NICE information for the public

Bedwetting in children and young people

Information for the public
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About this information

NICE guidelines advise the NHS on caring for people with specific conditions or diseases and the treatments they should receive. The information applies to people using the NHS in England and Wales.

This information explains the advice about bedwetting in children and young people that is set out in NICE guideline CG111.

Does this information apply to me?

Yes, if you are the parent or carer of a child or young person (under the age of 19) who has bedwetting.

No, if you are:

- aged 19 or over and have bedwetting
- the parent or carer of a child or young person who has daytime wetting (urinary incontinence)

Person-centred care

Some treatments may not be suitable for the child or young person, depending on their exact circumstances. If you have questions about specific treatments and options covered in this information, please talk to a member of your healthcare team.

In the NHS, patients and healthcare professionals have rights and responsibilities as set out in the NHS Constitution. All NICE guidance is written to reflect these. Children and young people with bedwetting and their parents and carers (where appropriate) have the right to be involved in discussions and make informed decisions about treatment and care with the healthcare team. Their choices are important and healthcare professionals should support these wherever possible. All patients and their parents and carers should be treated with dignity and respect.

To help children and young people, and their parents and carers where appropriate, to make decisions, healthcare professionals should explain bedwetting and the possible treatments for it. They should cover possible benefits and risks related to the personal circumstances of the child or young person. Children and young people, and their parents and carers, should be given relevant information that is suitable for them and reflects any religious, ethnic, or cultural needs they have. It should also take into account whether they have any physical or learning disabilities, sight or hearing problems or language difficulties. They should have access to an interpreter or advocate (someone who helps you put your views across) if needed.

If the child or young person is under 16, their parents or carers will need to agree to their treatment, unless it is clear that the child fully understands the treatment and can give consent.

When parents and carers are involved they should be able to discuss or review their child's care. As treatment progresses, or circumstances change, it is possible for children and young people (or, where appropriate, their parents and carers) to change their mind about treatment or care.

All treatment and care should be given with the patient's informed consent. If, during the course of their illness, they are not able to make decisions about their care, their healthcare professionals have a duty to talk to their family or carers unless they have specifically asked them not to. Healthcare professionals should follow the Department of Health's advice on consent and the code of practice for the Mental Capacity Act. In Wales healthcare professionals should follow advice on consent from the Welsh Government.

Care of young people who are moving from services for children to adult services should be planned according to guidance from the Department of Health (Transition: getting it right for young people).

Bedwetting in children and young people

Bedwetting (sometimes called nocturnal enuresis) is a common condition that affects many children and young people. Although most children grow out of it, this may take many years and

some may need help to become dry at night. It can be very distressing and have a considerable impact on the child or young person. It can also be very stressful for their family.

The causes of bedwetting are not fully understood and a number of factors may be involved, such as difficulties with holding on or waking up when the bladder is full during the night, or needing to pass a larger than normal volume of urine at night. It often runs in families.

Less often, there may be a bladder problem. This can mean the child or young person needs to empty their bladder frequently (even when it contains only a small amount of urine) or urgently before it is full. Children and young people with bladder problems may also have problems with wetting themselves during the day. This can be important when deciding on the best treatment. However, the assessment and treatment of children and young people with daytime wetting is not covered here.

For most children and young people, bedwetting can be successfully treated, boosting self-esteem. Even if treatment is not successful at first, it is important to persist. Advice and encouragement should continue and different treatment options should be considered.

The information here applies to all children and young people under 19 years, including younger children (under 7 years), unless otherwise stated. The care offered should be suitable for the child or young person's needs and circumstances, regardless of age.

Children and young people with bedwetting may be assessed and treated by a variety of different healthcare professionals, which may include nurses and doctors at a paediatric continence clinic, GPs, school nurses and health visitors.

Early support and reassurance

Information and advice

The healthcare team should explain to you and the child or young person that bedwetting is not the child or young person's fault, and they should not be punished or penalised for wetting the bed.

Support and information should be offered that are suitable for your family's needs and circumstances.

You should be given details of support groups and practical advice about reducing the impact of bedwetting, such as using bed protection and washable or disposable products.

If your child is under 5 years, the healthcare team should reassure you that bedwetting is common in children of this age.

Questions you might like to ask the healthcare team

- What could be causing the bedwetting? Could it be hereditary?
- Will my child grow out of wetting the bed? Is it just a stage he or she is going through?
- How old should he or she be before I start to worry about it?
- What can I do to help support my child?
- Is there any additional support that I might benefit from or be entitled to?

(Please note that a child or young person may want to ask such questions for themselves.)

Working out what is happening

All children and young people with bedwetting and their parents or carers should be offered an assessment that is suitable for the family's needs and circumstances.

Questions the healthcare team should ask

The healthcare team should ask questions about the following topics:

- Bedwetting, such as did it start in the last few days or weeks, how long has it been a problem for, how often does it happen, at what time of night, does there seem to be a large amount of urine, does the child or young person wake up and could something have acted as a trigger.
- Daytime problems, such as needing to pass urine frequently (more than seven times a day) or infrequently (fewer than four times a day), needing to pass urine urgently, wetting during the day, straining when passing urine, a weak urinary stream (dribbling) or pain when passing urine and whether daytime problems occur only in certain situations.
- Fluid intake, such as how much is the child or young person drinking during the day and are they drinking less because of concerns about the bedwetting or to avoid having to use particular toilets.

- Toilet use, such as avoiding particular toilets (for example, school toilets) or using the toilet more or less frequently than other children.

The healthcare team might ask for a record to be kept of the bedwetting, daytime urinary problems, drinks and toilet use over time to help work out what may be causing the problem and the best way to treat it.

Tests, assessment and referral

A urine test is not normally needed unless:

- the bedwetting started in the last few days or weeks
- there are other daytime urinary problems or
- another health problem is suspected (a urinary infection or diabetes in particular).

A healthcare professional should assess whether the child or young person has other problems that may cause or be related to bedwetting, in particular constipation and/or soiling; developmental, attention or learning difficulties; diabetes; behavioural or emotional problems; and family problems.

If a healthcare professional suspects type 1 diabetes, the child or young person should be referred to a diabetes care team on the same day, in line with the NICE guideline on diabetes (type 1 and type 2) in children and young people. If urinary tract infection or constipation and/or soiling are suspected, the child or young person should receive the care outlined in the NICE guidelines on urinary tract infection in children and constipation in children and young people.

Further assessment, tests or referral may be offered for severe daytime urinary problems; previous urinary infections; physical or neurological problems; development, attention or learning difficulties; and behavioural, emotional or family problems.

If the healthcare team suspects an emotional or behavioural problem, a healthcare professional with psychological expertise may be involved in the child or young person's care.

If there are daytime urinary problems as well as bedwetting, the healthcare team may consider it best to investigate and treat the daytime problems first if they are the main problem.

Assessment for children under 5 years

The healthcare team should ask you whether toilet training has been attempted, and if not, discuss the reasons for this with you.

If your child is between 2 and 5 years, and is able to use the toilet but still wetting or soiling themselves during the day as well as the night, your healthcare team may want to check if there is a particular medical cause.

Your child should be assessed for constipation as it is a common cause of bedwetting and soiling in children.

Deciding the best treatment approach

Children and young people with bedwetting and their parents or carers should be offered treatment and advice that is suitable for the family's needs and circumstances. Suitable treatment and advice should be available for all children and young people, including younger children (under 7 years).

The healthcare team should clearly explain:

- about bedwetting and how treatment will affect it
- the aims and pros and cons of possible treatments (for example, that alarms work well for long-term treatment and desmopressin is often effective for fast, short-term relief).

To help decide on the best treatment, the healthcare team should ask the child or young person for their views on their bedwetting, including what they consider to be the main problem and whether they need treatment for it.

The healthcare team should also discuss with you:

- the impact that the bedwetting has had on the child or young person and the family
- how you feel about the bedwetting, whether you are coping and whether you need extra support

- what you hope to achieve from treatment and what your priorities are, such as whether short-term dryness is important for family or social reasons (such as for a sleep-over)
- sleeping arrangements, such as whether the child or young person shares a bed or bedroom
- the time and commitment needed for different treatments.

The healthcare team will consider whether or not an alarm or drug treatment are suitable for the child or young person depending on their age, the frequency of bedwetting and the motivation and needs of the family.

General advice

Food and drink

It is important that the child or young person has enough to drink during the day. The healthcare team should give advice on the right amount (see table 1) and explain that this will depend on the circumstances (such as temperature, diet and activity). Drinks containing caffeine (such as cola, tea and coffee) should be avoided. The healthcare team should also give advice on a healthy diet. The child or young person's diet should not be restricted in any way to try and treat bedwetting.

Table 1 Suggested total daily intake of fluid from drinks

Age (years)	Sex	Total drink intake per day (ml)
4–8	Female Male	1000–1400 1000–1400
9–13	Female Male	1200–2100 1400–2300
14–18	Female Male	1400–2500 2100–3200

Toilet use

You should also be given help with any problems the child or young person has with their pattern of toilet use. The child or young person should be given advice on the importance of using the toilet regularly during the day and you should encourage use of the toilet at regular intervals (around

four to seven times a day, including just before bed). This should continue alongside any other treatment for bedwetting.

If any changes to drinking and toilet habits are needed, these should be made before treatment for bedwetting starts.

If the child or young person is wearing nappies or pull-ups at night, a trial without them may be suggested. The healthcare team should offer you advice on alternative bed protection.

Reward systems

The healthcare team should explain how you can use a reward system (using sticker or star charts, for example, although this will depend on the age of the child or young person) to help with bedwetting. Rewards can be used on their own or alongside other treatments, such as bedwetting alarms (see bedwetting alarms). If you have a young child who has some dry nights, the healthcare team should initially advise you to try a reward system on its own.

Rewards should be given for agreed behaviour rather than dry nights, for example, they may be given for drinking the correct amount during the day, using the toilet before sleep, helping to change wet sheets and, if appropriate, taking tablets or using an alarm correctly. These should be agreed with the child or young person beforehand. Systems that punish or take away rewards should not be used.

Lifting, waking and training programmes

The healthcare team should offer the following advice:

- Lifting (carrying or walking the child or young person with or without waking them) or waking the child or young person to take them to the toilet during the night will not help to keep them dry in the long term.
- Waking the child or young person during the night to take them to the toilet should only be used as a short-term practical measure (for example, if you are on holiday or away from home).
- Young people with bedwetting that has not responded to treatment might find that waking themselves up (for example, using a mobile phone alarm or an alarm clock) to go to the toilet during the night is a useful strategy to help prevent wetting the bed.

Types of training programme that should not be used are those that:

- involve holding on and waiting before urinating, or stopping the flow of urine
- use a combination of different rewards, punishments, training routines, waking routines and alarms (sometimes called dry-bed training).

Advice for children under 5 years

If your child is not yet toilet trained, the healthcare team should advise you to start toilet training, unless there are reasons why it should not be attempted. You should be offered support and advice about toilet training.

If your child has been toilet trained during the day for more than 6 months, the healthcare team should suggest that your child tries at least 2 nights in a row without nappies, and even longer if your child is closer to 5 years, or if wetness is reduced or it is acceptable to your family to continue. The healthcare team should offer you advice on alternative bed protection.

If your child wakes during the night you should take him or her to the toilet.

Initial treatment

Bedwetting alarms

An alarm should be offered as initial treatment for bedwetting if advice on drinks, toilet use and rewards is not successful, unless:

- the child or young person or you do not want to try it or
- the healthcare team thinks that it is unsuitable.

Alarms may not be the most suitable treatment if the child or young person wets the bed infrequently (only once or twice a week), if you are finding the bedwetting difficult to cope with, or if the priority is for fast or short-term improvement.

If the child or young person has a hearing impairment, an alternative type of alarm (such as a vibrating alarm) may be offered.

Alarms detect when wetting starts at night (through a sensor either worn in the pants or inside a mat under the sheet) and make a noise and/or vibrate to wake the child or young person. This helps the child or young person to recognise when they need to pass urine. Gradually they may learn to hold on or wake before the alarm goes off, and so eventually stop wetting the bed. The healthcare team should explain these aims, how to use the alarm (see box 1) and that alarms are often successful over time.

The healthcare team should explain that alarms are not suitable for everyone, and should assess whether they are suitable for your family. A lot of effort, involvement and commitment is needed. You may need to help the child or young person to wake up and go to the toilet when the alarm goes off, and your sleep may be disrupted for many weeks or months. You will also need to record progress, for example noting if and when the child or young person wakes to the alarm and how wet the bed is.

Box 1 Using an alarm

You and the child or young person may need a considerable amount of advice and support in learning how to use an alarm. You should agree with the healthcare team about how this should be obtained.

The healthcare team should explain:

- how to set, use and maintain the alarm, and how to manage problems
- that it may take a few weeks before a response to the alarm develops and it may take many weeks to achieve dry nights
- how to return the alarm when you no longer need it.

The healthcare team should assess progress with an alarm within 4 weeks. If there are no signs of an early response (such as smaller wet patches, waking to the alarm, the alarm going off later or less often, and fewer wet nights), alarm treatment should be stopped. If there are signs of an early response you should continue with the alarm until the bedwetting has stopped for at least 2 weeks of uninterrupted dry nights. If bedwetting starts again you can start using the alarm again immediately.

If bedwetting continues after 3 months of using an alarm, the healthcare team will assess whether you should keep using it. It should only be continued if the bedwetting is still improving and you and the child or young person want to continue.

Using an alarm with rewards

You and the child or young person should be told about the benefits of using the alarm with a reward system for agreed behaviour, such as waking up when the alarm goes off, going to the toilet after the alarm has gone off, and returning to bed and resetting the alarm. You and the child or young person should decide your roles and responsibilities together.

Desmopressin treatment

An alarm may not always be the most suitable initial treatment. A drug called desmopressin (see box 2) should be offered to treat bedwetting if:

- fast or short-term improvement is the priority
- you or the child or young person do not want to try an alarm or
- the healthcare team decides that an alarm is not suitable.

Children and young people should not have any drinks after they have taken desmopressin, so if they would find it difficult not to drink during the night it might not be suitable for them. If the child or young person has sickle cell disease and is offered desmopressin, advice should be offered about stopping desmopressin during a sickle cell crisis.

If offered desmopressin, the child or young person should not need to have blood and urine tests or have their weight and blood pressure checked.

If the bedwetting does not completely stop after 1 to 2 weeks of desmopressin treatment, the healthcare team may suggest that the dose is increased.

The healthcare team should assess progress with desmopressin treatment after 4 weeks. If there are signs of an early response (smaller wet patches, wetting the bed fewer times per night and fewer wet nights) or the bedwetting has stopped, desmopressin should be continued for 3 months.

If the bedwetting has not responded or only partially responded after 4 weeks, the healthcare team may suggest that the desmopressin tablets are taken earlier (1 to 2 hours before bedtime) and

continued for 3 months, but only if the child or young person can manage without drinks during the night, starting from 1 hour before taking the tablets. Alternatively, if there are no signs of a response, the healthcare team may suggest that desmopressin treatment is stopped.

After 3 months of desmopressin treatment, if bedwetting has improved but not stopped completely, the healthcare team may advise continuing treatment, as bedwetting may continue to improve for up to 6 months.

Alternatively, if desmopressin has only been partially successful, the healthcare team may offer an anticholinergic drug to take with desmopressin (see anticholinergics combined with desmopressin).

Box 2 Using desmopressin

If desmopressin is offered for bedwetting the healthcare team should explain:

- how the drug works in the kidneys to reduce the amount of urine produced during the night
- that many children and young people will have a reduction in wetness, but many will start to wet the bed again after treatment is stopped
- that it is important that your child or the young person does not have a drink (or only has small sips) from 1 hour before it is taken until 8 hours after taking it
- that it should be taken at bedtime
- how to increase the dose if needed
- that it should be taken for 3 months at a time, and further treatment can be given.

Questions you might like to ask about treatment

- Who will be treating my child? Does my child need to have treatment?
- Why have you decided to offer this particular treatment? Are there other options?

- How will the treatment help my child? What effect will it have on their bedwetting and everyday life?
- What sort of improvements might we expect and when should they start?
- How long will it take to have an effect?
- How long will treatment last?
- Are there any potential problems or side effects?
- Will the bedwetting start again when treatment is stopped?
- What should I do if the bedwetting doesn't improve?
- Are there different treatments that my child could try?
- Does the current treatment need to be altered?

(Please note that a child or young person may want to ask such questions for themselves.)

What happens if initial treatment does not work?

If you think that care for the child or young person does not match what is described in this information, please talk to a member of your healthcare team in the first instance.

Following alarm treatment

If alarm treatment is not successful, desmopressin should be offered (see box 2 in desmopressin treatment) to take as well as using the alarm. Alternatively, if the child or young person or you no longer want to use an alarm, desmopressin should be offered alone.

If the combination of an alarm with desmopressin has been only partially successful, the healthcare team should advise that alarm treatment is stopped and offer desmopressin alone.

Following desmopressin treatment

If desmopressin treatment is not successful, the healthcare team may offer an anticholinergic drug to take with desmopressin (see anticholinergics combined with desmopressin).

Following alarm and/or desmopressin treatment

If courses of treatment with an alarm and/or desmopressin are not successful, the child or young person should be referred for further review and assessment.

See also options for difficult-to-treat bedwetting.

What happens if bedwetting returns after initial treatment?

Recurrence after alarm treatment

If the bedwetting stopped when using an alarm, but has started regularly again, your healthcare team may offer further alarm treatment. If it happens again, the healthcare team should offer desmopressin (see box 2 in desmopressin treatment) to take as well as using the alarm.

Recurrence after desmopressin treatment

If the bedwetting stops while the child or young person is using desmopressin, but keeps starting again when treatment ends, the healthcare team may offer continued treatment with desmopressin (see box 3). This should be stopped every 3 months (for a week) to check if the child or young person can stay dry during the night without it. For children and young people receiving repeated desmopressin treatment, the dose should be gradually reduced at the end of a 3-month course.

Box 3 Children and young people receiving drug treatment for bedwetting that recurs

- For children and young people receiving drug treatment for bedwetting, in whom bedwetting recurs, the healthcare team should consider whether alarm treatment has become a suitable alternative to continuing drug treatment.
- If the child or the young person is offered repeated courses of drug treatment for bedwetting, the healthcare team should carry out regular medication reviews to assess the child or young person's progress with the treatment.

Options for difficult-to-treat bedwetting

If the bedwetting has not improved after treatment with an alarm and/or desmopressin, the healthcare team may consider the following further options.

Anticholinergics combined with desmopressin

The healthcare team may consider offering an anticholinergic drug to take with desmopressin (see box 4) following assessment by a healthcare professional with expertise in the management of bedwetting that has not responded to initial treatment. If there is an improvement, the child or young person may be advised to continue with this combination as bedwetting may carry on improving for up to 6 months.

If the bedwetting starts again after stopping treatment with an anticholinergic combined with desmopressin, the healthcare team may offer to repeat the treatment.

If the child or young person has daytime symptoms as well as bedwetting, treatment with an anticholinergic combined with desmopressin may be offered, but only following assessment by a member of the healthcare team who has expertise in giving this combination of drugs for bedwetting.

Anticholinergics alone should not be used for children and young people with bedwetting and no daytime symptoms.

Box 4 Using an anticholinergic with desmopressin

If an anticholinergic combined with desmopressin is offered for bedwetting the healthcare team should explain that:

- more children and young people are drier using this combination than with desmopressin alone
- desmopressin and an anticholinergic can be taken together at bedtime
- treatment should be continued for 3 months and may then be repeated.

Imipramine

If no other treatment has been successful, a drug called imipramine may be offered (see box 5), but only after assessment by a member of the healthcare team who specialises in the management of bedwetting that has not responded to treatment.

Imipramine should not be offered as an initial treatment and it should not be offered in combination with an anticholinergic.

Your doctor should carry out a check every 3 months for children and young people having repeated treatment with imipramine. It should be stopped gradually when treatment is finished.

Box 5 Using imipramine for bedwetting

If imipramine is offered for bedwetting your healthcare team should explain that:

- imipramine reduces wetness in many children and young people
- the drug works to improve the bladder's ability to hold urine
- it should be taken at bedtime
- the dose should be increased and stopped gradually
- for safety reasons, it is very important to take only the prescribed amount and to store the bottle securely out of the reach of children
- many children and young people start wetting the bed again after 3 months of treatment
- treatment should continue for 3 months. It may then be repeated, but only if it is helpful.

More information

The organisations below can provide more information and support for children and young people with bedwetting and their parents and carers. NICE is not responsible for the quality or accuracy of any information or advice provided by these organisations.

- ERIC (Education and Resources for Improving Childhood Continence), 0845 370 8008 www.eric.org.uk

- PromoCon, 0161 834 2001 www.promocon.co.uk

You can also go to NHS Choices (www.nhs.uk) for more information.

Changes after publication

August 2015: Change made in tests, assessment and referral section to refer to the updated NICE guideline on diabetes (type 1 and type 2) in children and young people rather than in the previous guideline (CG15). Hyperlinks in paragraph updated to current NICE style.

Accreditation