Non-responsive to Desmopressin?

- Increase dose to 240mcg (Desmomelt)
  0.4 mg (Desmotabs)
- Check bladder capacity – address if small for age
- Consider if nocturnal OAB – add in anticholinergic
- Check evening fluid intake / diet – exclude fluids and high salt/high protein food in hour before bed
- Check time of administration - advise desmopressin to be given an hour before sleep, if able to stop drinks an hour before given
- Ensure bladder emptied before sleep
- Try switching formulations of Desmopressin

Other leaflets in this series:
Understanding Nocturnal Enuresis – Improving Treatment Outcomes
Understanding Toilet Refusal – the child who will only poo in a nappy
Understanding Constipation in infants and toddlers
Understanding Constipation in Infants and Young Toddlers
Understanding Ano-Rectal Malformations
Understanding Hirschsprung Disease
Understanding Bowel Problems in Schools
Understanding Management of bedwetting in Children under the age of 7 years: Implementing NICE Guidelines

NICE has produced guidelines for the management of nocturnal enuresis: https://www.nice.org.uk/Guidance/CG111

For further information or advice contact Bladder and Bowel UK (formerly PromoCon).

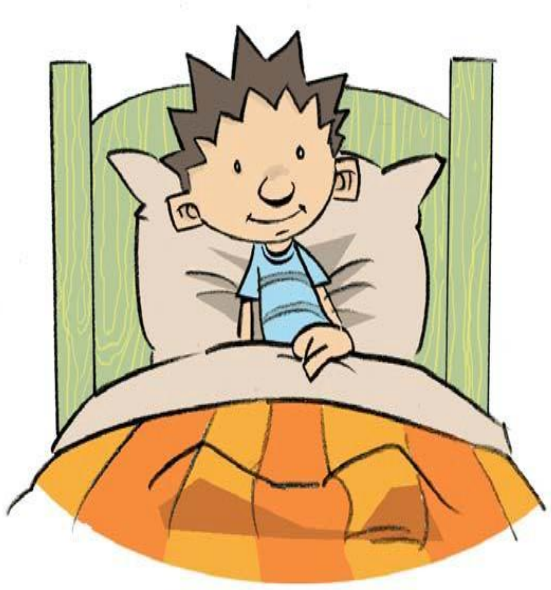
Bladder and Bowel UK, working under the umbrella of Disabled Living, provides impartial advice and information regarding resources, products and services for children and adults with bladder and bowel problems

Helpline: 0161 607 8219 www.bladderandboweluk.co.uk

June Rogers MBE – Bladder and Bowel UK Paediatric Continence Specialist
Illustrations - Les Eaves

Bladder and Bowel UK
formerly PromoCon
part of Disabled Living

Understanding Nocturnal Enuresis – improving treatment outcomes



Q. At **what age should you start treating children with nocturnal enuresis (bedwetting)?**
A. Bedwetting is a recognised condition from age 5 years and recent studies have identified that children with severe bedwetting (i.e. wetting every night) at age 5 years may go on to be persistent bedwetters. NICE make clear recommendations that younger children (i.e. those under age 7years) should not be excluded from treatment on the basis of age alone.

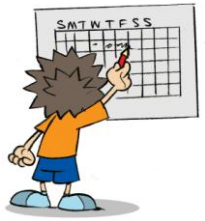
Q. What is the difference between monosymptomatic (MNE) and nonmonosymptomatic nocturnal enuresis (NMNE)?
A. Monosymptomatic bedwetting means that the child has no other symptoms, such as an overactive bladder or constipation. For children with NMNE it is important that any problem with the bladder and/or constipation is addressed first.

Q. What is the best treatment for bedwetting?
A. Treatment should always reflect the findings of the assessment and be tailored to the child's individual needs and family dynamics. However simple measures should always be tried first.

Empty bladder before sleep

Encourage regular voids and treat any underlying constipation

Ensure 6-8 drinks during the day. Stop food and drinks an hour before bed



Use charts/stickers to motivate towards achievable outcomes

TREATMENT - Tailor to underlying pathophysiology

- Normal night time urine output / no day time bladder symptoms / average bladder capacity
  - Consider either alarm or Desmopressin as first line treatment, taking into account child's age / motivation / previous experiences / parental expectations and preferences
- Nocturnal Polyuria (indicated by wetting large patches within a few hours of going to sleep)
  - Consider Desmopressin (Desmomelt) as first line treatment
- Small bladder capacity / apparent high arousability / good motivation and family support
  - Consider alarm as first line treatment taking into account child's age and motivation/ parental expectations and preferences
- Overactive bladder (OAB)
  - Initiate bladder retraining programme and introduce anticholinergics if tolerated
- If single first line treatment fails consider:
  - Desmopressin plus alarm for nocturnal polyuria with low maximum voided volume (MMV) i.e. small bladder / high arousal threshold
  - Desmopressin plus anticholinergic for nocturnal polyuria with suspected nocturnal OAB
  - Anticholinergic plus alarm for OAB / low MMV / high arousal threshold