

# Bedwetting (Enuresis) & Urinary Incontinence

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## What is Enuresis?

Enuresis is the medical term for bedwetting, which is the involuntary discharge of urine during sleep for one or more nights per month. Doctors do not even consider a child to have enuresis unless he is older than 6 years, or she is older than 5 years. About three in five children with enuresis are male, and nine in ten children who wet nightly are male.

## How Common Is Enuresis?

About 10-15% of children 6 years of age or older still wet the bed at least once a month, as do about 5% of children older than 10 years! It is estimated that about 5 to 7 million children and adolescents may suffer from this disorder. The condition has a 1 in 6 chance of resolving on its own each year past the age of 6 years.

Nearly half of children with enuresis have a parent who suffered from enuresis as a child. If both parents suffered enuresis as children, their child's risk will be three in four. Enuresis is more common in firstborns, in children from poor households, in children with ADHD (1 in 3), and in children in foster care.

## What Is The Most Common Type Of Enuresis?

Most children who have urinary incontinence have Primary Nocturnal Enuresis (PNE). This means the child who wets has never achieved night dryness on consecutive nights for longer than 6 months, and that the child only has urinary accidents at night.

Children with PNE usually have an inability to recognize the sensation of a full bladder during sleep. They may also have a smaller than average bladder capacity, and thus are often noted to urinate frequently during the day. Some children with PNE simply consume too many liquids in the evening, or throughout the day. Others consume caffeinated beverages for dinner or in the evening.

Only a small number of children with PNE have a medical cause for their wetting. The only test usually done in these children is a urinalysis, to make certain the child doesn't have a urinary tract infection, or an unusual disorder such as either diabetes insipidus or mellitus.

## What Is Secondary Nocturnal Enuresis (SNE)?

Some children begin wetting at night after a long period of dryness, longer than 6 months. While they do not have accidents during the day, they begin wetting at night, usually due to a moderate to severe life stress, such as moving, abuse, or a death in the family. Sometimes pre-school aged children, who are known to take "two steps forward and one step backward" in their development) will have SNE. Almost always SNE is benign, and without medical cause. Again, the only test necessary is a simple urinalysis.

### What Is Daytime Incontinence?

Only about 3 to 5% of children with enuresis have daytime accidents, which worry doctors much more than night wetting because there is usually a medical cause.

Children with daytime accidents may have a severe urgency to urinate, extreme frequency of urination, an abnormal urinary stream, dribbling or even soaking. The most common cause of sudden daytime accidents is a urinary tract infection, but other common causes include chronic constipation, dysfunctional voiding, and vaginal reflux.

Causes of chronic daytime accidents, especially if a child is older than 4 years and still having daily wetness, include a neurogenic bladder from some form of spinal disease, congenital anomalies (severe labial adhesions, an ectopic ureter, or an abnormal meatus), posterior urethral valves (males only), seizure disorders, or high urinary calcium.

Curiously, children can have daily bowel movements and still be constipated. This can lead to wetting accidents, and even urinary tract infections. Constipation is one of the most overlooked causes of urinary accidents, and for any child with daytime incontinence constipation must be investigated as a possible cause.

Dysfunctional voiding comes in many forms, mostly minor, including giggle incontinence (when a child, usually a girl, dribbles with giggling and laughter), stress incontinence (usually seen in athletes who do a lot of running, jumping, and/or high-impact landing), lazy bladder syndrome (usually in girls, and when the bladder size is overly large and has poor tone, leading to an infrequent sensation of fullness and thus easy overflow), and overactive bladder (due to chronic "holding" as a younger child, leading to an overstretched bladder and poor voluntary bladder muscle control often with bladder contractions and incontinence).

Vaginal reflux is dribbling associated with urine being trapped in the vagina after urinating, and leaking out when the child walks away. This condition is often seen in overweight girls, and in young thin girls who cannot balance themselves on the toilet. It is also seen in girls who have vaginal adhesions.

Included in the investigation of daytime incontinence will be a full history-taking and exam, a urinalysis and a urine culture, and possibly X-rays, ultrasounds, and/or urine flow testing.

### What Can Be Done About Bedwetting?

Enuresis may be embarrassing to the child, especially a child older than 7 or 8 years of age. It certainly is troublesome to most parents. However, parents must be reminded that the vast majority of children with enuresis have neither a medical nor a psychiatric illness! Enuresis is NOT a form of "acting out" or "willful misbehavior". Children do NOT willingly wet the bed, and it is NOT a form of laziness. No punishments or shaming is allowed!

For the most part, parents are urged simply to be patient, knowing that most children with nighttime accidents will outgrow the problem, almost always by early adolescence and usually sooner.

Parents must also convey patience and understanding to the child. Tell the child that "this happens to many kids your age...they just don't tell you about it". But also tell the child, in a positive manner, that "only you can stop this problem".

Some things that might reduce the number of nighttime accidents include:

- Keep fluids to a minimum (or none at all) after dinner
- No caffeinated beverages with or after dinner (and preferably none at all)
- Encourage toilet usage just before going to bed.
- Include the child in the cleanup of wet bedclothes.
- Keep a calendar of dry nights, rewarding stretches of 3-5 consecutive dry nights.
- Be certain toilet access is not a problem at night, by using night lights in the hallway and bathroom
- Consider conditioning the child to recognize the sensation of a full bladder. During daytime, encourage the child to hold the urine in the bladder until the point of discomfort, then hold for 2 minutes more before voiding. Help the child link this feeling of discomfort to the need to use the bathroom. Over time, this *might* help the child's brain better recognize the signal of a full bladder during sleep.

What About Bedwetting Alarms?

These are moisture-sensitive devices that attach to the pajama bottoms or underwear over the child's genital area, with a buzzer alarm that sounds at the first detection of wetness. The alarm is quite loud, and will likely awaken the entire household, and hopefully the child, too! The awoken child is then encouraged to go to the bathroom to finish urinating; bedclothes should be changed if necessary.

Though an alarm is the most difficult method to employ, it has a 60-70% cure rate, though it may take as long as 3-4 months to achieve cure. Success is when the child has worn the alarm for 4 consecutive weeks without wetting. The chance of success is greatest when the child wants to try the alarm method, and when the family is motivated enough to withstand the frequent nightly shrill waking. The cost is usually around \$50-70. A good source is The Bedwetting Store, at [www.bedwettingstore.com](http://www.bedwettingstore.com), where parents can also find waterproof bedding, books, and supplies.

What About Medications?

While they can be successful, medications are seldom used due to their potential side effects, and the high rate of relapse once the medication is discontinued. However, they can be useful in special circumstances, such as sleeping over at a friend's house, or going on vacation. The three most commonly used medications are:

- Desmopressin (0.1 or 0.2mg tablets, 1-3 taken 30 minutes before bedtime for 6 months, and then trialed off for 2 weeks...works in about 2/3rds of kids in reducing wet nights by 50% or more),
- Imipramine (25 or 50mg tablets taken 30 minutes before bedtime...must have an EKG before starting the medication...works in 60-80% of children, but problem returns in 3 out of 4 children once the medication is discontinued
- Oxybutynin (5,10,or 15mg tab daily...also in Elixir form...moderately effective but has potential side effects such as dry mouth, constipation, and flushing)

