzy drinks at bedtime and drinks which contain caffeine, such as tea, coffee and chocolate. These can cause more urine to be produced.
- Do ensure that the child goes to the toilet before going to bed and again before they go to sleep if they have been reading or watching TV in bed.
- Do leave a light on at night to ensure that the child has easy access to the toilet.
- Do make sure that the mattress and bed are adequately protected.
- Do allow the child to help with changing the bed and night clothes. It does help if they are actively involved in overcoming the problem.
- Do make sure that the child has a bath or shower each morning. This removes the smell of stale urine and avoids the child being teased and tormented at school.
- Do encourage your child to come out of nappies and "pull ups", but do make sure that the mattress and bedding are protected.

Information resources for sources of further information and advice:
Education and Resources for Improving Childhood Continence
ERIC Childhood Wetting and Soiling - info for parents and carers
ERIC Test for Childhood Bladder and Bowel Difficulties - Parents Guide
ERIC Bedwetting Guide
ERIC Growing Up and Coping with Bedwetting

or email:

- info@corecharity.org.uk
- info@eric.org.uk

3 Medicines management

Quick info:
Link to be added to joint formulary

4 Child with suspected bladder continence problems

Quick info:

- History and examination by GP.
- Consider further investigations, including urinalysis, if:
  - wetting started recently
  - child has daytime symptoms
  - child has any signs of ill health
  - UTI suspected
  - diabetis mellitus suspected
- GP to complete a neurological examination if any indication of gait abnormality, back pain or skill regression
- Consider differential diagnosis
- Give practical advice as per 'information resources for patients and carers' node.

5 RED FLAG!

Quick info:

Red flag signs include:

- Recurrent UTI
- Known back problems or other factors suggestive of neurological problems
- Continuous wetting
- Palpable bladder post void

Consider onward referral to specialist services as appropriate.

6 Consider safeguarding concerns

Quick info:

Consider maltreatment if:

- the child or young person is reported to be deliberately bedwetting
- child is being punished for bedwetting despite parents/carers being informed it is involuntary
- there is persistent secondary daytime wetting or bedwetting despite management and with no medical explanation
- secondary enuresis without clear explanation identified at primary care assessment

Gloucestershire Safeguarding Children Board
Bruises on Children
Working Together to Safeguard Children
Recognising Abuse and Neglect (Body Map)

7 Children under 5 - refer to Health Visitor

Quick info:

GP to refer children under the age of 5 with daytime wetting to a Health Visitor for further assessment and management of bladder continence problems, if initial advice and support has been unsuccessful.

8 Children over 5 - refer to School Nurse

Quick info:

GP to refer children over the age of 5 with daytime and/or night time wetting to a School Nurse for further assessment and management of bladder continence, if initial advice and support has been unsuccessful.

Published: Valid until: Printed on: 31-May-2013

9 Initial continence and toilet skills assessments and intervention

Quick info:

An initial baseline continence assessment and a toilet skills assessment should be carried out by a Health Visitor / School Nurse / Special School Nurse and child commences the most appropriate primary care pathway.

Give practical advice as per 'Information resources for patients and carers' node.

Review at 6 weeks, and again at 4-6 weeks before considering further action.

10 RED FLAG!

Quick info:

Red flag signs include:

- Recurrent UTI
- Known back problems or other factors suggestive of neurological problems
- Continuous bedwetting
- Palpable bladder post void

Consider onward referral to specialist services as appropriate.

11 Consider safeguarding concerns

Quick info:

Consider maltreatment if:

- the child or young person is reported to be deliberately bedwetting
- child is being punished for bedwetting despite parents/carers being informed it is involuntary
- there is persistent secondary daytime wetting or bedwetting despite management and with no medical explanation
- secondary enuresis without clear explanation identified at primary care assessment

Gloucestershire Safeguarding Children Board
Bruises on Children
Working Together to Safeguard Children
Recognising Abuse and Neglect (Body Map)

12 Consider enuresis alarm for night time wetting

Quick info:

Enuresis alarms (alarms that are triggered when the child passes urine) are the recommended first-line treatment in children and young people when bedwetting has not responded to advice on fluids, toileting, or an appropriate reward system unless:

- alarm is considered undesirable or inappropriate, particularly if:
  - bedwetting is infrequent (fewer than 1-2 times per week)
  - parents/carers have emotional difficulty coping with bedwetting
  - parents/carers express anger, negativity, or blame towards child or young person
  - the parents/carers or child do not want to use an alarm
  - the child is age less than seven years and unable to use an alarm
  - child shares a bed
  - more than one child in a family is being treated at the same time
  - child has daytime symptoms
- inform parents/carers that:

- alarms have high long-term success rate
- alarms are not suitable for all children or young people and their families:
  - commitment and the involvement of child or young person and parents/carers is important
  - alarms can disrupt sleep
  - the child or young person may need help to wake to the alarm
- progress must be recorded

- advise:
  - on the aims of alarm treatment
  - how to use, respond to, and maintain the alarm
  - what types of alarms are available
  - a positive rewards system, eg star chart, could be used with an alarm to reward desired behaviour
  - that it may take a few weeks for early signs of a response to occur
  - how to deal with problems with the alarm (and who to contact)
  - to return the alarm when they no longer need it
  - effectiveness is increased by attendant support and rewards, but is reduced by penalties

13 Consider prescribing desmopressin for night time wetting

Quick info:

Consider prescribing oral desmopressin:

- if rapid or short-term control of bedwetting is required, eg for sleepovers or school trips
- the child and parents/carers are unable to use an alarm or do not want to
- inform parents/carers and children:
  - how desmopressin works
  - that desmopressin should be taken at bedtime; and
  - fluid intake should be restricted to sips only, from 1 hour before until 8 hours after taking desmopressin
  - **most** children will relapse when treatment is withdrawn, but repeated courses may be used
  - many children, but not all, will experience a reduction in wetness

Seek specialist advise if desmopressin is being considered for children with:

- sickle cell disease
- cystic fibrosis
- behavioural, attentional, and emotional disorders

NB: The use of desmopressin for this indication in children age less than 5 years is outside of its marketing authorisation (product license) in the UK.

NB: Do not use intranasal desmopressin.

14 Review progress

Quick info:

Review progress after 1 month and continue with treatment if the child or young person is showing early signs of improvement. Only stop treatment if there are no early signs of response.

If there is a response to alarm treatment:

- continue alarm treatment in children and young people with bedwetting who are showing signs of response until a minimum of 2 weeks' uninterrupted dry nights have been achieved
- assess whether it is appropriate to continue with alarm treatment if complete dryness is not achieved after 3 months
- only continue with alarm treatment if the bedwetting is still improving and the child or young person and parents or carers are motivated to continue

If bedwetting does not respond to initial alarm treatment, offer:

- combination treatment with an alarm and desmopressin
- desmopressin alone if continued use of an alarm is no longer acceptable to the child or young person or their parents or carers

If there is a response to desmopressin at 4 weeks:

- continue treatment for 3 months
- consider stopping if there are no signs of response

Signs of response include:

- smaller wet patches
- fewer wetting episodes per night
- fewer wet nights

Once management plan is in place refer back to GP.

15 Consider referral to Children and Young People Emotional Wellbeing Service (CYPEWS)

Quick info:

Secondary enuresis can be the result of stressful life events, eg:

- birth of a younger sibling
- hospital admission
- trauma at home or school
- sexual abuse

However, the older the child, the more likely it is that enuresis is the cause, rather than the consequence, of stress.

Consider referral to CYPEWS if psychological symptoms are severe.

16 Consider referral to Specialist Paediatric Continence Service

Quick info:

For specialist advice, assessment and treatment

If symptoms have not improved following intervention(s), consider referral to the Specialist Paediatric Continence Service.

Referral by Choose and Book is the preferred method.

Paper referrals to:Specialist Paediatric Continence ServiceThe Orchard CentreGloucestershire Royal HospitalGreat Western RoadGloucesterGL1 3NN

Referrals to the Paediatric Continence Service will only be accepted if Paediatric Enuresis Assessment Care Pathway form has been undertaken and attached to the referral.

If referral from Health Visitor or School Nurse, a copy of the referral form is to be sent to the patients GP.

17 Consider discharge to GP

Quick info:

Consider discharging patient if:

- symptoms have significantly improved following advice, assessment, treatment and/or review.
- patient/carer or child is unwilling/unable to follow a personalised treatment/care plan.

Discharge letter to be addressed to GP to include appropriate recommendations for review.

18 Specialist advice, assessment and treatment

Quick info:

Referrals will be triaged on twice weekly by the Paediatric Continence Service. The service:

- carries out assessments for products
- carries out specialist assessment and treatment
- can refer to Consultant Paediatrician within secondary care

Products to be discussed with patient and parent/carer as appropriate.

Patients will be offered a clinical assessment at a local community clinic within 18 weeks.

19 Consider discharge to GP

Quick info:

Consider discharging patient if:

- symptoms have significantly improved following advice, assessment, treatment and/or review.
- patient/carer or child is unwilling/unable to follow a personalised treatment/care plan.

Discharge letter to be addressed to GP to include appropriate recommendations for review.

20 Consider referral to Consultant Paediatrician / Urologist

Quick info:

Specialist Paediatric Continence Service to consider referral to Consultant Paediatrician/Urologist as appropriate if:

- Symptoms have not improved following specialist advice, assessment, treatment and/or review.

Published: Valid until: Printed on: 31-May-2013

Enuresis - suspected

Key Dates

Published: , by
Valid until:

Evidence summary for Enuresis - suspected

