

## Enuresis

Dear [Dr \_\_\_\_],

Advice and guidance response pertaining to [Patient name].

Examination:

- abdominal and genital examination; and
- neurological examination of the lower limbs and spine.

Management:

- Treat any constipation symptoms.
- Fluid intake - aim for 1.5L per day; avoid tea/coffee/squash/fizzy drinks; and avoid drinking 1-2 hrs before bedtime.
- Regular voiding during daytime and immediately before bed. Note - “lifting” to void overnight is not helpful long term.
- Reward charts may be helpful if age appropriate. It is important to only reward what is achievable such as drinking required volumes, taking medication or helping to change the bed (when they are old enough).
- Alarm treatment is the usual first line treatment. Alarms are not provided in secondary care so would need to be sought from continence team or purchased privately.
- Consider a trial of desmopressin if alarm therapy is not tolerated/ineffective, as recommended in NICE guideline.
- If above management fails after 3-month trial period, consider referral to enuresis service (usually provided by community paediatrics or school nursing, see local guidelines).

Parental resources (e.g. advice, star charts etc) are available at [www.eric.org.uk](http://www.eric.org.uk)

Children presenting with the following red flags warrant a discussion/referral to general paediatrics:

- abnormal lower limb neurology – suggests spinal pathology;
- continuous wetting/dribbling – suggests bladder pathology;
- difficulty passing urine – suggests obstructive problem e.g. meatal obstruction;
- recurrent urinary tract infection;
- severe daytime symptoms; or
- safeguarding concerns (can rarely be a presenting symptom of abuse).

Nocturnal enuresis is common, affecting approximately 10% at 5yrs of age and 5% at age 10 years. There is often a history of enuresis in the family.

Primary enuresis (never been dry at night) is more likely to be physiological (deep sleep; small bladder capacity) but may rarely be associated with congenital/longstanding pathology (see red flags below).

Secondary enuresis (previously dry for >6months) is more likely to be associated with acquired pathology (e.g. constipation; recurrent urinary tract infection; physical effect of psychological distress).

If referring, please state that the referral has already been through Advice and Guidance and include previous correspondence, so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]