Because 98 percent of children attain daytime continence of urine by 36 months of age, the majority of parents do not have to contend with the challenges that occur when an older child continues to have wetting accidents in the daytime. For those parents who do, there can be frustration and anxiety when the problems don’t resolve as their child ages. Professionals who work with children in a medical or educational setting are likely to encounter children with daytime wetting over the years, and may feel at a loss as to how to best help them and their families.

Typically, evaluation of children and adolescents with bowel and bladder dysfunction involves taking an accurate history to establish the primary cause of the child’s voiding complaints and to identify conditions that may confound treatment or exist alongside the voiding issues, including constipation. Physical examination also is conducted, including palpation of the abdomen, examination of external genitalia, and inspection of the back to look for features such as café au lait spots, abnormal creases, dimples, hair tufts, and evidence of prior surgery.

Urine studies may be performed to screen for infection, diabetes, and other issues. Some advocate a sacral X-ray to screen for spina bifida occulta. In some cases imaging is done to look for abnormalities of the kidneys and bladder, as well as masses and obstructions.

(continues on page 2)
A uroflow, which is done by having the child void into a special type of commode, can give information about voiding patterns without requiring invasive techniques. Urodynamic studies are used in some cases to examine bladder filling and emptying.

Effective treatment depends on many factors, and primary care providers have different levels of comfort when recommending interventions. An overview of the evaluation and treatment of voiding dysfunction in pediatric patients is found in Palmer.

At UIHC, a collaborative clinic to treat children with continued urinary accidents has been established with professionals from pediatric urology and child psychiatry, called the Voiding Improvement Partnership (VIP) Clinic. Children are seen jointly by a child psychologist with either a nurse practitioner or pediatric urologist who specializes in the treatment of voiding dysfunction. Established in 2013, the VIP clinic is currently held every two weeks in the Pediatric Specialty Clinics. Patients are first screened in pediatric urology and are then referred to the voiding clinic.

Bladder and bowel dysfunction account for upwards of 40 percent of pediatric urology visits. Daytime and night wetting are common, occurring in two to seven percent of all school-aged children. While children with primary nocturnal enuresis are not typically seen in the VIP clinic, they can be seen in pediatric urology, and a variety of treatments are available.

Children with daytime wetting often have one or more of the following:

- Constipation
- Infrequent urination
- Urinary tract infections

Thus, it follows that the usual treatment involves making sure the child drinks plenty of water during the day, practices “timed toileting” (i.e., going to the bathroom at least every two hours whether they feel the need to or not), and avoids becoming constipated. Education is provided about why these practices are important, and there are several child-friendly videos that can be helpful in making families more knowledgeable. However, there is a subset of children who do not respond to these efforts, often because they can’t implement the recommendations effectively or other issues are getting in the way.

Sometimes there are psychological conditions that can contribute to these toileting problems. Children with voiding dysfunction are at increased risk for psychosocial difficulties compared with children seen in primary care settings. Psychological conditions can also impact response to treatment. In a retrospective analysis, 68 percent of children with daytime incontinence and ADHD became dry, compared to 91 percent of controls.

Various psychological issues, such as ADHD, oppositional behavior, and anxiety, are seen in some of the VIP clinic patients as well. Some children have specific fears related to using the bathroom or drawing attention to themselves by taking a rest room break. Others get busy engaging in preferred activities and don’t attend to the signals that their bodies are sending them until it is too late. Still others cannot maintain their attention or sit still long enough to complete the recommended toileting.
In our clinic, we try to take a problem-solving approach to determine what the child needs to be doing that s/he is not currently doing, and what is getting in the way. This may result in referrals for additional evaluations or therapies, the use of some targeted behavioral interventions, establishment of rewards for specific desired behaviors, and/or communication with schools or local providers about the treatment plan. With a medical professional and psychologist working together, the treatment can be individualized, and the child can be followed until treatment is no longer needed.

To our knowledge, there are only a handful of centers in the United States that currently provide psycho-urologic collaborative treatment of voiding dysfunction. We have performed a retrospective review of our early experiences surrounding the VIP clinic. Using a validated bowel and bladder dysfunction questionnaire, we identified that over time there is a significant improvement in symptoms experienced by our patients. In the future we plan to collect data on psychological adjustment, as well as on the financial impact of voiding dysfunction on families.

It is hoped that families who have children with bowel and bladder dysfunction are able to obtain effective treatment. The first line of treatment is typically the child’s primary care provider, who can make additional referrals if needed.

Resources
Did you know that poor oral health contributes to worsening chronic health conditions such as diabetes, heart disease, and even stroke? Are you aware that children have died from lack of timely and appropriate care from an acute oral health emergency?

Oral health care is a component of health care, and as a primary care provider a part of your charge. However, this should not be overwhelming as you have a support network here in Iowa to assist you.

The I-Smile Dental Home program, developed in 2006, was created to provide support to the primary care physician, link patients to a dental home, educate you and your staff on protocols to provide basic dental screenings and fluoride applications, and direct you to resources to answer your questions.

There are 24 I-Smile coordinators throughout Iowa, located in 22 local public health agencies throughout the state. As you consider implementing oral health screening services in your practice, your first step should be to reach out to your local I-Smile coordinator by accessing the following link: idph.iowa.gov/ohds/oral-health-center/coordinator. You will find a map and list of I-Smile coordinators and their contact information. You can use this information to find a coordinator near you.

Are you concerned that you aren’t trained in dentistry or do not know enough to be effective in providing oral health advice to your patients? Rest assured there are many resources to help you navigate the simple steps you need. Along with the support of your local I-Smile Coordinator, there are excellent online resources from credible professional associations for you to review and update your knowledge.


The addition of oral health screening to your practice should not be overwhelming or complex, nor are you asked to be an expert in oral disease identification.

(continues on page 7)
The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

**Oral Health Risk Assessment Tool**

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ▲ sign, are documented yes. In the absence of ▲ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

### Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver’s oral health. All other factors and findings should be documented based on the child.

### Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

---

**Caries Risk:**
- □ Low
- □ High

**Completed:**
- □ Anticipatory Guidance
- □ Fluoride Varnish
- □ Dental Referral

**Self Management Goals:**
- □ Regular dental visits
- □ Dental treatment for parents
- □ Brush twice daily
- □ Use fluoride toothpaste
- □ Wean off bottle
- □ Less/No juice
- □ Only water in sippy cup
- □ Drink tap water
- □ Healthy snacks
- □ Less/No junk food or candy
- □ No soda
- □ Xylitol

---


The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care.
Dental Home
According to the American Academy of Pediatric Dentistry (AAPD), the dental home is oral health care for the child that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. The AAP and the AAPD recommend that a dental home be established by age 1. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the primary care clinician should continue to do oral health risk assessment at every well-child visit.

Fluoridated Water/Supplements
Drinking fluoridated water provides a child with systemic and topical fluoride exposure, a proven caries reduction intervention. Fluoride supplements may be prescribed by the primary care clinician or dentist if needed. View fluoride resources on the Oral Health Practice Tools Web Page aap.org/oralhealth/PracticeTools.html.

Fluoride Varnish in the Last 6 Months
Applying fluoride varnish provides a child with highly concentrated fluoride to protect against caries. Fluoride varnish may be professionally applied and is now recommended by the United States Preventive Services Task Force as a preventive service in the primary care setting for all children through age 5 uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/dental-caries-in-children-from-birth-through-age-5-years-screening. For online fluoride varnish training, access the Caries Risk Assessment, Fluoride Varnish, and Counseling Module in the Smiles for Life National Oral Health Curriculum, smilesforlifeoralhealth.org.

Tooth Brushing and Oral Hygiene
Primary care clinicians can reinforce good oral hygiene by teaching parents and children simple practices. Infants should have their mouths cleaned after feedings with a wet soft washcloth. Once teeth erupt it is recommended that children have their teeth brushed twice a day. For children under the age of 3 (until 3rd birthday) it is appropriate to recommend brushing with a smear (grain of rice amount) of fluoridated toothpaste twice per day. Children 3 years of age and older should use a pea-sized amount of fluoridated toothpaste twice a day. View the AAP Clinical Report on the use of fluoride in the primary care setting for more information pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1699.
Oral Health Matters
(continued from page 4)

The goal is to identify simple risk factors for the development of future dental disease, scan the mouth and notice any suspicious change that doesn’t appear normal, and use the I-Smile dental home system. In addition, you or one of your staff may apply a simple fluoride varnish coating as a non-invasive preventive measure to the teeth to increase resistance to dental decay.

It’s not rocket science, but if you have never tried it before it can feel as if it will be difficult. The good news is that in Iowa – you have help. Contact your I-Smile coordinator to start protecting and improving the health of Iowans today.

How to Conduct a Dental Screening

Screening should be instituted at the 12-month well-child visit, with the child examined in a lap-to-lap position or supine on the examination table. If a child is in pain refer to a dentist or the I-Smile dental home system immediately. Once you have identified a child in need of an oral health screen, you will need a pair of gloves, tongue depressor or toothbrush, and a light source.

With gloved hands, move the lip to view and feel the teeth and soft tissues on the outer side of the mouth. Next, view and feel the teeth and soft tissues inside the mouth. Use a tongue depressor or toothbrush to move the tongue to allow a full view of the teeth and soft tissue. Here are some examples of what to look for:

- An abscess on the gums above or below the teeth. An abscess often looks like a “gum boil” with signs of infection such as swelling and pus drainage. If you suspect an abscess refer to a dentist or the I-Smile dental home system immediately.

- Are teeth coming in and being lost appropriately for the child’s age? Have there been any injuries to the mouth or teeth? If so, refer to the I-Smile dental home system. If you suspect abuse, call the Iowa Child Abuse Hotline (1-800-362-2178).

- Teeth that appear to have unusual color or shape, the presence of chalky appearing white spot lesions, stains, plaque, or brown or dark spots or “holes,” which can be signs of a cavity. If you suspect untreated caries refer to the I-Smile dental home system.
What’s in this issue

Pediatric Voiding Dysfunction ........................................... 1-3
Oral Health Matters ....................................................... 4, 7
Insert:
  Oral Health Risk Assessment Tool ................................. 5
  Oral Health Risk Assessment Tool Guidance ..................... 6

The EPSDT Care for Kids Newsletter is published three times a year, in print and online, as a joint effort of the Iowa Prevention of Disabilities Policy Council, the Iowa Department of Human Services, the Iowa Department of Public Health, and the Center for Disabilities and Development, which is nationally designated as Iowa’s University Center for Excellence on Disabilities. The goal of this newsletter is to inform Iowa health care professionals about the EPSDT Care for Kids program, to encourage them to make use of this important resource, and to provide them with information about a wide range of developments in the field of health care.

NEWSLETTER STAFF
Executive Editor  Ellen Link, MD
Production Editor  Lesly Huffman
Graphics Editor  Leigh Bradford

Please send correspondence concerning content to:
Ellen Link, MD
University of Iowa Health Care
Iowa River Landing
Office 2627
105 9th Street
Coralville, IA 52241
Iowa City, IA 52242-1011

Please send change of address information to:
Julie Temple
University of Iowa Children’s Hospital
Center for Disabilities and Development
100 Hawkins Drive
Iowa City, IA 52242-1011

If you have questions about billing related to EPSDT Care for Kids services, please call Provider Services: 1-800-338-7909. If you have questions about clinical issues and EPSDT Care for Kids services, please call 1-800-383-3826. Please note: Due to budget restraints, the EPSDT Care for Kids Newsletter is sent to offices and organizations, rather than to individuals. The newsletter is also available online at www.iowaepsdt.org. Readers are welcome to photocopy or download material from the newsletter to share with others. If you wish to reproduce material from the newsletter in another publication, whether print or electronic, please obtain permission prior to publication by contacting the editor. Please include the following acknowledgment with reprinted material: Reprinted by permission of the Iowa EPSDT Care for Kids Newsletter.