Nocturnal Enuresis/ Bedwetting

Cincinnati Children's
changing the outcome together

FAST FACTS

at least 20%
of children ≥6 years old have nocturnal enuresis. In late teenagers, the occurrence is 1–3%

bedwetting is more prevalent in boys than girls

~15%
of children who wet the bed outgrow the problem every year

Nocturnal enuresis is the involuntary leakage of urine overnight in a child who would otherwise be expected to have appropriate bladder control. It is extremely common.

- **Primary: The child has never obtained overnight bladder control**
- **Secondary: Bedwetting recurs after at least six months of no nighttime accidents**

ASSESSMENT

- **Obtain a detailed history focusing on daytime and nighttime urinary symptoms.**
  - Has the child had any period of dryness overnight?
  - Is the child experiencing daytime urinary symptoms, such as urgency, frequency and incontinence?
  - Is there a family history of bedwetting?
- **Assess for bowel function.** Constipation is extremely common and can affect bladder control significantly. Ask about frequency of stooling and fecal consistency (Bristol Stool Chart).
- **Perform physical exam focusing on abdomen and back.** Look for abdominal distention or tenderness. Does the spine appear normal? Are there sacral dimples?
- **Assess for psychosocial stress from nocturnal enuresis.**

HPE (HISTORY AND PHYSICAL EXAM) RED FLAGS

Daytime symptoms:
- Urinary incontinence
- Fecal incontinence
- Significant constipation
- Febrile urinary tract infections

Other symptoms:
- Secondary enuresis
- Spinal abnormalities/sacral dimples

MANAGEMENT/TREATMENT

Primary or secondary enuresis may be managed in the PCP setting or by a pediatric urology specialist based on PCP provider's preference.

The three mainstays of treatment for bedwetting are observation/reassurance, DDAVP (medication) and bedwetting alarms. Treatment course should be based on family preferences.

DDAVP decreases the amount of overnight urine production, making bedwetting less likely to occur. Standard start dose is 0.2 mg (one tab) at nighttime with fluid restriction at least two hours prior to bedtime. Dose can be titrated up to a max of three tabs.

Bedwetting alarms use a moisture sensor that attaches to the child's pajamas. Family support is vital to success. See page 2 for more information.

WHEN TO REFER

Pediatricians can typically treat bedwetting with success. Consider a referral if:
- Daytime urinary symptoms persist despite management
- Secondary enuresis persists
- Spinal abnormalities/sacral dimples are observed
- PCP prefers that the patient's bedwetting be managed by a specialist

For more information about bedwetting or the Healthy Bladder Clinic at Cincinnati Children's, please call 513-636-4975 or email pedsurology@cchmc.org.

If you would like additional copies of this tool, or would like more information, please contact the Physician Outreach and Engagement team at Cincinnati Children's.

Tool developed by Cincinnati Children's physician-hospital organization (known as Tri-State Children's Health Services, Inc.) and staff in the James M. Anderson Center for Health Systems Excellence. Developed using expert consensus and informed by Best Evidence Statements, Care Practice Guidelines, and other evidence-based documents as available. For Evidence-Based Care Guidelines and references, see www.cincinnatichildrens.org/evidence.

Nocturnal Enuresis/Bedwetting

Inclusion Criteria

Primary bedwetting: A child age ≥6 years has never obtained bladder control overnight
Secondary bedwetting: Bedwetting recurs after at least 6 months of continence

Patient Presents

Standard Workup

- Situational History
- Family History
- Physical Exam

HPE (HISTORY AND PHYSICAL EXAM) RED FLAGS

Daytime symptoms:
- Urinary incontinence
- Fecal incontinence
- Significant constipation
- Febrile urinary tract infections

Other symptoms:
- Secondary enuresis
- Spinal abnormalities/sacral dimples

Address daytime concerns prior to specialty referral

Management of Persistent Bedwetting in the PCP Setting

Pursue one of these three options based on family preferences

Observation/Reassurance

Communicate that bedwetting is extremely common and may resolve without treatment. At-home management tips include:
- Encourage the child to drink beverages during the early part of the day, and not after dinner
- Avoid dairy-based foods and salty snacks two to three hours before bedtime
- Encourage the child to take time to empty their bladder completely before bed
- Bedwetting is more likely to occur when a child is overtired. An earlier bedtime may be worth a try.

DDAVP (Medication)

- Fluid restriction prior to bedtime
- Titrate dose up to 3 pills (0.6 mg)

Bedwetting Alarm

The sensor triggers a bell or buzzer when the child begins to urinate at night. This wakens the child so that they can get to the toilet and empty their bladder. Eventually the child will get up on their own to use the bathroom or will hold their urine until morning.
- Improvement can take up to 3 months
- Disruptive to sleep for child/family for first several weeks
- Family support is vital to success

Consider a referral if

- Daytime urinary symptoms persist despite management
- Secondary enuresis persists
- Spinal abnormalities/sacral dimples are observed
- PCP prefers that the patient's bedwetting be managed by a specialist

Promote healthy daytime bladder and bowel habits

- Discuss child's voiding frequency at home and school:
  - Encourage voiding every 2 hours including at school
  - Review symptoms of UTI
  - Monitor stool frequency and caliber
- Encourage increasing water during daytime

For urgent issues, or to speak with the specialist on call 24/7, call the Physician Priority Link® at 1-888-987-7997.