



ADVICE FOR PROFESSIONALS

# Paediatric Continence Promotion Assessment and Treatment

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The aim of this booklet is to give an overall view of the assessment and treatment of children's continence problems.

It is important to remember that each child is an individual and interventions may often need to be tailored to meet, not only the needs of the individual child, but also the child's family.

Within the scope of this booklet it is not possible to give full details of treatments.

Further information can be obtained from the contact details listed at the back.

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# 1. Nocturnal Enuresis

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Nocturnal enuresis is the repeated involuntary passage of urine during sleep, in the absence of any pathology, in children over the age of five years.

Primary enuresis is usually described when the child has never achieved a period of dry nights.

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## Aetiology

There have been various reasons cited in the past as the cause of bedwetting including genetic, constipation, reduced functional bladder capacity, increased production of night time urine, psychological abnormalities, sleep disorders, bacteriuria, and diet.

Due to the variety of theories put forward regarding the cause of bedwetting the 'three systems approach' provides a useful way of conceptualising the problem and directing treatments. The three systems approach envisages the cause of bedwetting as the result of a problem in one or more of the following systems.

1. A lack of vasopressin release.
  2. A bladder instability problem.
  3. An inability to wake from sleep to full bladder sensations.
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## Management Policies

Enuresis policy for all age groups should aim to:

1. Exclude underlying pathology/medical problems.
  2. Explore social/emotional problems.
  3. Reassure and provide support.
  4. Give consistent advice and helpful hints.
  5. Address associated bowel/bladder problems  
e.g. constipation/daytime wetting.
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## Suggested Policies

### Age <5 years (e.g. school entry medical)

1. Meaningful advice to be given e.g. bedding protection, ERIC details.
2. This advice to be uniform and non-conflicting.
3. Basic ground work, such as fluid intake correction, can be carried out.
4. The level of motivation and environmental/social problems can be identified.
5. Treatments introduced as appropriate.

## Age 5-6 years

1. The child to have a documented assessment.
2. Exclude pathology/social/emotional factors.
3. Carry out baseline assessment - ask the child and parent to record number and types of drinks each day as well as number of voids. Measure functional bladder capacity by asking the child to pass urine into a jug when they get a strong urge to pass urine. This is best done at home, two or three times over a weekend. The child's functional bladder capacity can then be compared to the average capacity of a child of a similar age by multiplying the child's age by 30 and then adding 30.
4. Give helpful hints.
5. Introduce incentive/star charts for compliance.
6. Carry out a symptom profile to help decide on treatment.
7. Consider medication if indicated e.g. desmopressin/oxybutynin.
8. Keep a record chart.
9. Follow up regularly.

## Age 7 years and over

This includes features above and also involves the introduction, as appropriate, of different treatment methods.

1. Initial management as before.
2. Enhance motivation with ongoing advice and support.
3. Enuresis alarm and record chart if indicated.
4. Combined treatment programmes as appropriate.
5. Initial weekly follow-up then every 2-4 weeks.
6. Follow care pathway.

These management programmes are for general guidance only. Each child should be assessed as an individual and only the most appropriate management for each child, that can be carried out successfully within the family dynamics, should be used.

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## General aspects of developing treatment programmes

1. Monitor and support programme regularly.
2. Encourage removal of nappy if worn.
3. Focus on progress made however small.
4. Involve the child as much as possible in developing a programme and allow an element of choice if possible.
5. Have written instructions of the treatment programme available.
6. Evaluate carefully why any previous treatment methods have failed.
7. Involve the child when filling in the progress chart.

8. Encourage parents not to lift the child at night.
  9. Encourage parents to be supportive and avoid blame.
  10. Ask the child's viewpoint regarding the cause of the problem and treatments.
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## Treatment/management methods

Within the scope of this booklet it is not possible to go into details of each individual treatment method. Further advice can be obtained from ERIC or PromoCon (see address details at end)

1. Incentive/star charts for compliance with the programme (e.g. for drinking all their drinks).
  2. Correction of fluid intake and ensuring complete regular day time voids.
  3. Bladder training.
  4. Medication - oxybutynin/desmopressin.
  5. Body/bed enuretic alarm.
  6. Dry bed training.
  7. Overlearning.
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## Helpful hints for parents

1. Do not restrict fluids.
  2. Try avoiding tea/coffee/drinking chocolate/colas/blackcurrant juice before bed and continue restriction if it reduces the wetting.
  3. Do not use pads or nappies - use a mattress protector instead.
  4. Do not lift the child and take to the toilet if still asleep.
  5. Always wash the night clothes and bedding even if only a small patch has been wet, this will not only prevent triggering a false alarm but also reduce any unwanted odours.
  6. Encourage and praise when dry and try not to comment when wet.
  7. Do not blame the child, bedwetting is not deliberate. Punishments can make the bedwetting worse by increasing anxiety.
  8. Ensure the child has easy access to the toilet at night. A potty or bucket in the child's room, next to a night light, could be used instead.
  9. Have spare night clothes and bedding handy in the child's room so that wet articles can be changed quickly.
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# 2. Daytime wetting

Approximately 2-4% of 5-7 year olds wet at least once per week during the day and about half also wet during the night. Unlike nocturnal enuresis however, daytime wetting may have an organic cause and is always worth investigating if it does not respond to usual interventions.

Daytime wetting has recently been classified into diurnal enuresis and diurnal incontinence.

## Diurnal enuresis

- Maturation delay.
- Associated with uncomplicated UTI.
- 'Avoiders' children who 'hang on' until the last minute!
- 'Giggle' micturition.

## Diurnal incontinence

- Detrusor instability.
- Urge incontinence.
- Detrusor sphincter dyssynergia.

Structural problems

- Stress incontinence.
- Ectopic ureter.

Presentation	Possible underlying causes
<ul style="list-style-type: none"><li>• Always wet (girls)</li></ul>	<ul style="list-style-type: none"><li>• Ectopic ureter</li></ul>
<ul style="list-style-type: none"><li>• Stress incontinence</li></ul>	<ul style="list-style-type: none"><li>• Wide bladder neck anomaly</li></ul>
<ul style="list-style-type: none"><li>• Urge/frequency</li></ul>	<ul style="list-style-type: none"><li>• Detrusor instability (overactive bladder)</li></ul>
<ul style="list-style-type: none"><li>• Complete bladder emptying (involuntary)</li></ul>	<ul style="list-style-type: none"><li>• 'Giggle' micturition</li><li>• Maturation delay</li><li>• Avoiders</li></ul>
<ul style="list-style-type: none"><li>• Complete bladder emptying (voluntary)</li></ul>	<ul style="list-style-type: none"><li>• Behaviour problems</li></ul>
<ul style="list-style-type: none"><li>• Overflow incontinence, urgency, incomplete bladder emptying</li></ul>	<ul style="list-style-type: none"><li>• Non neuropathic bladder - detrusor sphincter dyssynergia</li></ul>

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## Assessment

1. Documented history.
2. Baseline/identification of amount/frequency/timing of wetting.
3. Fluid intake.
4. Physical examination.
5. Dipstick urine test/mssu.
6. Abdominal X-ray (if constipation or underlying pathology suspected).
7. Pre/post ultrasound scan of bladder and upper tracts (for those children in whom underlying pathology is suspected or who fail to respond to routine intervention).

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## Treatments

1. Correct fluid intake and ensure regular complete voids.
2. Instruct the child about the correct position to sit on the toilet (both girls and boys).
3. Medication - anticholinergics, prophylactic antibiotics.
4. Cognitive bladder retraining teaching the child when, how and the correct number of daily voids, involving - education, motivation and biofeedback.
5. Body wetting alarm - for children who fail to recognise the wetting. This incorporates a sensor, which is worn in the underwear and a sound box, which is pinned to the child's clothes. This signals when the child begins to wet.

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## When to refer

A small percentage of children may need specialist assessment or intervention. Any child who has a history of urinary tract infection, suspected underlying pathology, is always wet and those who fail to respond to traditional treatment should be referred for specialist advice.

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# 3. Constipation and soiling

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## Definitions

### Constipation

It is now generally agreed that 'constipation' is defined as the difficulty or delay in the passage of stools, without necessarily implying that the stools are hard. Also that the difficulty or delay in the passage of stools results in distress for the child, which may include pain, uncontrolled soiling, and anorexia.

## Soiling

This is the passage of loose stools into the underwear and is associated with constipation. This occurs outside the child's control.

## Encopresis

The passage of normal stools in an inappropriate place beyond the usual age of toilet training and in the absence of any organic pathology. There is usually a behavioural/emotional element involved.

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## Assessment

1. Record history including passage of meconium/previous interventions.
2. Record base line bowel frequency for 1-2 weeks.
3. Use the 'Bristol stool chart' to assess stools.
4. Check on diet and fluid intake.
5. Medical examination to exclude any underlying problem, e.g. sacral agenesis.
6. Abdominal X-ray if faecal loading is suspected and cannot be confirmed by abdominal palpation.

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## Treatment

If the child presents with constipation and has a loaded colon then this must be cleared at the start of the programme. The retained faeces need to be softened prior to the introduction of a stimulant laxative otherwise there will be a risk of abdominal cramps. During this 'clearing out' process the parents should always be advised that the soiling could increase at this time and not to stop giving the laxatives. Movicol has recently been given a license for use in children under the age of 12 years and has proved to be very successful in aiding bowel disimpaction.

Only if oral treatment fails should enemas be given and only after negotiation and consent (if appropriate) from the child. Once the bowel has been evacuated the child will need to commence a maintenance dose of laxatives. Experience has shown that this will need to be continued for a year or more to prevent relapse.

Many parents, whose child has been referred because of soiling, find it difficult to understand at first why laxatives should be given when their child has 'diarrhoea'. A careful explanation of how chronic constipation can cause seepage of loose stools should always be given.

1. Bowel Training programmes - this involves encouraging the child to sit on the toilet at specific times of the day (usually 20 minutes after a meal) to try and open their bowels. We have found encouraging the child to 'push' a set number of times, by blowing raspberries on the back of their hand for example, is helpful rather than setting a time limit.

2. Always ensure the child can sit comfortably on the toilet, using a trainer seat if necessary. A step or firm box should also be used to support the child's feet.
  3. Star/reward charts may help with compliance.
  4. The child should be encouraged to eat plenty of fruit and vegetables. High fibre cereals such as Weetabix are enjoyed by most children and they should also be encouraged to drink at least 6-8 drinks per day.
  5. Laxatives should be introduced as appropriate. It must be remembered that often children require a combination of a softener and stimulant with higher doses than normal. Long term therapy is often required to prevent relapse.
  6. Referral for family counselling may be necessary for some children if there are associated behavioural/emotional problems.
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## 4. Toilet training children with learning difficulties

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Children with learning difficulties differ widely in their development, with some children nearly up to their chronological age developmentally and others many years behind. However it has been found that those children with a mild to moderate learning difficulty do not differ very markedly in their ability to be toilet trained than their normal peers.

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### General assessment

Do not presume all wetting/soiling is due to the developmental delay. Check:

- General medical history.
  - Any surgical history.
  - Relevant family history.
  - Check urine.
  - Exclude constipation.
  - Review current medication.
  - Any age appropriate milestones.
  - Any diet related problems.
  - Fluid intake.
  - Baseline input/output chart.
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## Assessment - toilet training readiness check list

### Motor development

1. Non-mobile child - can sit with or without support.
2. Mobile child - attempts to squat without losing balance/independent walking developing.

### Cognitive development

1. Searches actively and appropriately for a toy - maybe by eye pointing.
2. Copies an action.
3. Engages in make-believe play e.g. gives dolly a pretend drink.

### Language development

1. Understands a simple request e.g. Where's daddy?
2. Is able to communicate using words, signs or gestures.

### Bladder and bowel development

1. Able to stay dry for at least an hour.
2. Passes normal bowel movements.
3. Starting to show some awareness of when wet/soiled (except if they constantly wear disposable nappies which absorb urine so the child never feels 'wet').

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## Training - children with mild/moderate learning difficulties

Children with more severe learning difficulties may require an adapted assessment in conjunction with the learning disability team, concentrating on physiological maturation of the bladder and bowel and a behavioural intervention programme.

The child will need a rigid potty or toilet seat adapted so that they can sit in comfort and feel secure. A musical potty can be used to make training more fun and enhance compliance. If possible the child could help choose the colour/type of potty.

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## When to start

1. The family should be advised to choose a time when the child is beginning to co-operate with simple instructions and when there is likely to be little disruption at home.
2. It is often easier to commence toilet training in warmer weather when the child is wearing less clothes and perhaps spending more time in the garden when 'accidents' are less of a problem.

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## How to start

1. Introduce the idea of toilet training by means of play. Encourage the child to sit on the potty/toilet regularly, e.g. after meals, before a bath.
2. Encourage the family to leave the bathroom door open so the child can see everyone going to the toilet.
3. Removing the child's nappy is important. The absorbency of modern disposable nappies means that the child often never experiences feeling wet and are consequently less aware of their bodily functions.
4. Start with a routine that fits in with the family and nursery/school. It is better to have a slightly compromised programme that can be carried out consistently rather than try to introduce something that the family find impractical and stop doing.
5. Any success should be rewarded immediately. If the child is reluctant to comply, the programme will need to be broken down into smaller steps.
6. Stickers/rewards may be useful for some children.
7. Body worn enuretic alarms have been found to be successful with some children. The child wears a sensor in their pants which signals when the child wets. The child's carer can immediately reinforce back to the child that they are 'doing a wee' and increase the child's awareness. The wetting alarm can also be used to carryout a baseline assessment of when the child voids.

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## Programme Development

### Questions to ask

- What is the level of physical/mental impairment?
- What skills does the child already have?
- Is there any use of the potty/toilet?
- What prompts are needed?
- What achievements are expected?

### Recommendations

All children referred should be offered an assessment and a trial toileting programme implemented before any disposable products are issued.

- Programmes should not be delayed due to the child's supposed 'disability'.
- Programmes will need to be tailored to meet the child's individual needs.
- Families will need lots of help and support.

Further information regarding toileting products, aids and appliances can be obtained from PromoCon which offers impartial advice and information to both professionals and the general public.

## National organisations available for information

### **PromoCon**

*Offers impartial, unbiased information about continence products and services. Managed and led by Disabled Living, Manchester.*

Redbank House,  
St Chad's Street, Cheetham,  
Manchester M8 8QA

Telephone: **0161 834 2001**

[www.promocon2001.co.uk](http://www.promocon2001.co.uk)

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### **ERIC (Enuresis Resource & Information Centre)**

*A national organisation for childhood bedwetting, daytime wetting and soiling issues for children, parents and professionals.*

34 Old School House,  
Britannia Road, Kingswood,  
Bristol BS15 8DB

Telephone: **0117 960 3060**

[www.eric.org.uk](http://www.eric.org.uk)

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