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Guest Editorial

10-Minutes Consultation: Nocturnal Enuresis

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Clinical Scenario

A mother brings her 6-year-old son to the GP, concerned that he is still wetting the bed at night.

What issues should you cover?

- **Is there an underlying organic cause?**

Although rare, anatomical or neurological abnormalities must be excluded. Enquire about:

- Any associated symptoms (e.g. constipation, back pain, abnormal gait).
- Birth history.
- Developmental milestones.
- Past medical history or any parental concerns.

- **Any dry nights?**

A history of even one or two dry nights, or consistent daytime dryness, suggests that an organic cause is unlikely.

- **Distinguish between primary and secondary nocturnal enuresis:**
  - **Primary nocturnal enuresis:** Bedwetting in a child aged ≥5 years who has never achieved six months of uninterrupted nighttime dryness.
  - **Secondary nocturnal enuresis:** Recurrence of bedwetting after at least six months of dryness; often associated with emotional stress or illness.
- **Consider the physiological basis of primary enuresis:** Often reflects a delay in the normal neuromuscular maturation of bladder control. A positive family history is not uncommon.
- **Evaluate for possible stressors in secondary enuresis:**
  - Explore stress at home or school (e.g. parental separation, arrival of a new sibling).
  - Enuresis can significantly affect self-esteem and strain family dynamics—explore its emotional and social impact.
- **Previous treatments:** Ask whether any treatments or strategies have been tried, and their outcomes.
- **Screen for diabetes:** Ask about a family history of diabetes and screen for symptoms such as excessive thirst, weight loss, and frequent urination.

What should you do?

- **Physical examination:**
  - Examine the lower back for signs of spinal dysraphism (e.g. sacral dimple, tuft of hair).
  - Check ankle reflexes to exclude underlying neurological issues.
- **Urinalysis:** Test for glucose, protein, and nitrites to rule out diabetes, renal disease, or urinary tract infection.
- **Reassure and normalise:**
  - Around 10% of 6-year-old boys regularly wet the bed (primary nocturnal enuresis).
  - Approximately 15% of affected children achieve dryness each year without intervention.
  - Emphasise that this is often a normal developmental delay.
- **Treatment considerations:**
  - Active treatment is usually deferred until after age 6 unless the problem is causing distress to the child or family.
  - Tailor treatment to the degree of impact and parental concern.
- **Desmopressin:**
  - Intranasal or oral desmopressin can offer rapid short-term relief.
  - Relapse is common once treatment stops.
- **Enuresis alarms:**
  - Meta-analyses of RCTs support their long-term efficacy and low relapse rates.
  - Safe and suitable for home use.
- **Other pharmacological options:** Tricyclics (e.g. imipramine) are sometimes used but are limited by side effects such as agitation and drowsiness.
- **Avoid punitive approaches:** Emphasise to parents that threats, punishments, or reward systems alone are ineffective and may worsen anxiety.
- **Empower the family:**
  - Highlight that effective treatment options are available if spontaneous resolution does not occur.
  - Provide reassurance and education to reduce anxiety.

Further Support and Resources

Parents may benefit from accessing reputable enuresis support services such as: www.eric.org.uk (The Children's Bowel and Bladder Charity).

Further Reading

1. Pharmacological strategies-desmopressin plus anticholinergics

"Pharmacological treatment of pediatric nocturnal enuresis: a systematic review and network meta-analysis" (PubMed, 2025).

A network meta-analysis of 23 RCTs (1,658 children) showing that combination therapy (desmopressin with propiverine, solifenacin, tolterodine) achieved greater complete response rates compared to monotherapy, with low adverse effects pubmed.ncbi.nlm.nih.gov+5reddit.com+5pmc.ncbi.nlm.nih.gov+5onlinelibrary.wiley.com+2pubmed.ncbi.nlm.nih.gov+2pubmed.ncbi.nlm.nih.gov+2.

2. Efficacy of standard urotherapy

"The efficacy of standard urotherapy in the treatment of nocturnal enuresis in children: A systematic review" (2022).

Reviews 39 studies (including 22 RCTs) and highlights the mixed and generally low-quality evidence for first-line standard urotherapy (voiding schedules, lifestyle advice) pubmed.ncbi.nlm.nih.gov.

3. Combination therapy outcomes

"The pooled analysis evaluates the therapeutic efficacy of desmopressin combined with anticholinergic drugs in pediatric nocturnal enuresis" (Wiley, 2024).

Analysis of 8 RCTs (659 patients) showing combination therapy results in significantly higher complete response rates and fewer recurrences than desmopressin alone pubmed.ncbi.nlm.nih.gov+1onlinelibrary.wiley.com+1.

4. Alarm therapy vs desmopressin

"Alarm therapy or desmopressin? Insight for pediatric monosymptomatic nocturnal enuresis in meta-analysis approach" (*Journal of Pediatric Urology*, 2024).

Among 9 comparative studies, alarms outperformed desmopressin in well-motivated families. Structured desmopressin withdrawal was recommended to reduce relapse reddit.com+15jpurol.com+15pubmed.ncbi.nlm.nih.gov+15.

5. Updated ICCS guidelines

"Management and treatment of nocturnal enuresis—an updated standardization document from the International Children's Continence Society" (PubMed, 2020).

ICCS consensus on definitions, evaluation pathways, and tiered treatment: urotherapy first, followed by desmopressin or alarm, then anticholinergics, with antidepressants as needed.

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