

Bedwetting



ERIC's guide for parents

This booklet has been written to help parents support their child or young person with bedwetting.

Bedwetting is not a child's* fault, it happens during sleep and there is no conscious awareness that it is happening. For most children something can be done to help manage or resolve bedwetting. The first steps for a parent are to maintain a positive attitude ensuring their child knows that dry nights can be achieved and to help with motivation to continue with whatever intervention is offered.

The extent of the problem

In the UK approximately half a million children between the ages of five and sixteen wet the bed. For many of these children bedwetting can become a difficult and socially isolating problem.

The likelihood of bedwetting decreases as children get older. At the age of four and a half it is estimated that eight per cent of children wet the bed; by the time they reach nine and a half only one and a half percent are still wetting the bed. As they get older, the number reduces year on year with only one per cent continuing into adulthood. Children with more severe wetting, for example wetting every night, are less likely to spontaneously become dry than those who wet less frequently.

It is known that boys are more likely than girls to wet the bed, but once they reach their teenage years there is less of a difference between the sexes.

** References to 'child' in this booklet will include young people.*

What is bedwetting?

Most children gain daytime bladder control by the age of three and can recognise the sensation of a full bladder and respond to the need to get to a toilet; night time control takes a little longer. Bedwetting is involuntarily wetting whilst asleep - the medical name is nocturnal enuresis.

Most children who wet the bed have never been consistently dry at night – this is called primary enuresis. Secondary enuresis occurs when a child who has previously been dry for six months or more starts wetting the bed. There is no difference in the way primary and secondary enuresis are assessed and treated.

Some children wet every night, others wet a few times a week and others wet less often. For those that wet every night an assessment with a health professional and continued support will help resolve bedwetting.

What causes bedwetting?

It isn't fully understood why some children take longer than others to become dry at night, but we know it is not linked to poor toilet training or laziness. We believe it is the result of one or a combination of the following reasons:

Not waking to bladder signals

Some children don't wake to the signal the bladder gives when it needs to empty at night. The reason for this doesn't appear to be connected to sleeping deeply, but rather to the strength or ability of the signal to rouse them from sleep. A bedwetting alarm can help strengthen the signal from the bladder to the brain.

Lack of vasopressin

Some children do not produce adequate amounts of the hormone vasopressin at night. This hormone is released continuously within the body but peaks at night, causing the kidneys to reduce urine

production during sleep. If there is not enough vasopressin the kidneys continue to produce large amounts of urine which the bladder cannot hold overnight.

Indications that night time vasopressin is lacking includes large, wet patches of urine in the night, wetting more than once in the night and wetting in the early part of the night. Medicine (desmopressin) to replace the hormone can be prescribed and can be helpful for some children to enable them to take part in sleepovers and other activities that take them away from home at night.

A child who lacks vasopressin and doesn't wake up to use the toilet, will also lack the signal to wake as described above.

Bladder overactivity

Some children have wetting problems in the day which can cause or have an effect on night time wetting. The most common problem is an overactive bladder; this occurs when the muscles in the bladder contract before it is full causing a need to go to the toilet urgently and frequently. The spasms caused by an overactive bladder can also occur in the night during sleep.

Indications of an overactive bladder are damp pants during the day and at night. There will often be variable size wet patches in the bed and the child will often wake up after wetting. An assessment of daytime wetting by a suitable health professional is always recommended as medicine and other treatments can be prescribed.



What else can cause bedwetting?

Constipation

A full constipated bowel can exacerbate an existing bedwetting problem or can cause bedwetting when a child or young person has previously been dry at night (secondary enuresis). If the bowel is stretched and full with constipation it can press against the bladder and create day and night time wetting difficulties.

If a child empties their bowel less than three times a week, or has problems with soiling, or finds it hard to pass stools, they may be constipated. A visit to a GP for an assessment is always recommended and medicine can be prescribed to soften the stools and empty the bowel.

Urinary Tract Infection

A urinary tract infection (UTI) can give a feeling of always needing to go to the toilet and can cause or exacerbate day and night time wetting. A visit to a GP for an assessment is always recommended where a simple urine test can check for an infection and medicine can be prescribed.

Family traits

Bedwetting can run in families - if a child has one parent who wet the bed as a child there is a 45% chance they will inherit this trait. If both parents wet at night as children their child will inherit a 72% chance of wetting the bed.

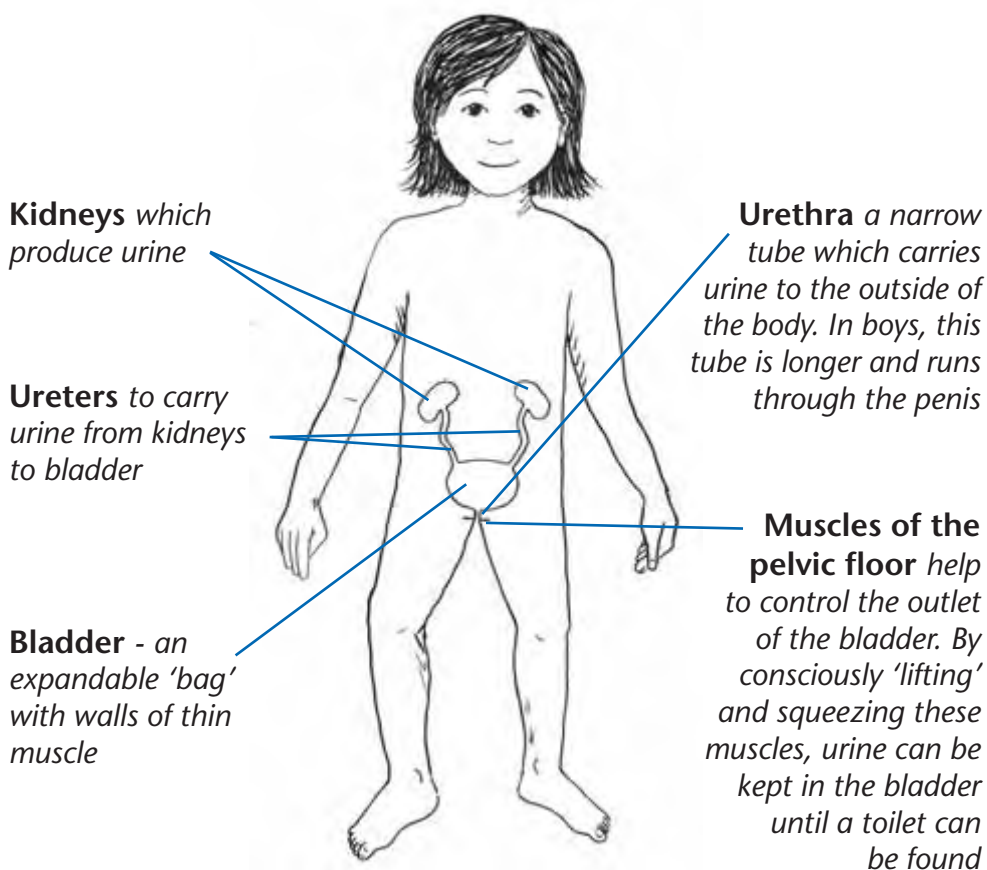
Anxieties

It is known that anxiety, stress or changes in routine can delay a child becoming dry at night or can cause bedwetting in a child who had previously been dry (secondary enuresis).



Anxiety or stress can be associated with changes in routine such as starting school, the birth of a new sibling, exams and worries or bullying. If a child begins wetting at night after being dry for a while, talking with them may help them to try and identify and resolve any of these causes. Bedwetting that continues after the reason for the anxiety or stress has been resolved can often be successfully treated with a bed wetting alarm.

How the system works



When to intervene

The best time to seek ways to overcome bedwetting is when the child is ready and is feeling motivated. There is no right age to intervene but they need to be mature enough to be fully involved with the chosen intervention - this is unlikely in a child under five. For some, a strong desire to become dry occurs when they wish to take part in a social activity such as a sleepover or a trip away. But many children simply decide they are now ready to become dry at night.

It is always preferable to arrange an appointment with a health professional or bedwetting clinic for an assessment, support and information about treatment options.

Clinic waiting lists and age restrictions need not delay intervention for a child who is ready to become dry at night. ERIC has lots of information about bedwetting on its website and a call or email to the ERIC Helpline will provide useful support. Practical products such as bedding protection and alarms to support the process of becoming dry can be purchased from the ERIC web shop at www.eric.org.uk.

What interventions are available?

There are two main treatments for bedwetting - bedwetting alarms and medicine. Bedwetting alarms are usually the preferred treatment for bedwetting without daytime symptoms, but are not suitable for all children and in particular if the child wets infrequently (less than 1-2 nights a week) or the family and child are finding the wetting particularly emotionally burdensome or onerous.

Desmopressin is useful when rapid or short-term improvement is required or if the alarm is unsuitable. An assessment by a health professional will determine whether an alarm, medicine or a combination of alarm and medicine is more suitable.



Bedwetting alarms

There are two types of bedwetting alarm – the bed mat alarm and the body worn alarm. The principle is the same for both: the sensor detects when a child has started to wet and this triggers the alarm; waking and alerting the child.

Over time they begin to link the sensation of a full bladder with the need to wake up to go to the toilet and gradually learn to hold on or wake before the alarm goes off. Alarms can only be effective if a child wants to use one to become dry at night and is motivated to work with it. It is therefore crucial that they are involved in choosing to use the alarm and supported in using it.

Signs that an alarm is working include waking to the alarm, smaller wet patches at night, holding more in the bladder after the alarm has sounded and the alarm going off later or less often. Once 14 consecutive dry nights have been achieved the alarm can be removed.

The use of a bedwetting alarm requires sustained involvement, commitment, and effort but they do have a good, long term success rate. If there has been no improvement after using the alarm consistently for three months alternative treatments should be considered.

More information on how to use bedwetting alarms is available in ERIC's booklets 'Your Child's Alarm' and 'You and Your Alarm' (for children).



Medicines

There are two prescribed medicines that are used as alternatives to an alarm to help children become dry at night. Occasionally both medicines will be offered together.

Desmopressin

Desmopressin is an artificial form of the naturally occurring hormone vasopressin. It works in a similar way to the hormone by causing the kidneys to concentrate urine overnight; the bladder is therefore able to contain the smaller volume of urine that is produced overnight.

Desmopressin is available on prescription in tablet or melt form and is taken before sleep; it works for about 8-10 hours. It is only fully effective for about a third of children, another third will have some reduction in the amount of urine they make in the night and for the remaining children it will have no effect.

The medicine does not stimulate production of the missing hormone, therefore when a child stops using it they may start to wet the

bed again. Production of vasopressin is part of a child's individual development and some produce it at a later age than others.

Desmopressin alleviates rather than remedies bedwetting but it can be useful when immediate dryness at night is required, for example nights away from home. As it doesn't work for every one a trial run is recommended before a night away.

Desmopressin requires restricting fluids from an hour before and until eight hours after taking it and it is important not to drink more than a small drink to relieve thirst after taking this medicine. When prescribing desmopressin, the health professional will explain about drinking, how the medicine should be taken and possible side effects.

Desmopressin is usually taken for three months and then stopped for one week to check whether the child's natural vasopressin has started working.

Anticholinergics - Oxybutynin

Oxybutynin is an anticholinergic medicine that is used for an overactive bladder. It works by relaxing the muscles of the bladder and calming involuntary bladder contractions. This enables the bladder to relax and fill to hold more urine. It is used in combination with desmopressin for bedwetting and is prescribed by a health professional with experience in bedwetting who will explain how the medicine should be taken and possible side effects.



What if the treatment doesn't work?



It is always recommended that any treatment offered is tried for a reasonable time before it is considered unsuccessful. Signs of progress should be recorded when a bedwetting alarm is used and if there are no early signs of improvement after four weeks, or dryness after three months, then the alarm treatment should be reconsidered.

If bedwetting starts again after previous successful use of a bedwetting alarm, the alarm should be used again until there have been 14 consecutive dry nights.

Reduced urine production will be evident fairly quickly when taking desmopressin, but the dose may need to be increased after two weeks if the child is not dry. If there are signs of response at four weeks it should be continued for three months.

The full effectiveness of oxybutynin takes time to build up and an assessment will usually be made between three and six months after starting it.

When parents consider that an intervention for bedwetting is unsuccessful a referral for further assessment, investigation and management should be requested. An alternative treatment or a combination of treatments may be offered.

A bedwetting assessment – what will happen?

At a bedwetting assessment a health professional will check how much the child drinks in a day, how often they go to the toilet and whether there are daytime accidents. They will also ask how often the child wets the bed.

If there appears to be daytime wetting problems, this will be dealt with before recommending an intervention for bedwetting.

Advice will be offered on fluid intake and toileting routines and a bladder capacity check may be suggested.

For younger children a trial without nappies or pull ups may be suggested if there have been some dry nights. This trial could be linked to a reward for achievable behaviours such as drinking more in the day or going to the toilet before going to sleep.

The child may be asked to complete some charts for two weeks and with this information, support and treatment tailored to the needs and circumstances of the child will be offered.



Where to get help

When a child is ready and expressing a desire to become dry an assessment with a health professional will identify which intervention is best for each individual and their family.

The type of health professional providing support with bedwetting varies in each area but will often be one of the following:

- School nurse – the child's school will be able to provide contact details of the local school nurse.
- GP.
- Enuresis Nurse – usually based in bedwetting clinics. Some clinics require a referral from a GP.
- Health visitor – for children under five.

What can parents do?

It can be frustrating for parents dealing with bedwetting every day. Because children are asleep when they wet they are not aware of what is happening. It is very important to understand that it is not the child fault; punishment is never a useful way to try and stop bedwetting.

Here are some tips on how you can help manage and resolve bedwetting:

- Seek support to overcome bedwetting when your child is ready to be dry at night. This will ensure they are motivated to work to become dry and will help avoid a build up of negative feelings about themselves related to the bedwetting.
- Children should be actively engaged in decisions about treatment for bedwetting and treatment should always be tailored to individual needs.



- Encourage your child to visit the toilet to empty their bladder regularly through the day – between four and seven times spread throughout the day is best.
- A bedtime routine of going to the toilet as part of getting ready for bed and again just before settling down to sleep will ensure that the bladder is empty before going to sleep.
- Always remove nappies or pull ups at night before starting any intervention for bedwetting.
- Ensure your child can get to the toilet easily in the night. A night light or a light switch near the bed, or leaving a light on in the hall can be useful.
- Placing a potty or a bucket in the bedroom can help a child who is reluctant to venture into the hall in the night.
- Moving down from the top bunk to sleep on the bottom bunk will make it easier for a child to get to the toilet.
- Remind your child that if they wake in the night, it may be because they have woken to go to the toilet. Instead of turning over to go back to sleep they should get up and go to the toilet and try to empty their bladder.
- Because the release of vasopressin is part of the winding down process at night and the change in light helps this process, it is important that the child sleeps in a darkened bedroom and doesn't fall asleep with the TV on.
- A good winding down routine each night may help, for example, a bath or shower and then some relaxed quiet time, perhaps reading, before sleeping.
- Ensure your child feels positive and motivated to become dry.
- Remain calm and positive and supportive of your child.

Success is when a child has been dry for 14 consecutive nights.

Drinking

It can't be over-emphasised how important it is for a child to have a good daily fluid intake. Fluids are essential for healthy bladders and bowels.

Many children think if they don't drink in the day they will stay dry at night. But this is not the case, reducing day time drinks will reduce the size of the bladder so it will hold less. As well as exacerbating bedwetting, reducing fluid intake can create a need to go to the toilet very frequently in the day and perhaps lead to an overactive bladder or a urinary tract infection (UTI).



It is important to ensure the bladder is allowed to fill and empty fully during the day and a good toilet routine can help with this. If you have concerns about how much your child drinks or suspect that their bladder is not holding as much as it should, speak to their nurse or GP who can do a bladder capacity check and advise how to increase fluid intake.

Water based drinks are preferable as some drinks such as fizzy drinks, tea, coffee, dark squashes (such as blackcurrant) and drinking chocolate can have a diuretic effect on the bladder causing the need to go to the toilet more often.

The chart shown suggests children's recommended daily fluid intake. A simple figure to remember is six to eight glasses or beakers of fluid a day, spread out through the day – for example: breakfast, morning break, lunch, afternoon break, home from school, evening meal.

The amount of fluid required varies according to the temperature, dietary intake and physical activity of each child or young person.

Recommended daily fluid intake

Age	Sex	Total drinks per day
4-8 years	Female	1000-1400 ml
	Male	1000-1400 ml
9-13 years	Female	1200-2100 ml
	Male	1400-2300 ml
14-18 years	Female	1400-2500 ml
	Male	2100-3200 ml

NICE clinical guideline 111 www.nice.org.uk



Waking up or lifting

‘Lifting’ is carrying or walking a child to the toilet or potty in the night. Many parents ‘lift’ younger children when they start to have a drier nappy in the mornings. Combined with a trial run of removing the nappy at night, this can be a useful way of moving towards night time dryness for children under five.

In order to overcome bedwetting a child needs to learn to wake spontaneously to the signal of a full bladder. Waking or ‘lifting’ older children to go to the toilet at night may result in a dry bed but doesn’t help them recognise and wake to the sensation of a full bladder on their own.

Lifting will not promote long term dryness at night and should only be used as a practical short term measure to manage bedwetting. Lifting can cause the child to become dependent on the parent to ensure they are dry at night.

If parents choose to lift, it is better to do so at a different time each night and to ensure that their child is fully awake and aware of why they are being woken and of emptying their bladder.

Teenagers who have not responded to treatment for bedwetting may find that self instigated waking, for example: using a mobile phone alarm or alarm clock, a useful strategy for managing bedwetting.

Nights Away from home

Some children are dry on nights away from home and parents are often bemused by this. It is not fully known why it happens but it is thought that because a child is in a strange bed and it is very important to them to stay dry, they are less relaxed whilst sleeping and the need to stay dry is in the front of their minds. This enables some children to be able to wake for the toilet or hold on through the night.

Thinking positively

- "I will be dry tonight."
- Give lots of support and praise for the efforts your child is making to become dry at night and of course always give praise when there is a dry or drier bed.



- Rewards should be given for agreed, achievable behaviour such as drinking more in the day, going to the toilet twice before going to sleep or helping to change the sheets. Rewards should never be offered for dry nights as this is something which is outside of your child's conscious ability to achieve. Offering rewards for being dry implies that a child can be dry if they try hard enough. Reward systems need to be clear, consistent and immediate and they should be fair, affordable and achievable.
- Positive self instruction has been found to be useful for some children who wet the bed, for example repeating statements as they fall asleep such as "I will be dry tonight" or "I will wake for a wee tonight".

Practical things that can help

- Use protective covers for mattress, duvet and pillows.
- Provide a laundry bag in the child's bedroom for wet bedding and night clothes.
- Store clean night clothes and bedding somewhere easily accessible.
- Disposable or washable bed pads can help with a quick change of sheets in the night.
- A shower or bath each morning ensures the smell of urine does not linger.

NICE Guidelines CG111 (Oct 2010) 'Understanding NICE guidance - Bedwetting in children and young people' can be downloaded from www.nice.org.uk. The booklet explains the bedwetting care and treatment options that should be available in the NHS.

ERIC provides information and support on bedwetting and has a range of supportive resources including the Helpline, website and webshop.



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For information and support on bedwetting, daytime wetting, constipation
and soiling and potty training call ERIC's Helpline – available 24/7

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Email:
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Text:
447 624 811 636

www.eric.org.uk

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