| **Body System:** Nephrologic | | |
|---|---|---|
| **Session Topic:** Enuresis | | |
| **Educational Format** | | **Faculty Expertise Required** |
| **REQUIRED** | Interactive Lecture | Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required. |
| **OPTIONAL** | Problem-Based Learning (PBL) | Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form. |

| **Professional Practice Gap** | **Learning Objective(s) that will close the gap and meet the need** | **Outcome Being Measured** |
|---|---|---|
| • Knowledge gaps regarding the prevalence and diagnostic criteria for enuresis.<br>• Knowledge gaps regarding counseling families that most cases of enuresis resolve spontaneously and counsel them about eliminating guilt, shame, and punishment for the condition.<br>• Knowledge gaps regarding the development an individualized management plan when children with enuresis are able and willing to adhere with treatment.<br>• There is a lack of current U.S. clinical practice guidelines for the treatment or management of pediatric enuresis.<br>• Parents are not aware that primary nocturnal enuresis (PNE) is a physical problem, and would be | 1. Determine which children in their practice meet the diagnostic criteria for enuresis.<br>2. Identify and manage comorbid (especially psychiatric) conditions that can cause or contribute to enuresis.<br>3. Reassure families that most cases of enuresis resolve spontaneously and counsel them about eliminating guilt, shame, and punishment for the condition.<br>4. Develop an individualized management plan for children with enuresis who are able and will to adhere with treatment. | Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations. |

 

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|---|---|---|
| uncomfortable initiating a conversation with their healthcare provider.<br>• Physician training in the evaluation and management of this condition is often minimal or inconsistent. | | |

| **ACGME Core Competencies Addressed** (select all that apply) | | | |
|---|---|---|---|
| X | Medical Knowledge | X | Patient Care |
| X | Interpersonal and Communication Skills | | Practice-Based Learning and Improvement |
| | Professionalism | | Systems-Based Practice |

**Faculty Instructional Goals**

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
  - Visit http://www.aafp.org/journals for additional resources
  - Visit http://familydoctor.org for patient education and resources
- [insert bullet related to session topic]
- [insert bullet related to session topic]

**Needs Assessment**

More than 63.9% of American Academy of Family Physician (AAFP) members report providing pediatric care in their practice.[1] Urinary incontinence is a common problem in children, occurring in an estimated 5 to 7 million children in the United States.[2] Unfortunately, only approximately one third of families with children who have enuresis, seek help from a physician.[3]

Physician training in the evaluation and management of this condition is often minimal or inconsistent; therefore, patient care is not optimal, and often has a negative impact on affected children and their families.[4] While the majority of family physicians report providing pediatric care, data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians indicate that the management of enuresis is

 

not highly rated as an area of relevance in their practice. This suggests that enuresis may be underreported and undertreated.[5] In fact, some studies suggest that parents are not aware that primary nocturnal enuresis (PNE) is a physical problem, and would be uncomfortable initiating a conversation with their healthcare provider.[6,7]

Some studies point to a potential genetic predisposition for nocturnal enuresis (NE), and possible associations with attention deficit hyperactivity disorder (ADHD).[8,9] Physicians should understand how these associations apply to their care of children with enuresis. Additionally, physicians should also be kept up to date on new treatment therapies, changes to therapies, or warnings associated with existing therapies. For example, some studies suggest that desmopressin melt, compared to the tablet form, can improve response and compliance.[10]

Physicians may improve their care of children with enuresis by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[2,4]

- Initial laboratory evaluation for a child with monosymptomatic enuresis should be limited to urinalysis.
- Daytime symptoms and constipation should be identified and treated before beginning enuresis therapy in children. Secondary causes and contributing factors to enuresis should also be identified and treated appropriately.
- Bed alarm therapy is effective for the treatment of monosymptomatic enuresis in children.
- Desmopressin is effective for the treatment of monosymptomatic enuresis in children.
- Subspecialist referral should be considered in children with primary monosymptomatic enuresis whose symptoms do not respond to alarm therapy or desmopressin; in children who have signs or symptoms of nonmonosymptomatic enuresis or an underlying medical condition; or in children with a suspected comorbid psychiatric disorder.
- Treatment is unnecessary in younger children (<5 years of age) in whom spontaneous cure is likely. (Level of evidence: 2; Grade of recommendation: A).
- Voiding diaries or questionnaires should be used to exclude daytime symptoms (Level of evidence: 2; Grade of recommendation: A).
- A urine test is indicated to exclude the presence of infection or potential causes such as diabetes insipidus (Level of evidence: 2; Grade of recommendation: B).
- Supportive measures have limited success when used alone; they should be used in conjunction with other treatment modalities, of which pharmacological and alarm treatment are the two most important (Level of evidence: 2; Grade of recommendation: B).
- Alarm treatment is the best treatment for arousal disorder with low relapse rates. There may be family compliance problems (Level of evidence: 1; Grade of recommendation: A).
- For the treatment of night time diuresis, desmopressin treatment has shown to be effective. The response rate is high around 70%, relapse rates are high (Level of evidence: 1; Grade of recommendation: A).
- The choice of the treatment modality can be made during parental counselling. The parents should be well informed about the problem and advantages and disadvantages of

 

each one of the two treatment modalities should be explained (Level of evidence: 4; Grade of recommendation: B).

Additionally, the National Institute for Health and Clinical Excellence (NICE) has developed tools to help physicians implement their clinical guidelines for Nocturnal enuresis: the management of bedwetting in children and young people. Key priorities for implementation are as follows:[11]

- Inform children and young people with bedwetting and their parents or caregiver that bedwetting is not the child or young person's fault and that punitive measures should not be used in the management of bedwetting.
- Offer support, assessment and treatment tailored to the circumstances and needs of the child or young person and parents or caregivers.
- Do not exclude younger children (for example, those under 7 years) from the management of bedwetting on the basis of age alone.
- Discuss with the parents or caregivers whether they need support, particularly if they are having difficulty coping with the burden of bedwetting, or if they are expressing anger, negativity or blame towards the child or young person.
- Consider whether or not it is appropriate to offer alarm or drug treatment, depending on the age of the child or young person, the frequency of bedwetting and the motivation and needs of the child or young person and their family.
- Address excessive or insufficient fluid intake or abnormal toileting patterns before starting other treatment for bedwetting in children and young people.
- Explain that reward systems with positive rewards for agreed behavior rather than dry nights should be used either alone or in conjunction with other treatments for bedwetting. For example, rewards may be given for:
- Drinking recommended levels of fluid during the day
- Using the toilet to pass urine before sleep
- Engaging in management (for example, taking medication or helping to change sheets)
- Offer an alarm as the first-line treatment to children and young people whose bedwetting has not responded to advice on fluids, toileting or an appropriate reward system, unless:
- An alarm is considered undesirable to the child or young person or their parents and caregivers or
- An alarm is considered inappropriate, particularly if:
- Bedwetting is very infrequent (that is, less than 1-2 wet beds per week)
- The parents or caregivers are having emotional difficulty coping with the burden of bedwetting
- The parents or caregivers are expressing anger, negativity or blame towards the child or young person
- Offer desmopressin to children and young people over 7 years, if:
- Rapid-onset and/or short-term improvement in bedwetting is the priority of treatment or
- An alarm is inappropriate or undesirable
- Refer children and young people with bedwetting that has not responded to courses of treatment with an alarm and/or desmopressin for further review and assessment of factors that may be associated with a poor response, such as an overactive bladder, an underlying disease or social and emotional factors.

 

Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.[12,13]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Enuresis in children[2]
- Nocturnal enuresis[3]
- NICE: Nocturnal Enuresis Clinical Guideline[11]
- Practical consensus guidelines for the management of enuresis[4]
- Adding health education specialists to your practice[14]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[15]
- The benefits of using care coordinators in primary care: a case study[16]
- Engaging Patients in Collaborative Care Plans[17]
- The Use of Symptom Diaries in Outpatient Care[18]
- Health Coaching: Teaching Patients to Fish[19]
- Medication adherence: we didn't ask and they didn't tell[20]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[21]
- Integrating a behavioral health specialist into your practice[22]
- Simple tools to increase patient satisfaction with the referral process[12]
- FamilyDoctor.org. Enuresis (Bed-wetting)[23]

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