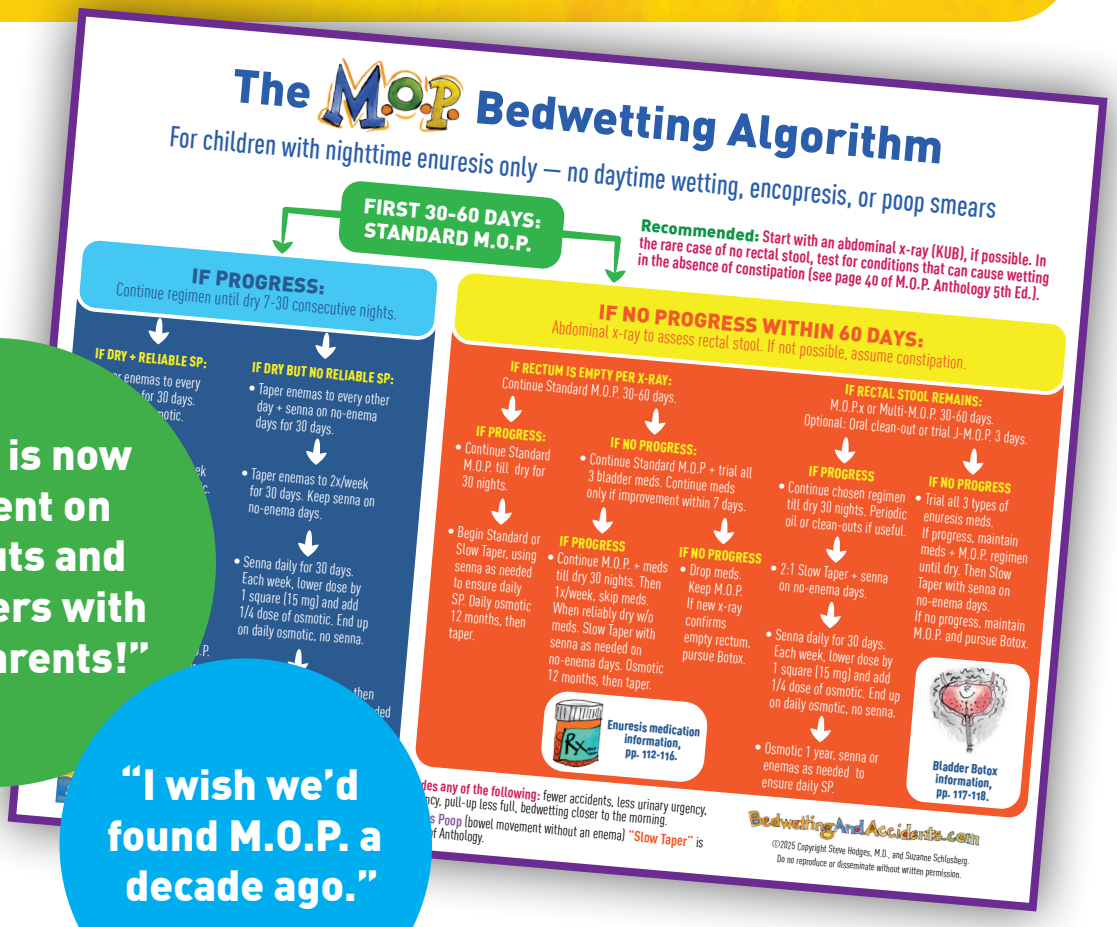
An Introduction for Parents

How to Stop Bedwetting with M.O.P.

DON'T WAIT FOR YOUR CHILD TO "OUTGROW IT."

Restore your child's confidence, and leave pull-ups behind!



"My son is now confident on campouts and sleepovers with grandparents!"

"I wish we'd found M.O.P. a decade ago."

BedwettingAndAccidents.com

5 STEPS TO HELP YOU GET STARTED

Dear parents,

Few conditions are as misunderstood and mismanaged as nocturnal enuresis, aka bedwetting.

Parents are told their child will "outgrow it," that bedwetting is a "normal part of childhood development" and doesn't warrant treatment until age 7, 10, or older. Common explanations run the gamut: an underdeveloped bladder, deep sleep, hormone imbalance, a bladder that "hasn't caught up with the brain," emotional stress or anxiety. *Bedwetting* has even become political shorthand for "excess worry," with headlines like, "Democrats need to quit bedwetting." As if accidents are within a child's control!

But they're not, and all those explanations are wrong.

In reality, bedwetting is caused by chronic constipation. A child's enlarged, stool-packed rectum aggravates the nearby bladder nerves, triggering forceful "hiccups" that empty the bladder overnight. Constipation is easily seen on a plain abdominal x-ray, yet many parents have no idea their child is constipated. Even severe cases are often missed, because the standard definition of constipation is inadequate, and common diagnostic methods are unreliable. Children who poop daily can still be constipated, but that's not common knowledge.

Misinformation sends families on wild goose chases — fluid restriction, midnight wake-ups, bedwetting alarms, special diets, sleep studies, reward charts, talk therapy, chiropractic, and drugs that fail. But these remedies don't address the root cause: rectal stool buildup. **Even when constipation is recognized, it's often undertreated; kids may spend years on Miralax (PEG 3350) to no avail.**

By the time families land in my clinic, children and parents alike feel discouraged, even despondent. Kids, terrified of being "found out," avoid sleepovers and school trips. One mom in my private support group wrote, "Enuresis has basically ruined this kid's social life and crushed his self-esteem, and I kept listening to 'Don't worry, he'll outgrow it.'" A dad of a 17-year-old told me, "The poor kid is humiliated and feels trapped and stressed about going anywhere overnight, including the future he wants in college."

"My son had the first dry night of his life a month before his 11th birthday. He is off enemas completely and will start weaning Ex-Lax soon. It took over a year, but when he finally healed, progress happened fast. **Stay the course, parents! It is so worth it.** My son is now confident on campouts and sleepovers with grandparents!"

"**M.O.P. has changed our son's life.** He is now 14 and has been accident-free for months. He does not need enemas or laxatives anymore and has a normal stool schedule. We tried every option offered by the doctors, and they all ended with frustration. I wish we'd found M.O.P. a decade ago."

BedwettingAndAccidents.com

Families grow tired of waiting for the magical day when bedwetting stops — a day that never seems to come. While most children do eventually stay dry without treatment, an unlucky minority never do. I see no benefit in waiting years to learn which group a child will end up in (nor any benefit in buying pull-ups for an extra 5 years). I treat bedwetting at age 4 and encourage early action. I've never met a parent who said, "I'm so glad we waited."

Most families believe they've "tried everything" — but they haven't tried the **Modified O'Regan Protocol (M.O.P.),** the most effective treatment available. M.O.P., based on the pioneering research of Sean O'Regan, M.D., a pediatric kidney specialist, and refined over 20 years, isn't a single regimen but rather a whole treatment approach. M.O.P. tackles constipation aggressively using enemas and laxatives. The goal: fully empty the rectum and keep it empty long enough for it to shrink to normal size and stop bothering the bladder. M.O.P. has multiple variations tailored to each child's symptoms, history, preferences, and treatment response.

Know that M.O.P. is not magic. Chronic constipation develops over years and takes more time to reverse than most families expect. Setbacks are common. Success requires experimentation and persistence. Expect two steps forward, one step back.

This packet includes the M.O.P. Bedwetting Algorithm — a treatment roadmap built on two decades of experience. The algorithm is not a rigid formula; there's always more than one path to dryness. But this game plan will save you time. Use it to make educated guess when you come to a fork in the road.

"We had tried all the bedwetting meds to no avail. Our physician was not on board with M.O.P., but my son was willing to do anything, so we did it on our own. At first, he was very resistant to enemas. We were patient and did not pressure him. It took 3 months of daily enemas to resolve bedwetting before we started tapering. We are so thankful for the protocol. **My son plays high school sports and can go to football camp without fear.**"

"We presented M.O.P. to our then-12-year old, which brought lots of tears. But he came around to the idea. The first several months, he had about 7 dry nights per month. Finally, we had a clear x-ray and 28 dry nights, so we added bladder medication. It worked! Soon he was off all enemas and meds. He is almost 15, doing great, and sleeping well. **This process has been a challenge but has matured and empowered him.** My son has learned he can do hard things and what perseverance can bring."

Let us know how we can help your family!

Steve Hodges, M.D.
Professor of Pediatric Urology
Wake Forest University School of Medicine

NOTE: This guide pertains to nighttime enuresis only. If your child also has daytime and/or encopresis, please see our other guides.

BedwettingAndAccidents.com

STEP 1: Understand what does — and doesn't — cause bedwetting.

Myths about bedwetting abound, causing children to shoulder shame and blame and waste time on inappropriate treatments. Even the American Academy of Pediatrics offers parents erroneous information — claiming, for example, that "stress can cause bedwetting; treating the stress can stop the bedwetting." Untrue! And the American Psychiatric Association includes bedwetting in its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), even though enuresis is not a mental disorder. The following articles separate fiction from fact.

- Don't Assume Your Child Will Outgrow Bedwetting
- "Medical Groupthink Gone Awry": Why Doctors Get Bedwetting Treatment All Wrong
- To the American Academy of Pediatrics: Please Update Your Bedwetting Advice
- Nope, "Deep Sleep" Doesn't Cause Bedwetting (It's Impossible)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Diaper companies, celebrities, and even respected medical organizations inadvertently propagate misinformation about the root cause of bedwetting.

- Nope, Stress and Caffeine Don't Cause Bedwetting
- Goodnites' Alarming New Campaign Will Harm Children with Enuresis (Bedwetting)
- Sarah Silverman's "The Bedwetter" Is Emotionally True But Medically Wrong
- Enuresis and Encopresis Are Not "Mental Disorders." Let's Remove Them from the DSM-5.

PREFER TO LISTEN?

In these 4 podcast interviews, I tackle myths about bedwetting, among other topics. For more interviews, check out our podcast page.

- Ask Dr. Jessica: Answers From a Pediatrician

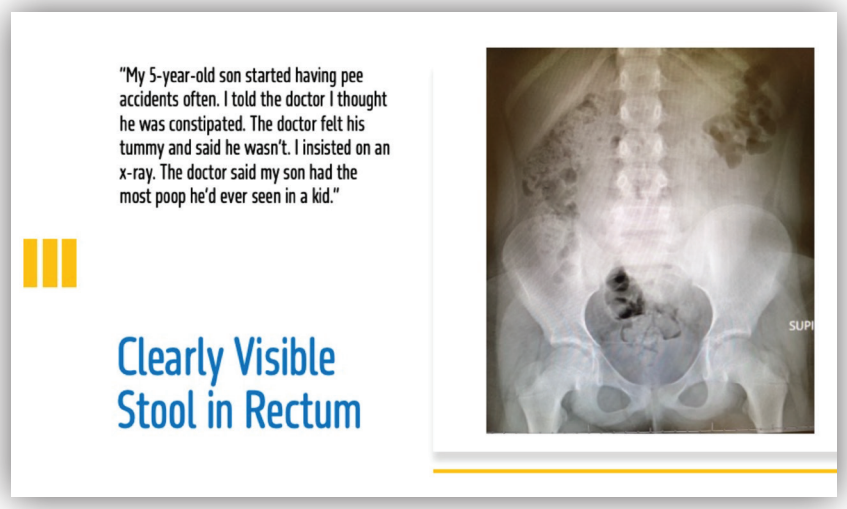
- The Hamilton Review: Where Kid and Culture Collide

- Talking About Kids with R. Bradley Snyder

- The Pediatrician Next Door with Dr. Wendy

STEP 2: Confirm constipation, ideally with an x-ray.

Many parents insist their child is not constipated ("She poops every day!") and tell me their previous doctors never mentioned constipation as a possible cause, let alone the most likely explanation by far. But with enuresis patients, my motto is: ***Constipated until proven otherwise***. And constipation is easy to prove! The most accurate method is an abdominal x-ray (called a KUB, for kidneys, ureters, and bladder), ideally with a measurement of rectal diameter. A rectum wider than about 3 cm in diameter indicates constipation. Most of my enuresis patients have a rectum wider than 6 cm.



Learn to spot a stool-packed in our 45-minute M.O.P. Essentials course.

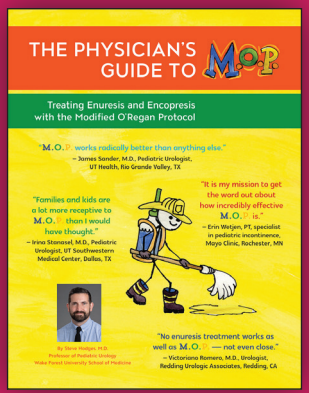
What if your child isn't constipated? An x-ray, if evaluated correctly, will prove that, too. A handful of rare medical conditions, including posterior urethral valves and tethered cord syndrome, can cause bedwetting in the absence of constipation. I discuss these in the *M.O.P. Anthology 5th Ed*. Once in a blue moon, an x-ray will show an empty rectum; that's when I proceed with tests for other conditions.

The articles below explain why x-rays are valuable and why other diagnostic methods fall short.

- When to X-Ray a Child for Constipation
- Even Severe Constipation Goes Undiagnosed in Bedwetting Children. Here's Why.
- Why an X-ray for Childhood Constipation Can Seem Like a Rorsach Test
- To Help Bedwetting Children, We Need a New Definition of Constipation
- The "Wild West" Of Bedwetting Treatment: What Your Doctor Didn't Learn in Med School
- Doctors Order Unnecessary Tests for Bedwetting and Daytime Accidents When the Cause Is Obvious

Does Your Doctor Oppose X-rays?

Many doctors believe x-rays for constipation are either 1.) unsafe or 2.) unwarranted. In The Physician's Guide to M.O.P., I explain to colleagues why I strongly disagree on both counts. The 50-page guide can be downloaded here. Print it out and hand it to your doctor!



STEP 3: Learn the science behind M.O.P.

Once your child's constipation is confirmed, you might think: ***Why subject a child to enemas? Why not use Miralax?*** Many doctors consider enemas "overly aggressive" and believe PEG 3350 will work just fine, perhaps with a short course of Ex-Lax (senna). But if oral laxatives were a reliable method for treating bedwetting, M.O.P. would not exist!

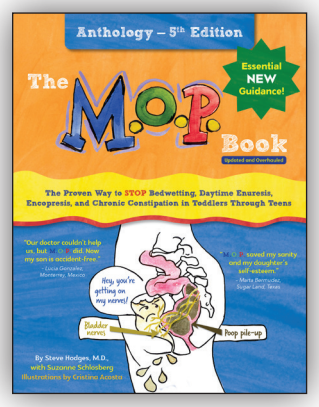
Both osmotic and stimulant laxatives are valuable tools but don't often suffice as a stand-alone treatment. Enemas are the game-changer. Yes, they are safe, even when used daily, and no, enemas are not traumatic for children.

The following articles delve into the research showing M.O.P. is more effective than the alternatives.

- Children with Encopresis and Enuresis Deserve the Best Treatment, But Most Aren't Getting It
- Why Most Bedwetting Treatments Don't Work
- The "Long Lag": Why Bedwetting Takes Longer to Fix Than Daytime Accidents
- A Japanese Twist on Bedwetting Treatment: Olive Oil Enemas Plus Liquid Glycerin

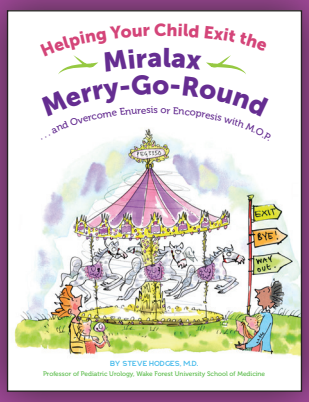
Our "bible": The M.O.P. Anthology 5th Edition

Our comprehensive treatment manual delves deeply into M.O.P. — its origins and supporting studies, the nuances of the six M.O.P. variations, and guidance on tracking progress, along with the supplies and know-how to implement this approach with confidence. Plus: DIY instructions that make M.O.P. quite inexpensive — a lot cheaper than purchasing pull-ups for years on end!



- Download the Introduction at no cost.
- Purchase the PDF for easy searching and instant delivery or the amazon paperback in black-and-white or premium color.

M.O.P. v. Miralax



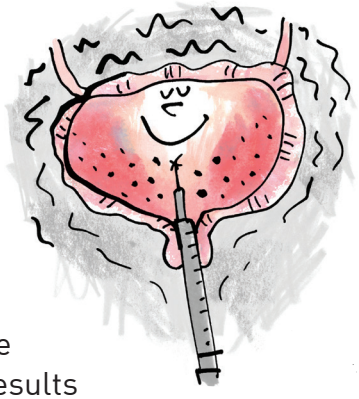
Years ago, I treated bedwetting the way I'd been taught: with PEG 3350. If a daily dose didn't help, I'd add high-dose Miralax "clean-outs." But often, accidents would persist, so I'd recommend more Miralax. Then more.

That's how children end up on the Miralax merry-go-round, a slow-moving, never-ending carousel to nowhere.

In *Helping Your Child Exit the Miralax Merry-Go-Round*, a free guide, I explain why PEG 3350 fails, why doctors keep pushing it, anyway, and when to move on. I also discuss six key studies and explain three scenarios where osmotic laxatives do prove useful.

NOTE: The 2024 version of the* M.O.P. Anthology 5th Edition *contains updated guidance. If you have an older version, email suzanne@bedwettingandaccidents.com for a coupon code to upgrade.

STEP 4: Learn about the role of bedwetting medication and bladder Botox — and whether your child is a candidate.



What if **M.O.P.** doesn't stop my child's bedwetting? Fair question! In most of my patients, a combination of enemas and laxatives will, sooner or later, shut down overnight accidents. However, in some children, wetting drags on, and when I do a follow-up x-ray, I see why: The rectum, though empty, remains enlarged, so it continues to irritate the bladder nerves. In this scenario, enuresis medication can often help — not as a cure,

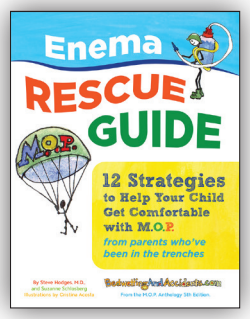
but as a way to reduce or stop accidents while the child continues **M.O.P.** and the rectum continues to heal. When meds fall short, bladder Botox, a short surgical procedure, will do the trick. It's the most effective tool we have for seemingly intractable cases, but results are lasting only if the rectum has been emptied first.

The articles below discuss the three categories of bedwetting medications, which children are the best candidates for these drugs, and when to pivot to Botox.

- Bedwetting Medication: When It Works, When It Doesn't
- Bladder Botox and InterStim: Two Breakthrough Bedwetting Treatments

STEP 5: Gain your child's buy-in.

Children are usually more receptive to **M.O.P.** than parents predict, and enemas pretty quickly become routine. Still, it's only natural for families to feel apprehensive. We have lots of materials to help.

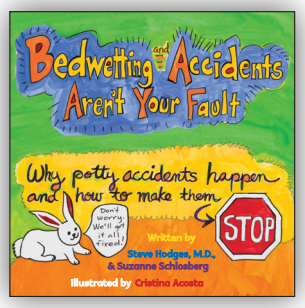


The Enema Rescue Guide, included in the *M.O.P. Anthology*, offers creative, kid-tested strategies to help children become more comfortable with enemas. All the ideas came straight from folks who've been in the trenches: parents in our private Facebook support groups.

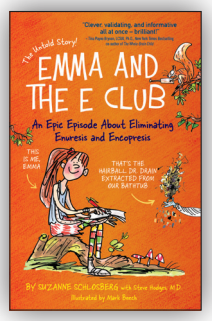
In addition, our children's books reassure kids of all ages that bedwetting is never a child's fault, that millions of children have enuresis, and that kids around the world use enemas to treat their constipation.

Parents often tell us our books gave their child the motivation and courage to try **M.O.P.**

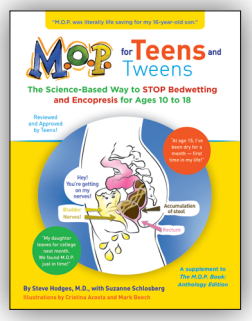
We offer books for three different age groups/maturity levels:



Ages 5-10



Ages 7-12



For middle-school and high-school students.

The M.O.P. Bedwetting Algorithm

For children with nighttime enuresis only — no daytime wetting, encopresis, or poop smears

FIRST 30-60 DAYS: STANDARD M.O.P.

Recommended: Start with an abdominal x-ray (KUB), if possible. In the rare case of no rectal stool, test for conditions that can cause wetting in the absence of constipation (see page 40 of M.O.P. Anthology 5th Ed.).

IF PROGRESS:

Continue regimen until dry 7-30 consecutive nights.

IF DRY + RELIABLE SP:

- Taper enemas to every other day for 30 days. Keep daily osmotic.
- Taper enemas to 2x/week for 30 days. Keep osmotic.
- Maintain daily osmotic 6-12 months. Then taper off.
- Watch for signs of constipation. If accidents recur, restart Standard M.O.P. till dry with 2:1 Slow Taper and senna as needed.

IF DRY BUT NO RELIABLE SP:

- Taper enemas to every other day + senna on no-enema days for 30 days.
- Taper enemas to 2x/week for 30 days. Keep senna on no-enema days.
- Senna daily for 30 days. Each week, lower dose by 1 square (15 mg) and add 1/4 dose of osmotic. End up on daily osmotic, no senna.
- Daily osmotic 12 months, then taper. Senna or enemas as needed to ensure daily pooping. Stay vigilant to prevent recurrence.

IF NO PROGRESS WITHIN 60 DAYS:

Abdominal x-ray to assess rectal stool. If not possible, assume constipation.

IF RECTUM IS EMPTY PER X-RAY:

Continue Standard M.O.P. 30-60 days.

IF PROGRESS:

- Continue Standard M.O.P. till dry for 30 nights.
- Begin Standard or Slow Taper, using senna as needed to ensure daily SP. Daily osmotic 12 months, then taper.

IF NO PROGRESS:

- Continue Standard M.O.P + trial all 3 bladder meds. Continue meds only if improvement within 7 days.

IF PROGRESS

- Continue M.O.P. + meds till dry 30 nights. Then 1x/week, skip meds. When reliably dry w/o meds. Slow Taper with senna as needed on no-enema days. Osmotic 12 months, then taper.

IF NO PROGRESS

- Drop meds. Keep M.O.P. If new x-ray confirms empty rectum, pursue Botox.

Enuresis medication information, pp. 112-116.

IF RECTAL STOOL REMAINS:

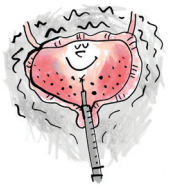
M.O.P.x or Multi-M.O.P. 30-60 days.
Optional: Oral clean-out or trial J-M.O.P. 3 days.

IF PROGRESS

- Continue chosen regimen till dry 30 nights. Periodic oil or clean-outs if useful.
- 2:1 Slow Taper + senna on no-enema days.
- Senna daily for 30 days. Each week, lower dose by 1 square (15 mg) and add 1/4 dose of osmotic. End up on daily osmotic, no senna.
- Osmotic 1 year, senna or enemas as needed to ensure daily SP.

IF NO PROGRESS

- Trial all 3 types of enuresis meds. If progress, maintain meds + M.O.P. regimen until dry. Then Slow Taper with senna on no-enema days. If no progress, maintain M.O.P. and pursue Botox.



Bladder Botox information, pp. 117-118.

Details for all M.O.P. protocols can be found in the M.O.P. Anthology 5th Edition.

"Progress" includes any of the following: fewer accidents, less urinary urgency, less urinary frequency, pull-up less full, bedwetting closer to the morning.

"SP" = Spontaneous Poop (bowel movement without an enema) **"Slow Taper"** is described on pp. 68 of Anthology.

BedwettingAndAccidents.com