

Timer Watch Assisted Urotherapy in Children: A Randomised Controlled Trial.

Hagastroem at al., Aarhus University, Denmark.

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Conclusion from this research:

“A programmable timer watch significantly improves the effect of standard urotherapy. When using the timer watch as a supplement 60% of children obtained complete and sustainable daytime continence “. This was “compared with only 18% treated without timer assistance”.

Malem Medstat suggest the Wobl watch, which vibrates at pre-set times, as a very effective timer watch for managing daytime incontinence as used in this trial . Malem Medstat are also trialing an alternative which allows the user to add the style of alert most likely to be effective eg a mothers instruction “go to the toilet now” or “take your tablet now”. Please contact Malem Medstat if you wish to assist evaluate this model.

Management of bedwetting in children and young people: summary of NICE guidance

on bmj.com

NICE is the National Clinical Guideline Centre of the Royal College of Physicians of London and develop guidelines for the UK NHS.

A summary of new NICE guidelines was published in the British Medical Journal in late 2010 (Nunes et al, BMJ 2010; 341:c5399). This paper is also available on the BMJ website at [www. bmj.com](http://www.bmj.com)

(search on www.bmj.com for NICE ENURESIS 2010)

A comment on the NICE guidelines by the Medical Advisor to Malem Medstat is also available on www. bmj.com

Search on www.bmj.com using search terms NICE ENURESIS 2010 KNAPP.

One conclusion from the NICE report: “Offer an alarm as initial treatment for children and young people whose bedwetting has not responded to advice on fluids, toileting, or an appropriate reward system”

Combination management of enuresis with alarms and medication. Martin S Knapp, Nephrologist

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From his comment:

“A recent community paediatric clinic audit from Australia confirmed that utilising a body-worn-alarm as a standard initial strategy provided satisfactory results for most patients (Cutting). It is of interest that the NICE guidelines reinforce the proposals made 50 years ago that alarms should be the first active intervention, despite the availability now of a wider range of pharmaceuticals.

The NICE guidelines do make it clear that management strategies need to be modified for individuals. Those adolescents and adults, who present to tertiary and adult care facilities most often "failed" or relapsed after using one or many strategies. This sub group have been common among those who have been treated in clinics by myself and nursing colleagues and among those who have contacted the telephone enuresis advisory service we set up for Australia in 1985(5). In recent years I have found the use of combination therapy of an alarm and either desmopressin or/and anti-cholinergics, as supported by the NICE guideline, to be effective in this group. Attention to detail is critical and may not have been stressed enough in the BMJ "guideline" summary or even within the 473 pages of the full NICE report.

An analysis of reasons for previous "failures" is important before embarking on alternative strategies, such as adding medication, even after apparent "failure" of alarm management. An alarm system that does not result in waking (with the help of parent or carer if needed) will not be effective; and an unreliable alarm that gives false signals when there is no wetness will not be continued by the user. Consideration may need to be given to the type of alarm used, and an alternative considered, eg the combination of noise with vibration or vibration only. A change of alarm should be considered before a move to the combination of alarm with medication as suggested by NICE and the choice of an alarm should not only be on the basis of unit cost. The style of alarm if effective initially should remain available for early reintroduction if there is relapse after "response".

An alarm with desmopressin, in doses suggested by NICE, may be effective but may provide control but not "cure". Desmopressin can sometimes be too effective and reduces nocturnal urine flow to a level when there is no wetting. No wetting so no alarm to generate "conditioning" and combination therapy is then controlling but probably not "curing". My strategy is now to titrate desmopressin downwards in this situation, to a dose that does not stop wetting but delays wetting to once most nights and also to later in the night. Later in the night there is a less "drowsy" response to the alarm and multiple alarms are avoided (which are very tiring and can result in use of the alarm being discontinued). This titration is now easier with the availability of "DesmoMelts" which can more easily be reduced in size to reduce the dose and so obtain the required result.

The NICE guidelines are a valuable step in progress to reverse the philosophy of "they will grow out of it" still held by some - even if this is a better viewpoint than "bedwetting should be beaten out of them" as was common in the era when alarm management was first reported. The NICE guidelines should also encourage more practitioners, not only those in the UK, to consider alarms as first line management and move only later to the prescription pad unless there is a short term urgent need for night-time dryness.

Martin S Knapp MD, FRCP, FRACP
Nephrologist and Director Malem Medstat, Australia.
knappm@optusnet.com.au

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Competing interests: In 1993 I set up a non-profit national telephone advisory service for Australians to provide advice on enuresis management and also a company that distributes Malem enuresis alarms and other products in Australia. I am also in private clinical nephrology practise and provide advice on enuresis management and clinical nephrology and declare competing interests to patients, professional colleagues and others.

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