A 4-year-old boy is brought to the physician for bedwetting. Toilet-training was initiated at age 2 when he learned the words "pee" and "poop." He has a soft bowel movement in the toilet every day. However, his parents are frustrated and concerned that the boy still urinates in his bed at least 1 night a week despite avoiding fluid intake 2 hours prior to bedtime. His older sisters were toilet-trained during the day and night by age 3. He has no medical problems and takes no medications. Physical examination shows a well-nourished, talkative boy. There is no sacral dimple or hair tuft. Testes are descended bilaterally and the urethral meatus is at the tip of the glans. He can hop on each foot for a few seconds. He identifies the colors of "pee" and "poop" as yellow and brown, respectively. What is the most appropriate next step in management of this patient?

- A. Advise gentle spanking of the buttocks to discourage bedwetting
- B. Order abdominal x-ray
- C. Order scrotal ultrasound
- D. Order urinalysis
- E. Prescribe an enuresis alarm
- F. Prescribe desmopressin
- G. Reassurance

Submit

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- A. Advise gentle spanking of the buttocks to discourage bedwetting [0%]
- B. Order abdominal x-ray [0%]
- C. Order scrotal ultrasound [0%]
- D. Order urinalysis [5%]
- E. Prescribe an enuresis alarm [23%]
- F. Prescribe desmopressin [2%]
- ✔ G. Reassurance [71%]

Proceed to Next Item

Explanation: **User Id:** [redacted]

Developmental milestones during toddlerhood				
Age	**Gross motor**	**Fine motor**	**Language**	**Social/Cognitive**
12 months	• Stands well • Walks first steps independently • Throws a ball	• 2-finger pincer grasp	• Says first words (other than "mama" & "dada")	• Separation anxiety • Follows 1-step commands with gestures
18	• Runs	• Builds a tower of 2-4 cubes	• 10- to 25-word vocabulary	• Understands "mine"

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18 months	• Runs • Kicks a ball	• Builds a tower of 2-4 cubes • Removes clothing	• 10- to 25-word vocabulary • Identifies ≥1 body part	• Understands "mine" • Begins pretend play
2 years	• Walks up/down stairs with both feet on each step • Jumps	• Builds a tower of 6 cubes • Copies a line	• 50+-word vocabulary • 2-word phrases	• Follows 2-step commands • Parallel play • Begins toilet training
3 years	• Walks up/down stairs with alternating feet • Rides tricycle	• Copies a circle • Uses utensils	• 3-word sentences • Speech 75% intelligible	• Knows age/gender • Imaginative play
4 years	• Balances & hops on 1 foot	• Copies a square	• Identifies colors • Speech 100% intelligible	• Cooperative play
5 years	• Skips • Walks backward	• Copies a triangle • Ties shoelaces • Dresses/bathes independently • Prints letters	• Counts to 10 • 5-word sentences	• Has friends • Completes toilet training

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This patient is a developmentally normal child who has not yet achieved complete urinary continence. Most children are ready to **begin toilet-training at age ≥2** with the acquisition of the following skills:

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This patient is a developmentally normal child who has not yet achieved complete urinary continence. Most children are ready to **begin toilet-training at age ≥2** with the acquisition of the following skills:

- Voluntarily control sphincters
- Walk
- Remove pants
- Follow 2-step commands
- Communicate the need to urinate and stool
- Imitate actions of other people (eg, sit on toilet)

Premature initiation of toilet-training can prolong the duration of training. Parents should be reminded not to rush the child and that **bedwetting is normal before age 5**. Most children master daytime continence within months, but nighttime continence can sometimes take years to accomplish. Also, **boys generally complete toilet-training later** than girls. Encouragement and **positive reinforcement** should be provided when the child demonstrates readiness and succeeds in staying dry.

(Choice A) Corporal punishment (eg, spanking) significantly increases the risk of aggression, depression, and interpersonal conflicts throughout life. In addition, punishment can lead to anxiety and stress with elimination, resulting in stool withholding and subsequent constipation/encopresis.

(Choice B) **Chronic constipation** can reduce bladder capacity and contribute to urinary incontinence. **Stool burden can be assessed by abdominal x-ray** but is unnecessary in the setting of soft, regular bowel movements.

(Choice C) **Displacement of the urethral meatus** is associated with other urologic anomalies (eg, **cryptorchidism**) and incontinence problems, but this child has a normal genitourinary examination.

(Choices D, E, and F) The prevalence of urinary incontinence decreases to 15% at age 5, and **urinalysis** should be performed in children age ≥5 to screen for urinary tract infection, diabetes mellitus, and diabetes insipidus. These comorbidities are unlikely in an asymptomatic toddler who is gradually achieving complete continence. The prevalence decreases with increasing age as children achieve control at their own pace. Some older children may benefit from acceleration of continence from **alarm** or **desmopressin** therapy, but interventions are unwarranted for children age <5.

Educational objective:
Bedwetting is normal before age 5. Mastery of nighttime continence can take months to years, and boys generally achieve this milestone later than girls.

Premature initiation of toilet-training can prolong the duration of training. Parents should be reminded not to rush the child and that **bedwetting is normal before age 5**. Most children master daytime continence within months, but nighttime continence can sometimes take years to accomplish. Also, **boys generally complete toilet-training later** than girls. Encouragement and **positive reinforcement** should be provided when the child demonstrates readiness and succeeds in staying dry.

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References:

1. **Sequential acquisition of toilet-training skills: a descriptive study of gender and age differences in normal children.**
2. **Relationship between age at initiation of toilet training and duration of training: a prospective study.**
3. **Toilet training: methods, parental expectations and associated dysfunctions.**

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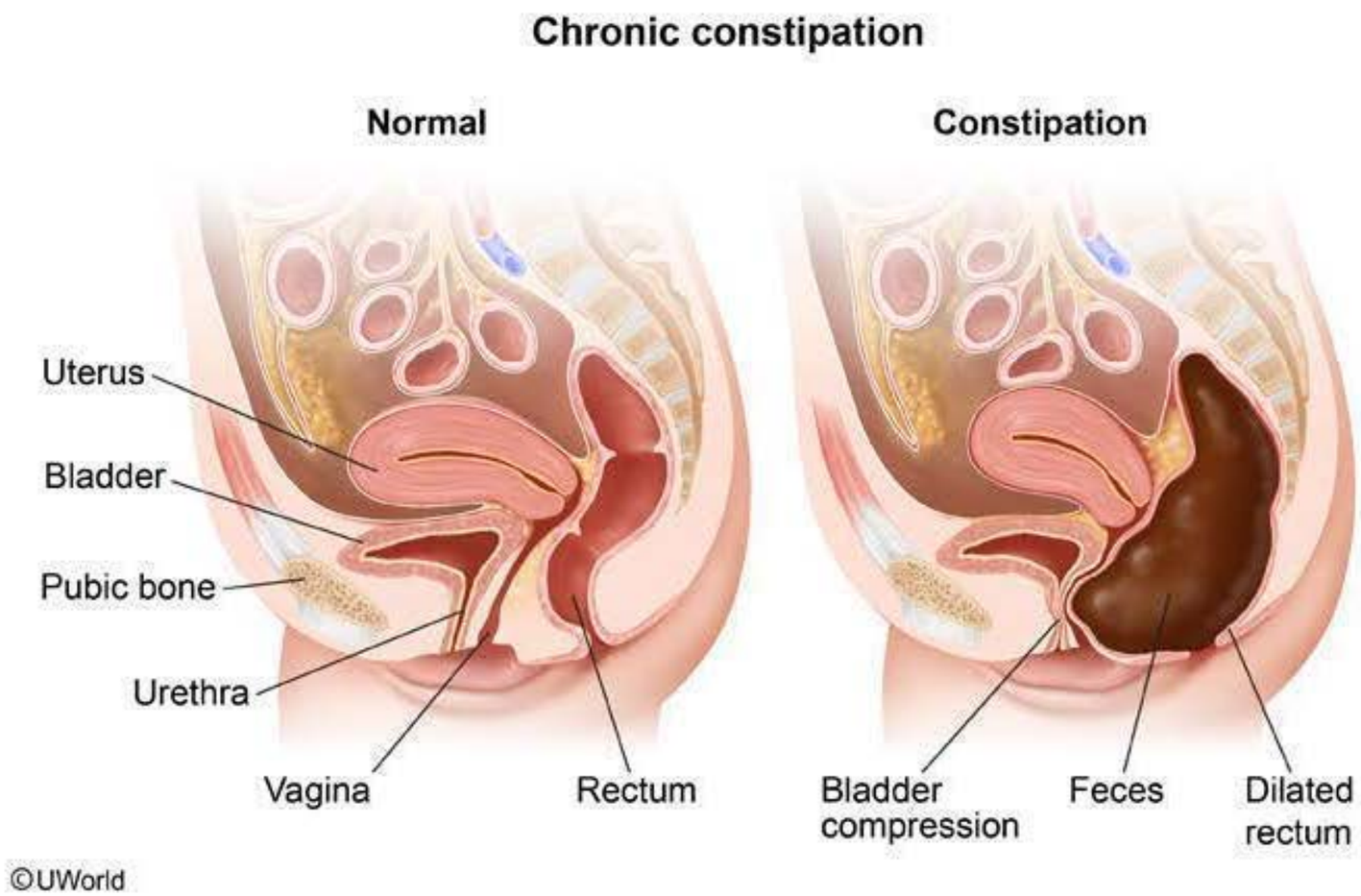
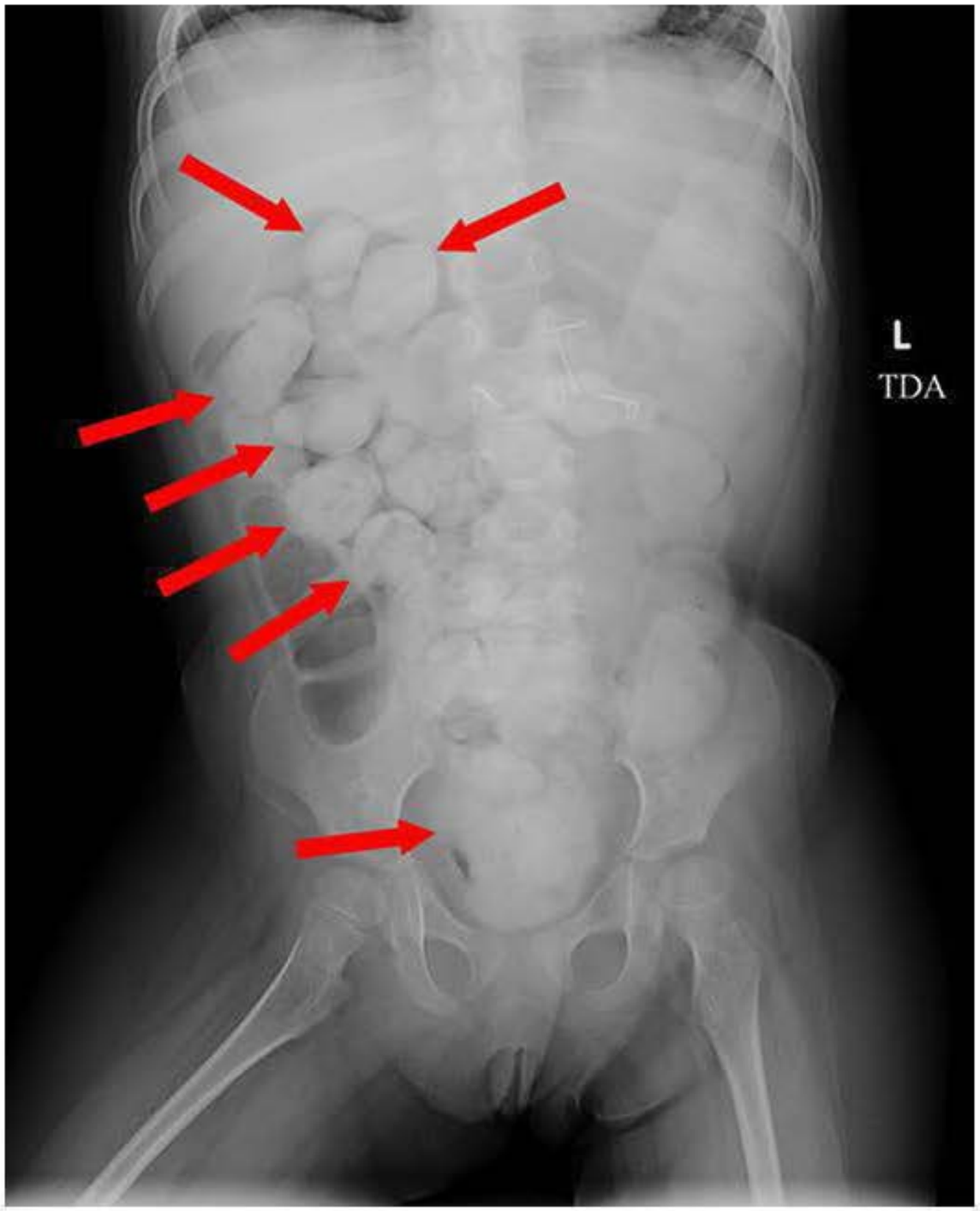
Media Exhibit

c constipation



constipation



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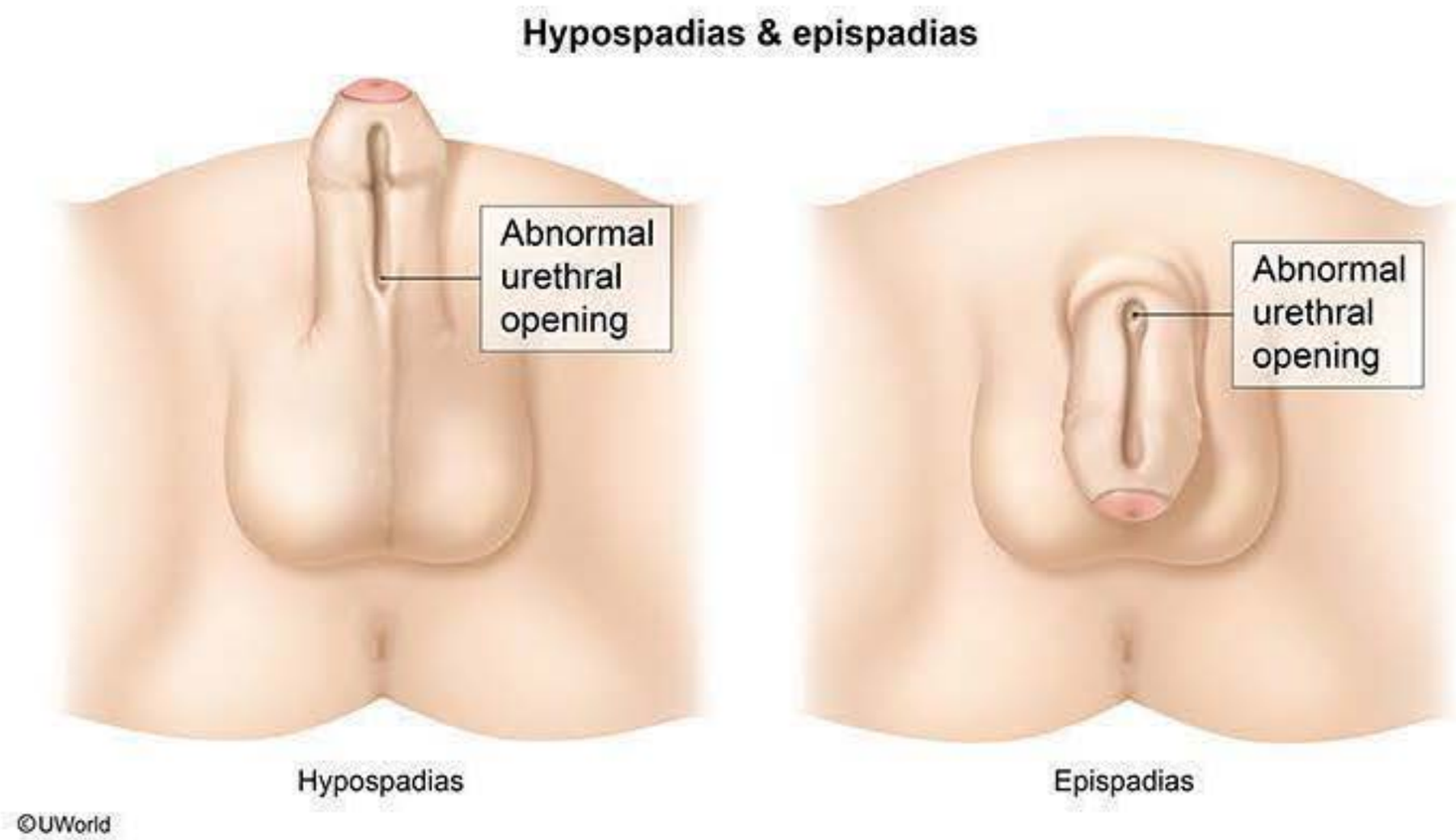

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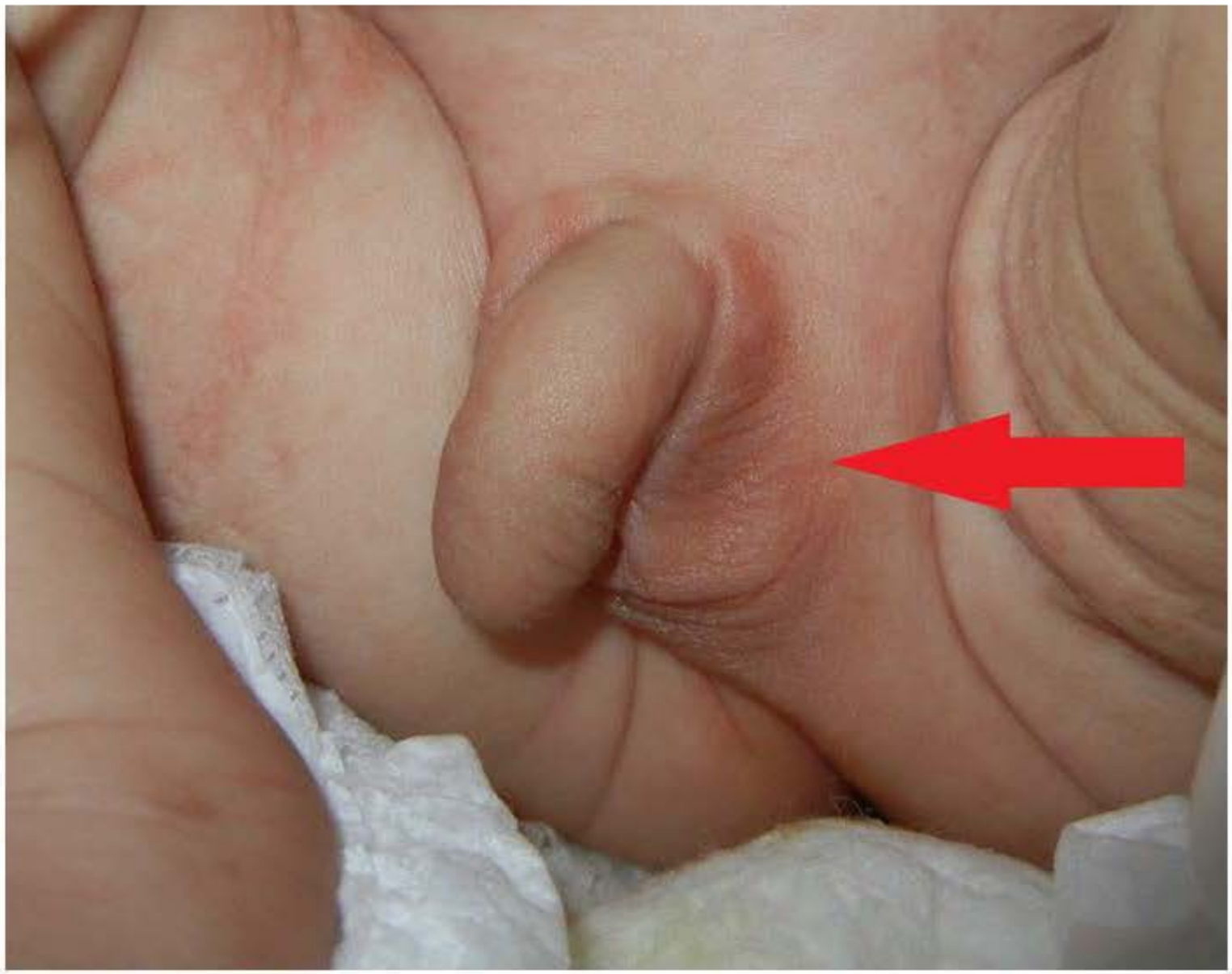
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