



CONTINENCE EDUCATION PROGRAM SERIES 2007/08

AN INITIATIVE OF THE NATIONAL CONTINENCE
MANAGEMENT STRATEGY

A Learning Guide for

Program 718b

**CONTINENCE:
CHILDREN AND ADOLESCENTS**



Continence: Children and Adolescents

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About the Rural Health Education Foundation

The Rural Health Education Foundation is a non-government, not-for-profit organisation that provides an education and information "lifeline" to rural and remote health professionals. The Foundation produces and broadcasts distance education programs using digital satellite technology, the Internet, "enduring" materials (DVDs and videos) and other television services. The Foundation operates a growing network of more than 650 receiving sites, called the Rural Health Satellite Network.

For the doctors, pharmacists, nurses, administrators and other health workers involved, the programs are invaluable for they provide an opportunity to undertake continuing professional education and receive timely information emanating from national launches or events of national importance.

The Rural Health Education Foundation is always interested in developing new sites. If your organisation is interested in becoming a Foundation satellite site and gaining access to up to date education programs covering a wide range of topics for professionals employed in medical and allied health fields, please contact the Foundation office on 02 6232 5480.

Program summary

We are all born incontinent, and we gradually acquire bladder and bowel control over the first few years of our lives. For some children though this may be more difficult for all kinds of reasons, and this program deals with all types of toileting problems for children and adolescents, including bed wetting, day time wetting – also known as urinary incontinence - and faecal incontinence, or encopresis.

Bedwetting or nocturnal enuresis is a very common problem in children. The incidence of bedwetting is dependent on the age of the child. For example, bedwetting occurs in 20% of five year olds, 10% of ten year olds, and up to 2-3% of teenagers. So as a child grows up they are less likely to wet the bed.

The major causes of bedwetting are:

- Small bladder capacity - This means the bladder is not large enough to hold all the urine produced overnight;
- Very deep sleep - This is very common in children who wet the bed. During the night their bladder sends a message to their brain saying it is full. The child, though it needs to wake up and go to the toilet, continues to sleep through this signal;
- Large volumes of urine produced at night - Some children produce double the normal amount of urine at night so that even if their bladder capacity is normal it will not be big enough to hold all the urine they produce. Overnight these children often have abnormally low levels of the antidiuretic hormone, vasopressin.
- Constipation - This can lead to pressure building up in the area around the bladder reducing the amount of urine the bladder can comfortably hold. It can also lead to tightening of the muscles, which need to relax so the bladder can empty fully.

Bedwetting has implications which are often underestimated by both the community and those advising on its treatment. It places a huge burden on the whole family.

Parents often become very distressed and might even suspect that their child is deliberately causing mischief, which they are not, or the parent may feel they have failed because their child is not dry “like other children”. Children can become anxious about their own ability to influence the outcome. Try as they might, they feel powerless to stop wetting the bed, and in time their self-esteem may even suffer. Sleepovers with friends and school camps can become a source of considerable stress to the child.

Many parents become resigned to the fact that they are unable to help their child. Doctors can be dismissive, offering only reassurance that the child will eventually outgrow the problem, when the family requires immediate help.

Whilst bedwetting is a very common problem, it is often needlessly tolerated because of a certain reluctance to discuss what is an awkward and embarrassing subject for many people.

Part 1

Introduction – *Continence: Children and Adolescents*

This kit has been produced by the Rural Health Education Foundation (the Foundation) as a complete learning resource, for use in either workshop or individual settings. The kit consists of:

The Rural Health Education Foundation program DVD: *Continence: Children and Adolescents*

The program DVD contains a recording of the Foundation's satellite broadcast. The program was broadcast across the Rural Health Satellite network to over 650 sites Australia wide on 12/2/08. The broadcast is also available as a webcast or podcast at the Foundation's website (www.rhef.com.au).

Learning guide: *Continence: Children and Adolescents*

The **Learning Guide** has been designed with a number of activities that can be used to facilitate group discussion and engage with the material covered in the DVD. This **Learning Guide** has been designed to provide a framework for discussion of the key issues raised in the program.

The **Learning Guide** has also been designed to support the learning of participants and to provide a record of the information presented in the broadcast and the activities covered in the group facilitation.

Guide to Facilitating Adult Learning

A **Guide to Facilitating Adult Learning** booklet has been developed by the Foundation to support the facilitation of discussion with small groups. It covers the basic aspects of how people think and learn, running groups and facilitating learning in face-to-face settings. It is designed to provide some basic instructional information to assist people facilitating face to face learning. We encourage you to read this brochure before you work with groups as a guide to facilitate the **Learning Guide** discussion.

Presenters



Dr Norman Swan (Panel Chair)

Dr Norman Swan regularly presents Rural Health Education Foundation satellite broadcasts.

He is best-known for his wide broadcasting experience, including the award-winning *Health Report*, which he produces and presents for ABC Radio National - as well as his other ABC Radio and Television program hosting.

Dr Swan trained in Medicine in Scotland and in Paediatrics in London and Sydney. A broadcaster and journalist with the ABC's Science Unit since 1982, he has been Australian Producer of the Year and was awarded a Gold Citation in the United Nations Media Peace Prizes.

In 2004 Dr Swan was honoured by the Australian Academy of Science, which presented him with an Academy Medal, only the third time such an award has been made. The Academy gave it for his outstanding contributions to science in the public domain. Around the same time, the Royal College of Physicians and Surgeons of Glasgow made him a Fellow.

He has won an Australian Writers' Guild Award, three Walkley National Awards for Journalism and the Michael Daley Award for Science Journalism on two occasions.

In addition to his broadcasting, he edits his own newsletter, *The Health Reader*, published in association with *Choice* magazine, and has been the Australian correspondent for the *Journal of the American Medical Association* and the *BMJ*. He has also consulted to the World Health Organisation (WHO) in Geneva.



Dr Patrina Caldwell

Patrina is a general paediatrician with a special interest in paediatric continence issues. She currently runs a continence service at the Children's Hospital at Westmead and is also actively involved in continence research. She is a senior lecturer for Paediatrics and Child Health at the University of Sydney and Staff Specialist at the Centre for Kidney Research, NHMRC Centre of Clinical Research Excellence in Renal Medicine, at the Children's Hospital at Westmead.



Ms Janet Chase

Janet Chase is a continence physiotherapist whose chosen area of practice for nearly thirty years has been the treatment of incontinence in children and adults.

She presently works at the Monash Medical Centre Paediatric Continence Clinic and the Murdoch Children's Research Institute at the Royal Children's Hospital, Melbourne. Her area of research is Slow Transit Constipation in children. She is Chair-person of the Continence Foundation of Australia Paediatric Advisory Sub-committee, a Board member of the International Children's Continence Society and paediatric representative on the Australian Government Continence Management Advisory Committee.



Dr Susie Gibb

Susie Gibb is a general paediatrician working at the Royal Childrens Hospital, Melbourne and in suburban private practice. She has a clinical and research interest in bladder and bowel dysfunction in children and has worked in the Continence Clinic for almost 10 years.



Dr Geoff Chapman

Geoff is a GP who spent 9 years in solo rural general practice at Bothwell, in the Central Highlands of Tasmania, before moving to the city to facilitate his children's education.

As of 2008, he is a principal in a busy, 6-doctor practice in Sandy Bay on the shores of the Derwent River in Hobart, as well as Medical Director of the Division of General Practice in southern Tasmania. He is also on the Boards of the state Divisions body and the regional training provider, General Practice Training Tasmania.

He has a long-standing interest in continence, particularly in the context of chronic diseases such as multiple sclerosis. Dr Chapman is Chairman of the MS Society of Tasmania, and on the Board of MS Australia.

Ms Angela Cheers



Angela Cheers graduated as an occupational therapist from Cumberland College of Health Sciences, University of Sydney, in 1990. She has spent all of her working career in the area of paediatrics both in Australia and overseas.

Angela worked for the Spina Bifida and Hydrocephalus Association of Queensland for fourteen years and it was during that time that Angela developed an interest in assisting children with toileting difficulties. Her experience has been with children who have neurogenic problems in bowel and bladder development as well as poor independence and behavioural concerns when toileting.

She has presented at national and international conferences and has written several papers related to these topics including developing early independence with self catheterization. She currently works in private practice and supports families, children and schools in Brisbane, Queensland.

Angela's interests away from work include camping, surfing and hiking.

Session Planning

The following table overviews the activities within this learning guide. Activity time is based on numbers of 5-6 per group. Larger groups may take up to twice as long.

Activity	DVD Chapter	Activity time	Page
1. Video Clip – Case Study – Karen Matthews – Introduction to Continence	1	15 minutes	10
2. Alarms	2	1 Week	13
3. Case Study 2 - Urinary incontinence - Tim	3	20 Minutes	14
4. Teaching Toileting	3	30 Minutes	15
5. Constipation	3	1 Week	15
6. Case Study 3 – Adolescent Urinary Incontinence - Adam	4	15 Minutes	16
7. Resources For Children with Special Needs	5	2 Weeks	17
8. Case Study 4 – Bowel Dysfunction - James	5	15 Minutes	17
9. Case Study 5 – Chronic Constipation - Oliver	5	15 minutes	18
10. Dealing With Constipation	5	20 minutes	19
11. Case Study 6 -Video Clip – Blue Care Continence Advisory Service	5	15 minutes	19

The table provides approximate timings for the activities within this guide. Session planning should include time to view the particular DVD chapter as a prompt to the activity and delivery of the background material provided for each section. As a guide, the entire training package could be covered in a 3-4 hour workshop.

Activities contained within the learning guide are short and not designed to tell the entire story; rather they provide a stimulus for participants to think about the information and the issues arising from it. The case studies and activities are designed to reflect real life situations, providing opportunities to integrate learning into practice.

Part 2

Program Summary

More than 100,000 children in Australia will wet the bed tonight. Poor bladder and bowel control is common in children and good toilet habits are something we learn as part of healthy development. If incontinence becomes a continuing problem and is not treated, it is often carried into adolescence and sometimes adulthood.

There is a significant impact on children and families. Incontinence can affect children's self-esteem, their schooling and their relationships with peers. Children are often embarrassed and reluctant to go away on school excursions or to attend sleepovers. Incontinence problems for adolescents can have a serious impact on their social functioning, sporting activities and their developing sexuality.

This program aims to improve the knowledge of health professionals relating to continence for children and adolescents. It will assist health professionals to normalise incontinence in the context of children's development, and to treat, manage or refer the problem if it becomes chronic. The program provides strategies for engaging parents and children and assists health professionals to assess and determine any underlying factors or conditions that may be associated with incontinence in children and adolescents.

Learning outcomes

After watching this program, participants will be able to:

- Describe the continence issues relating to children and adolescents.
- Recognise, assess, treat and manage incontinence effectively.
- Undertake early intervention related to children's incontinence.
- Address stigma and promote healthy bladder and bowel habits for children.

Program Duration

62 minutes

Key messages from the program:

- The most common type of incontinence in children and adolescents is nocturnal enuresis.
- There is help available.
- Constipation plays a large part in incontinence.
- Children often need to learn correct toileting techniques for effective elimination
- There are a range of resources available to assist children and parents in education about continence, both generally and for children with special needs.
- Parents need support and reassurance over the long-term to manage the situation effectively.

Activity 1

View Case Study 1



Activity 1

Case Study 1 – Bedwetting – Karen Matthews

- Karen Matthews, is a mother of two children who both experienced bed wetting problems up to the age of 10.

After watching the video clip, in small groups, identify the issues raised including the problems and differences between the children, the effect on their lives and the issues around children's embarrassment and parental guilt.

Issues raised include:

- Feelings of failure as a parent
- Fear of sinister cause
- Self esteem issues for the child
- Management issues including waking up before parents go to bed, alarm mat
- Role of Dry Bed Program

Key issues from case study

- This is a typical story.
- It's important to see both parents and deal with their expectations of what is normal and what is not normal.
- As a child grows up their chances of wetting the bed are less. However, if a child is still wetting the bed by the time the child reaches adolescence, they are much less likely to grow out of it.
- It's important to distinguish between simple bed wetting from more complex continence problems.
- Keep asking the questions regularly to determine progress.
- Discuss the natural history with the parents and child.
- Behavioural problems can develop secondary to the enuresis as a reaction to the problem.
- It's important to de-stress the situation and the environment – continue to reassure the parents and child.
- Restricting fluids can make the situation worse – it won't make any difference to the wetting. At the same time, it's important that parents don't encourage a lot of fluids at night as it can exacerbate the problem.
- Some fluids such as caffeine can be a bladder irritant and diuretic and thus exacerbate the problem.
- Artificial sweeteners can also be an irritant for some sensitive people
- Choose the right technology with alarms.
- Ensure the GP educates and supervises the management of treatment.

Normal bowel and bladder habits in children

Normal bladder filling and emptying cycle - from about 3 yrs of age:

- The bladder fills with urine (takes around 2 hrs).
- At a certain point the child feels the need to pass urine.
- The child holds on until the potty/toilet is reached.
- The bladder empties with a combination of sphincter relaxation/bladder contraction.

- The urine flow continues until the bladder is empty.
- The bladder refills and the cycle starts again (Berk and Friman 1990).

Developing control

Developing control of the continence sphincters normally follows a set pattern:

1. Control of bowel while asleep.
2. Control of bowel while awake.
3. Control of bladder while awake.
4. Control of bladder while asleep.

There is a level of development required for independent toilet training. This includes:

- Physiological maturation – the child needs the ability to sit, walk and dress itself
- External feedback – the child needs to understand and respond to instructions
- Internal feedback – the child needs to have good self esteem and motivation, and the desire to imitate and identify with peers which will foster self determination and independence (Brazelton, 1962)

Types of Nocturnal Enuresis

- Mono Symptomatic Nocturnal Enuresis – when a child has always wet the bed at night, and is dry during the day, and has no constipation.
- Non-mono Symptomatic Nocturnal Enuresis – when there are daytime symptoms, bladder dysfunction or constipation as well.
- Primary Nocturnal Enuresis – a child who has always wet the bed.
- Secondary Nocturnal Enuresis – when a child has been dry for over 6 months and then begins wetting the bed again (need to ensure they were *completely* dry).

Three components for mastery of nocturnal enuresis:

1. Adequate bladder capacity.
2. Non-excessive urine production.
3. Need to be able to wake up in the night when the bladder is full to urinate.

The child needs to be neurologically and physically developed enough to determine this.

Incidence of bedwetting

The incidence of bedwetting is dependent on the age of the child. As children grow and develop the incidence of bedwetting declines – thus bedwetting occurs in 20% of five year olds, 10% of ten year olds, and up to 2-3% of teenagers.

Myths

- That you grow out of wetting the bed by the time you are a teenager – a small proportion of teenagers (up to 2-3%) will wet the bed at night in adolescence and “not grow out of it” readily.
- That parents have “failed” or that “inadequate” parenting has caused the problem.
- The child who still wets the bed is slow to develop.
- The child is naughty, lazy, emotionally upset and is reacting by wetting the bed
- Restricting fluids, especially at night, will reduce or stop the problem.

Investigations

With non-mono symptomatic nocturnal enuresis and secondary enuresis, it is important to investigate the issues thoroughly. This includes:

- determining if there is any constipation – check with the child about their bowel function once the child is of school age
- micro urine for urinary tract infection / diabetes

Remember: It is important to rule out something more unusual and complex.

Treatment

Bed wetting before the age of five is normal and does not require treatment. Bed wetting beyond the age of five is when to start thinking about treatment. The age of the child, their own desire for treatment, their level of maturity and motivation are all factors which determine whether treatment is appropriate. For example, if a young child (less than five or six years of age) presents with simple bed wetting, with no day time symptoms, and they have always wet until that time, it would be most appropriate simply to reassure the parents.

Generally, six and seven year olds tend to be less motivated for treatment, and because treatment requires motivation from parent and child, it will often not work. Waiting until the child is at least seven, unless the child is very keen and very motivated and wants to participate, will prove more successful.

When children are not being actively treated, it's important to talk to the parents about management strategies that are going to make their life easier. The bed-protective devices, pull-ups pants and other products are designed to assist with the management process.

Alarm treatment

Alarms are an excellent first line treatment for primary mono-symptomatic nocturnal enuresis because they have the potential to 'cure' the problem. Other treatments are symptomatic – stopping the problem but not resolving the underlying cause. Alarms address the arousal component to remain dry at night by behavioural conditioning.

There are two types of alarm – the body worn alarm and the alarm mat. It is important to have an alarm that is functional, reliable and will go off if the child wets and not one that will have false alarms. It is important, as part of prescribing an alarm, that the GP actually goes through the process with the child and family and demonstrates exactly how it works. This can be the most important part of the management; it also enables the GP to ensure the alarm is in working order.

When choosing an alarm, factors to consider are availability, patient choice, and cost. In many rural areas, there may not be access to pad and bell alarms, especially since they are very expensive. A body worn alarm can be purchased directly by a family, remembering that it is vital that the family then consult with their GP for education on how to most effectively use it and for ongoing supervision.

The effectiveness of alarm training is that the child is woken when the alarm sounds. If a child does not wake to the alarm, the parent will need to wake the child when the alarm goes off. They will then need to get the child to turn off the alarm, walk the child to the bathroom (even if they have completely emptied their bladder) and then get the child to help remake the bed. There is no sense of punishment here. This is just a routine process.

It often takes up to two weeks for a child to start responding to the alarm. The child can monitor and record progress, and can bring the chart to each supervision consultation. GP's need to ensure they have a follow-up appointment in a set amount of time. It is important to reassure parents that it will take a good couple of months before they will see any real success. Parents need to understand and accept that the bed wetting problem is going to be there for a while, but it shouldn't add to their burden of care for the child.

When the child is dry the alarm treatment can be discontinued. It is important to reassure parents that about a third of children who have become dry on an alarm program will actually relapse. So at the first sign of that, the family needs to get back in touch with their GP and restart the program. The sooner the child is back on the program, the sooner the child will be successful again.

Activity 2

Activity 2 - Alarms

Visit your local community pharmacy and identify the range of bed wetting alarms they have for sale or rent. Become familiar with how they work and how you can educate your clients in their use.

Medications

If alarm training has not been successful after three months then it probably won't work. The second line treatment for simple bedwetting is the use of medication with a synthetic antidiuretic hormone analogue such as Desmopressin. This is an authority prescription in Australia, and children need to have failed alarm therapy before it can be prescribed. There are added precautions with taking it because there is a risk of hyponatremia if the child drinks excessively after taking the medication.

Desmopressin can be used in a number of ways.

- It is particularly helpful if the child is having a sleepover or something like that and they are not completely trained yet. It can be used just for those nights of the sleepover.
- It can be useful in a child who has partial response to alarm training, but not complete response – for example, a child who makes a lot of urine overnight because of a deranged circadian secretion of anti diuretic hormones, is on alarm training and wakes three or four times during the night because they wet so much. Desmopressin can be used in conjunction with alarm training to improve the outcomes.

- Desmopressin is only available for three months at a time. After 3 months it is stopped to determine progress. If the child starts wetting again it can be recommenced immediately. Some children may require Desmopressin for life.

Activity 3

View Case Study 2

Activity 3 - Case Study 2 - Urinary incontinence - Tim

- Tim is a healthy 11 year old boy
- His mother brings him to see the GP
- He is wetting the bed 5 or more nights per week and has episodes of daytime urgency
- His mother has stopped fluids after 5pm and woken him for toileting during night
- He has never been dry for longer than 6 months
- Tim is frightened of getting out of bed at night
- He also has a problem with constipation and occasionally soils his pants
- His older sister also had bedwetting problems

Key issues from the case study

There are some “red flags” here including:

- Tim has been dry for some months and is now bedwetting again.
- He is fearful of getting up in the night
- He is constipated
- He has day time urgency

Toileting Techniques

A lot of the children have no real history of pushing or straining out a stool. They may also have low sensation in the lower half of their rectum, and as such may not be aware when they need to go to the toilet.

Most children don't understand how their body works. They don't understand how faeces is made or where urine comes from. The child, and often the parents, need to be educated about how these processes develop, and in particular about what is normal. Many of these parents are so used to the child's unusual behaviours of passing stools that they lose a sense of what is normal.

Show them how to use the toilet.

- Show them how to sit on the toilet properly (most of the children are too old for potties).
- Make sure that the child is supported under their feet. A lot of children are very short and small so their feet dangle off the end of the toilet rim. Make sure they've got a stool.
- The child needs to be leaning forward and bearing down or bracing forward.
- If the child is fearful or if they're little, insert a ring or something inside the toilet to make the opening narrower. This helps the child to feel safe and secure while sitting on the toilet.
- A lot of the children aren't active when they're sitting on the toilet. They sit,

literally, and don't do anything. Children should be actively encouraged to push when they are on the toilet, not just sit and wait for something to happen.

Activity 4

Activity 4 - Teaching Toileting

In pairs, role play your role as the GP or health professional teaching correct toileting techniques to a child aged 6 years old and his parents.

Ensure you cover the following issues using appropriate language and examples:

- How the body works to make and eliminate faeces and urine – what is normal
- The basic toileting training techniques for optimum emptying of bowel – how to use the toilet properly (sitting, bearing down etc)
- Toilet timing to train the bowel to defecate regularly

Treating constipation

- Education - explain what constipation is and how it can present – ie constipation can also present as diarrhoea - constipation with overflow.
- Need to look at diet and ensure it is adequate, including adequate fluids.
- Provide fibre supplements (not too much).
- Long term constipation needs laxative treatment.
 - First line – a softener such as paraffin oil based softener or polyethylene glycol based medication – macrogol 5550 derivative of small volume which is easily drunk and which softens and enhances peristalsis.
 - Senna is still useful but can cause abdominal cramping.
 - Novacol is better tolerated than senna and takes water directly to the bowel.

Activity 5

Activity 5 - Constipation

Visit your local community pharmacy and become familiar with a range of products available over the counter to treat constipation including their actions, dosage, side effects and contra-indications. Ensure you are able to discuss the differences between these products with parents.

Complex enuresis

If a child is wet both in the daytime and at night time after treating the constipation it is time to refer on. The specialist will undertake some or all of the following:

- Take a thorough history
- Get a bladder diary – what the child drinks and voids over a three day period to assess bladder function:
 - Determine the bladder's largest volume during the day.
 - Assess how much urine the child is producing at night - does the child have nocturnal polyuria? Is it excessive or normal?
 - How often is the child voiding? Does the child have frequency?
 - Does the child have bladder instability or an overactive bladder (which

can then be treated with an anticholinergic medication).

- Do a urine flow rate and scan the bladder post voiding to see if the bladder is emptying efficiently.
- Test for infections, diabetes.

If there is bladder overactivity, usually the first line of treatment is a voiding program. The child is set up with a program whereby they regularly go and empty their bladder, and they regularly drink fluids. They will also need to be trained in how to sit on the toilet and how best to empty their bladder. A lot of children go to the toilet, don't sit down properly, or hurry. They don't want to miss what's going on in the playground, so they let the top off their bladder and then back they go and run and play. All these sorts of issues need to be addressed.

If a regular voiding program by itself is not helpful, then anticholinergic medication can gradually be added. Some uromodulation with electrical stimulation can be also used.

It is important to also be aware of, and support the child with, self esteem issues, especially if there have been unsuccessful treatments for the incontinence.

Activity 6

View Case Study 3



Activity 6 - Case Study 3 – Adolescent Urinary Incontinence - Adam

- Adam is a nineteen year old boy who had bedwetting problems as a child that continued into adolescence and has only recently become dry.

After viewing the video clip, discuss in small groups the key issues and management of a similar presentation of adolescent enuresis.

Develop a system to ensure any current patients have had a routine follow up to determine progress, to avoid any patient “slipping though the cracks”

Key issues

- Social restrictions - managing sleep-overs etc.
- Self esteem issues.
- Staying up late to avoid time in bed to wet it.
- Nocturnal enuresis is very private.
- Need to seek treatment.
- Follow up to avoid “falling though the cracks”.
- Normalising it by arranging to meet with the adolescent in a casual way (eg. at McDonalds) if possible
- Use of an alarm.
- Takes 2- 3 months to be fully dry.
- Can regress temporally with infections etc.
- Need to eat right, drink right, sleep right and use the alarm to develop a healthy routine.
- Failure of alarm treatment, if it has been undertaken correctly, is a prompt to look for other causes - don't assume it is primary nocturnal enuresis.
- Develop appropriate questioning techniques to evaluate the adolescent patient.
- It's obviously better to intervene before adolescence.

- Children with more severe nocturnal enuresis are more likely to carry it on into adolescence.
- A lot of adolescents and young adults with bed wetting have voiding dysfunction – they don't empty their bladders well when they go to the toilet so the bladder becomes overactive and unstable.
- Treatment depends on the diagnosis.
- Desmopressin may be useful, and the combination of medication and night products would best suit the lifestyle of young adults.
- Need to revisit diagnosis and investigations periodically to ensure it is correct.

Children with Special Needs

The issues associated with incontinence become more complicated when the child has a behavioural problem such as attention deficit disorder or is part of the autism spectrum, etc.

Children need routine and regularity. Parents need a lot more support because of the added challenges, for example, a child who is not cooperative or able to sit on the toilet for long enough to empty their bladder or bowel.

In some cases the goal will be to help the child achieve social continence rather than to become completely continent.

Activity 7

Activity 7 - Resources for children with special needs

Research various resources available for teaching children with special needs about toileting and continence. Share your findings of both organisations and resources with your colleagues.

Activity 8

View Case Study 4

Case Study 4 - Bowel Dysfunction - James

- James is a four year old boy.
- His parents are concerned about ongoing constipation which has become worse in last 6 months.
- He is always straining and only passes tiny stools.
- He was breastfed until 9 months and then on formula and cow's milk at 12 months.
- His stools were firm and no distress until the age of about 3 when problems first started.
- He clings to mother and resists examination.

Key issues for discussion from case study

- Clarify definition of constipation.
- Determine dietary habits and intake.
- Determine toileting habits and techniques.
- Child could be “withholding” – straining to hold on rather than to pass stool. This is the most common type of constipation. The child is getting up on their tip-toes, clenching their buttocks, and trying not to poo, and all that escapes is the little bit they couldn’t hold on to.

Treatment

- Education for proper toileting techniques – to push and not strain/withhold. Teach the child how to actively use those muscles, both practicing when they need to use the toilet and at other designated times to re-educate their muscles appropriately.
- Alter diet if necessary.
- Laxative treatment may be used to provide the child with a prolonged period of time where they have soft, easy to pass stools that don’t cause them pain, thereby encouraging them to improve bowel technique.

Hirschsprung’s Disease is a disease that children are born with that affects the functioning of the nerves within segments of the colon. More information can be found at: http://digestive.niddk.nih.gov/ddiseases/pubs/hirschsprungs_ez/

Activity 9

View Case Study 5

Case Study 5 - Chronic Constipation - Oliver

- Oliver is six years old and presents with his parents who are concerned about ongoing constipation
- Has no problems prior to this
- He is always straining and only passes tiny stools
- Oliver has been at school for two months

Key issues for discussion from case study

- This is becoming a real issue and impacting on the child’s self esteem.
- Need to work out a plan, including both the child and their parents.
- Need to address issues around toileting at school – is the child avoiding toileting at school, or rushing etc.
- Check diet and fluids.
- Child may have lost rectal sensation and not know when he needs to empty his bowel as a result of chronic over distension.
- Need to develop a regular toileting training and regular passing of stools by:
 - The ongoing use of laxatives for a period of at least 6 months. Once the child is regular and there is no soiling, keep the child on a laxative for a further 3 to 6 months, slowly weaning them off.
 - Behaviour modification training to develop appropriate habits and routines which takes months to “anchor”.
- Reassure parents that laxatives are safe to use.
- Parents need to keep up the motivation, reward and support for this child over time.
- There is no evidence that exercise contributes positively to reducing constipation.

Activity 10

Activity 10 - Dealing with constipation

In small groups discuss the two case studies above - James and Oliver - and compare and contrast their presentation, key issues and treatment options.

Activity 11

Case Study 6 – Karen Matthews – Blue Care Continence Advisory Service

View Case Study 6

After watching the case study footage, discuss in small groups the following:

- Main types of disabilities presenting.
- Intervention and management of children with disabilities.

Key issues from the case study

- The main types of disabilities presenting are spina bifida, cerebral palsy, autism and behavioural problems.
- Understanding the disability assists in developing strategies to best support toileting.
- These children do not want to go to the toilet and do not want a bowel management program.
- There are usually high levels of frustration felt by parents trying to manage their child's continence and toileting – there is a need to support the parents too.
- The child may not be able to communicate verbally.
- There needs to be a thorough assessment of the child's continence and the development of an individualised plan.
- It is important to persevere in discussion and education of both parents and child because the child is often listening and taking in the discussion, even if they appear not to be engaged.
- There is a range of resources available for the education of children with disabilities such as “are you ready” which uses flash cards.
- It is important to help the child acquire a correct technique and that there be support for the child's legs etc so they can relax their buttocks, further assisting toileting.
- It is vital to stress the importance of good toileting routines.

Key take home messages from the program

- Reassure parents, and make them aware that there's no quick fix solution. The relationship that you are going to have with the parent is going to be over a longer period of time, not just a week or two, whether the child is disabled or not.
- Build a rapport with that family, and establish a relationship that's going to last over some period of time.
- Develop your resource base.
- It's important not to underestimate the role of constipation in children who might be presenting primarily with a urinary problem. Just asking the question, “Is your child constipated”, is not enough. You need to go into the history and really tease that out. Sometimes treating the constipation will resolve the urinary problem.

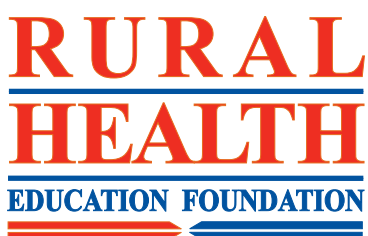
- Talk to the child. It's the child who can tell you about their bladder and bowel and give you a lot of information about that.
- Education of the child and the family is the cornerstone of success.
- Take a thorough history and good physical examination because it is only on that basis that you can make an accurate diagnosis and plan the management appropriately.

Online Resources

Australian Nurses for Continence (ANCF)	http://www.anfc.org.au/
Australian Physiotherapy Association (APA)	http://apa.advsol.com.au
Continence Foundation of Australia	http://www.continence.org.au/
National Continence Helpline	1800 33 00 66
Department of Health and Aging	http://www.health.gov.au/
National Continence Management Strategy – Bladder & Bowel Website	http://www.bladderbowel.gov.au/
National Digestive Diseases Information Clearing House (US)	http://digestive.niddk.nih.gov
Hershsprung's Disease	http://digestive.niddk.nih.gov/ddiseases/pubs/hirschsprungs_ez/
Rural Health Education Foundation	http://www.rhef.com.au
Continence and Men's Health Program	http://www.rhef.com.au/programs/718b/718b.html

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