



## Complete Summary

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### GUIDELINE TITLE

Management of neurogenic bladder in children. In: Guidelines on paediatric urology.

### BIBLIOGRAPHIC SOURCE(S)

Management of neurogenic bladder in children. In: Tekgul S, Riedmiller H, Gerharz E, Hoebeke P, Kocvara R, Nijman R, Radmayr C, Stein R. Guidelines on paediatric urology. Arnhem, The Netherlands: European Association of Urology, European Society for Paediatric Urology; 2008 Mar. p. 34-43. [71 references]

### GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT

SCOPE  
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## SCOPE

### DISEASE/CONDITION(S)

Neurogenic bladder sphincter dysfunction

### GUIDELINE CATEGORY

Evaluation  
Management  
Treatment

### CLINICAL SPECIALTY

Pediatrics  
Surgery  
Urology

## **INTENDED USERS**

Physicians

## **GUIDELINE OBJECTIVE(S)**

- To outline a practical and preliminary approach to paediatric urological problems
- To increase the quality of care for children with urological problems

## **TARGET POPULATION**

Children and adolescents with neurogenic bladder sphincter dysfunction

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Evaluation**

1. Classification of neurogenic bladder
2. Urodynamic evaluation studies: uroflowmetry and cystometry
3. Abdominal ultrasound
4. Voiding cystourethrogram
5. Spinal magnetic resonance imaging

### **Management/Treatment**

1. Medical care
  - Clean intermittent catheterization
  - Pharmacotherapy: oxybutynin, tolterodine, trospium, propiverine, alpha-adrenergic blockade, botulinum toxin, antibiotics (treatment and prophylaxis for urinary tract infection)
  - Bowel continence management
  - Counseling about sexual development
2. Surgical care
  - Bladder augmentation
  - Bladder outlet procedures: bladder neck reconstruction, other urethral reconstructions, surgical closure of the bladder neck
  - Construction of a continent stoma
  - Total bladder replacement
  - Follow-up duration and frequency

## **MAJOR OUTCOMES CONSIDERED**

- Degree of upper urinary tract changes
- Renal function
- Maintenance of continence

## METHODOLOGY

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The guidelines were based on current literature following a systematic review using MEDLINE.

### **NUMBER OF SOURCE DOCUMENTS**

Not stated

### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

#### **Levels of Evidence**

**1a** Evidence obtained from meta-analysis of randomized trials

**1b** Evidence obtained from at least one randomized trial

**2a** Evidence obtained from at least one well-designed controlled study without randomization

**2b** Evidence obtained from at least one other type of well-designed quasi-experimental study

**3** Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

**4** Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

### **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Application of a structured analysis of the literature was not possible due to a lack of well-designed studies. Whenever possible, statements have been classified in terms of level of evidence and grade of recommendation. Due to the limited

availability of large randomized controlled trials – influenced also by the fact that a considerable number of treatment options relate to surgical interventions on a large spectrum of different congenital problems – this document is therefore largely a consensus document.

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

### **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.
- The second step is to establish a working group. The working groups comprise about 4-8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. In general, general practitioners or patient representatives are not part of the working groups. A chairman leads each group. A collaborative working group consisting of members representing the European Society for Paediatric Urology (ESPU) and the EAU has gathered in an effort to produce the current update of the paediatric urology guidelines.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. The strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

### **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

#### **Grades of Recommendation**

- A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
- B. Based on well-conducted clinical studies, but without randomized clinical studies
- C. Made despite the absence of directly applicable clinical studies of good quality

### **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

### **METHOD OF GUIDELINE VALIDATION**

Internal Peer Review

### **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

There is no formal external review prior to publication.

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline.

The AGREE instrument, to be used by two to four appraisers, was developed by the AGREE collaboration ([www.agreecollaboration.org](http://www.agreecollaboration.org)) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

Levels of evidence (**1a-4**) and grades of recommendation (**A-C**) are defined at the end of the "Major Recommendations" field.

#### Definition

Neurogenic bladder sphincter dysfunction can develop as a result of a lesion at any level in the nervous system, including the cerebral cortex, spinal cord or the peripheral nervous system.

The most common presentation is at birth with myelodysplasia. The term myelodysplasia includes a group of developmental anomalies that result from defects in neural tube closure. Lesions may include spina bifida occulta, meningocele, lipomyelomeningocele, or myelomeningocele. Myelomeningocele is by far the most common defect seen and the most detrimental. Traumatic and neoplastic spinal lesions of the cord are less frequent in children. Additionally, different growth rates between the vertebral bodies and the elongating spinal cord can introduce a dynamic factor to the lesion. Scar tissue surrounding the cord at the site of meningocele closure can tether the cord during growth.

In occult myelodysplasia the lesions are not overt and often occur with no obvious signs of neurological lesion, but in many patients, a cutaneous abnormality overlies the lower spine. Total or partial sacral agenesis is a rare congenital anomaly that involves absence of part or all of one or more sacral vertebrae. This anomaly can be part of the caudal regression syndrome and has to be considered in any child presenting with anorectal malformation (ARM). Cerebral palsy patients may also present with varying degrees of voiding dysfunction usually in the form of uninhibited bladder contractions, voiding dysfunction often due to spasticity of the pelvic floor and sphincter complex and wetting.

Bladder sphincter dysfunction is poorly correlated with the type and spinal level of the neurological lesion.

#### Classification

The purpose of any classification system is to facilitate the understanding and management of the underlying pathology. There are various systems of classification of neurogenic bladder.

Most systems of classification were formulated primarily to describe those types of dysfunction secondary to neurological disease or injury. Such systems are based on the localization of the neurological lesion and findings of the neuro-urological examination. These classifications have been of more value in adults, in whom neurogenic lesions are usually due to trauma and more readily identifiable.

In children, the spinal level and extent of congenital lesion are poorly correlated with the clinical outcome. Urodynamic and functional classifications have therefore been more practical for defining the extent of the pathology and planning treatment in children.

The bladder and sphincter are two units working in harmony to make a single functional unit. The initial approach should be to evaluate the state of each unit and define the pattern of bladder dysfunction. According to the nature of the neurological deficit, the bladder and sphincter may be in either an overactive or an inactive state:

- The bladder may be overactive with increased contractions, low capacity and compliance or inactive with no effective contractions.
- The outlet (urethra and sphincter) may be independently overactive causing functional obstruction or paralyzed with no resistance to urinary flow.
- These conditions may present in different combinations.

This is mainly a classification based on urodynamic findings. The understanding of the pathophysiology of disorders is essential to plan a rational treatment plan for each individual patient. In meningomyelocele, most patients will present with hyperreflexive detrusor and dyssynergic sphincter, which is a dangerous combination as pressure is built up and the upper tract is threatened.

### **Urodynamic Studies**

Urodynamic studies enable the clinician to observe lower urinary tract function and its deviations from normal. Since the treatment plan mainly depends upon a good understanding of the underlying problem in the lower urinary tract, a well-performed urodynamic study is mandatory in the evaluation of each child with neurogenic bladder.

As the bony level often does not correspond with the neurological defect present, and as the effect of the lesion on bladder function cannot be entirely determined by radiographic studies or physical examination, the information gained from a urodynamic study is priceless. A urodynamic study also provides the clinician with information about the response of the vesicourethral unit to therapy, as demonstrated by improvement or deterioration in follow-up.

It is important to determine several urodynamic parameters, including:

- Bladder capacity

- Intravesical-filling pressure
- Intravesical pressure at the moment of urethral leakage
- Presence or absence of reflex detrusor activity
- Competence of the internal and external sphincteric mechanisms
- Degree of coordination of the detrusor and sphincteric mechanisms
- Voiding pattern
- Postvoiding residual urine volume

### **Method of Urodynamic Study**

There is very little comparative data evaluating the complexity and invasiveness of urodynamic testing for neurogenic bladders in children.

### **Uroflowmetry**

As uroflowmetry is the least invasive of all urodynamic tests, it can be used as an initial screening tool. It provides an objective way of assessing the efficiency of voiding, and together with an ultrasonographic examination, residual urine volume can also be determined. Unlike in children with non-neurogenic voiding dysfunction, uroflowmetry will rarely be used as a single investigational tool in children with neurogenic bladders, as it does not provide information for bladder storage, yet it may be very practical to monitor emptying in the follow-up. The main limitation of a urodynamic study is the need for the child to be old enough to follow instructions and void on request.

The recording of pelvic floor or abdominal skeletal muscle activity by electromyography (EMG) during uroflowmetry can be used to evaluate coordination between detrusor and the sphincter. As it is a non-invasive test, combined uroflowmetry and EMG may be very useful in evaluating sphincter activity during voiding. The absence of an indwelling catheter during this study eliminates false-positive findings caused by the catheter (**Level of evidence: 4**).

### **Cystometry**

Although moderately invasive and dependent on a cooperative child, cystometry in children provides valuable information regarding detrusor contractility and compliance. The amount of information obtained from each study is related to the degree of interest and care given to the test.

It is important to be aware of the alterations in filling and emptying detrusor pressures as the infusion rates change during cystometry. Slow fill cystometry (filling rate <10 mL/min) is recommended by the International Children's Continence Society (ICCS) for use in children. However, it has been suggested that the infusion rate should be set according to the child's predicted capacity, based on age and divided by 10.

Several clinical studies using conventional artificial fill cystometry to evaluate neurogenic bladder in children have reported that conventional cystometry provides useful information for diagnosis and follow-up of children with neurogenic bladder. All the studies were retrospective clinical series and lacked comparison with natural fill cystometry, so that the grade of recommendation for an artificial

cystometry in children with neurogenic bladder is not high (**Level of evidence: 4**). Additionally, there is evidence suggesting that natural bladder behaviour is altered during regular artificial filling cystometry.

However, conventional cystometry in infants is useful for predicting future deterioration. Urodynamic parameters, such as low capacity and compliance and high leak-point pressures, are poor prognostic factors for future deterioration. Resolution of reflux is less likely to happen in such bladders (**Level of evidence: 4**).

During natural fill cystometry, the bladder is allowed to fill naturally and the recording of bladder and abdominal pressure is done using microtransducer catheters. Theoretically, this allows investigation of bladder function in near-physiological conditions. Studies on natural fill cystometry in children report similar results to those of studies done in adults. Natural fill cystometry gives a lower detrusor pressure rise during filling and lower voided volumes with higher voiding pressures. The incidence of bladder overactivity is higher with natural filling cystometry when compared to conventional artificial filling cystometry.

Although only a few studies on natural fill cystometry have been done in children with neurogenic bladder, the results suggest that natural fill cystometry detects new findings compared with diagnoses delivered by conventional cystometry (**Level of evidence: 3**). However, the comparison between natural fill and artificial fill cystometry has not been performed against a gold standard, so making it difficult to conclude which study is a true reflection of natural bladder behaviour. Findings in the non-neurogenic adult population have questioned the reliability of natural fill cystometry, as natural fill cystometry has shown a high incidence of bladder overactivity in totally normal asymptomatic volunteers.

The main disadvantage of natural fill cystometry is that it is labour-intensive and time consuming. Especially in children, the recording of events is difficult and there is an increased risk of artefacts, which makes interpretation of the huge amount of data even more difficult. Natural fill cystometry still remains a new technique in the paediatric population. More data needs to be gathered in a standard way before it can be widely accepted.

## **Management**

The medical care of children with myelodysplasia with a neurogenic bladder requires constant observation and adaptation to new problems. In the first years of life, the kidneys are highly susceptible to back-pressure and infection. During this period of life, the emphasis is on documenting the pattern of neurogenic detrusor sphincter dysfunction and assessing the potential for functional obstruction and vesicoureteral reflux (VUR).

## **Investigations**

An abdominal ultrasound obtained as soon as possible after birth will detect hydronephrosis or other upper genitourinary tract pathology. Following ultrasound, a voiding cystourethrogram should be obtained to evaluate the lower urinary tract. Measurement of residual urine during both ultrasound and cystography should also be done. These studies provide a baseline for the

appearance of the upper and lower urinary tracts, can facilitate the diagnosis of hydronephrosis or VUR, and can help identify children at risk for upper genitourinary tract deterioration and impairment of renal function.

A urodynamic evaluation can be done after some weeks and needs to be repeated at regular intervals, in combination with evaluation of the upper tracts (**Level of evidence: 3, Grade B recommendation**).

### **Early Management with Clean Intermittent Catheterization (CIC)**

Overwhelming experience gained over the years with early management of neurogenic bladder in infants has led to a consensus that children do not have upper tract deterioration when managed early with CIC and anticholinergic medication. Clean intermittent catheterization should be started soon after birth in all babies, especially in those with signs of possible outlet obstruction (**Level of evidence: 2, Grade B recommendation**).

The early initiation of CIC in the newborn period makes it easier for parents to master the procedure and for children to accept it as they grow older.

Early management results in less upper tract changes, but also better bladder protection and lower incontinence rates. It has been suggested that increased bladder pressures due to detrusor sphincter dyssynergia cause secondary changes of the bladder wall. These fibroproliferative changes in the bladder wall may cause further loss of elasticity and compliance, resulting in a small non-compliant bladder with progressively elevated pressures.

Early institution of CIC and anticholinergic drugs may prevent this in some patients (**Level of evidence: 3**). The retrospective evaluation of patients has also shown that significantly less augmentations were required in patients with an early start to CIC (**Level of evidence: 4**).

### **Medical Therapy**

At present, oxybutynin, tolterodine, trospium and propiverine are the most frequently used drugs. Most of the studies have been done on oxybutynin. Although the clinical outcome is imposing, the level of evidence is low since there are no controlled studies (**Level of evidence: 3, Grade B recommendation**).

The use of medication in children with neurogenic bladder to facilitate emptying has not been well studied in the literature. A few studies investigating the use of alpha-adrenergic blockade in children with neurogenic bladder have reported a good response rate, but the studies lacked controls and long-term follow-up is warranted (**Level of evidence: 4, Grade C recommendation**).

#### *Botulinum Toxin Injections*

In neurogenic bladders, which are refractory to anticholinergics and remain in a small-capacity, high-pressure state, a novel treatment alternative is injection of botulinum toxin into the detrusor. Initial promising results in adults have initiated its use in children.

So far, studies of the clinical effect of botulinum toxin in children have been open trials and there is a lack of prospective controlled trials. However, injection of botulinum toxin in therapy-resistant bladders appears to be an effective and safe treatment alternative. The treatment seems to be more effective on bladders with a more active component. Stiff bladders without an active component are unlikely to respond to botulinum toxin. Currently, it is unclear how many times this treatment can be repeated. In adults repetitive treatment has been found to be safe (**Level of evidence: 3**).

### **Management of Bowel Incontinence**

Children with neurogenic bladder have disturbances of bowel function as well as urinary function. Bowel incontinence in these children is frequently unpredictable. It is related to the turnover rate of faecal material in the anal area after evacuation, the degree of intactness of sacral cord sensation and motor function, and reflex reactivity of the external anal sphincter.

Bowel incontinence is managed most commonly with mild laxatives, such as mineral oil, combined with enemas to facilitate removal of bowel contents. A regular and efficient bowel emptying regimen is often necessary to maintain faecal continence and may have to be started at a very young age. With antegrade or retrograde enemas, most of these children will have decreased constipation problems and may attain some degree of faecal continence (**Level of evidence: 3**).

Biofeedback training programmes to strengthen the external anal sphincter have not been shown to be more effective than a conventional bowel management programme in achieving faecal continence. Electrostimulation of the bowel may also offer a variable improvement in some patients (**Level of evidence: 3**).

### **Urinary Tract Infection**

Urinary tract infections (UTIs) are common in children with neurogenic bladders. In the absence of reflux, UTIs should be treated symptomatically. There is strong evidence for not prescribing antibiotics to patients who have bacteriuria but no clinical symptoms. Although bacteriuria is seen in more than half of children on CIC, patients who are asymptomatic do not need treatment (**Level of evidence: 3**). Patients with VUR should usually be placed on prophylactic antibiotics to reduce the incidence of pyelonephritis, which can potentially lead to renal damage.

### **Sexuality**

Sexuality, while not an issue in childhood, becomes progressively more important as the patient gets older. This issue has historically been overlooked in individuals with myelodysplasia. However, patients with myelodysplasia have sexual encounters. Studies indicate that at least 15%-20% of males are capable of fathering children and 70% of females can conceive and carry a pregnancy to term. Counselling patients regarding sexual development is therefore important in early adolescence.

## **Bladder Augmentation**

Children with a good response to anticholinergic treatment and an overactive sphincter may be continent between catheterizations. Bladder pressure and development of the upper urinary tract will determine whether additional treatment is necessary.

Therapy-resistant overactivity of the detrusor, or small capacity and poor compliance, will usually need to be treated by bladder augmentation. A simple bladder augmentation using intestine may be carried out if there is any bladder tissue, a competent sphincter and/or bladder neck, and an urethra that can be catheterized. Stomach is rarely used as an augmenting patch because of the associated complications, but it is the only available intestinal segment for patients with impaired renal function. Ileal or colonic patches are used frequently for augmenting the bladder, with either intestinal segment appearing to be equally useful. Despite some advantages (e.g., avoiding mucus, decreased malignancy rate and less complications), alternative urothelium-preserving techniques, such as autoaugmentation and seromuscular cystoplasty, have not proven to be as successful as standard augmentation with intestine.

## **Bladder Outlet Procedures**

Children with detrusor overactivity, but with underactive sphincters, will be better for protecting their upper tracts. However, they will be severely incontinent. Initial treatment is CIC (as it may reduce the degree of incontinence and offers a much better control over UTIs) with anticholinergic drugs. At a later age, the outlet resistance will be increased in order to render them continent. No medical treatment available has been validated to increase bladder outlet resistance. Alpha-receptor stimulation of the bladder neck has not been very effective.

When conservative measures fail, surgical procedures need to be considered for maintaining continence. Although a simple augmentation is sufficient for most low-capacity, high-pressure bladders, augmentation with additional bladder outlet procedures is required when both the bladder and outlet are deficient. Bladder outlet procedures include bladder neck reconstruction or other forms of urethral reconstruction.

There are various procedures used on the bladder neck to increase resistance, but all these procedures may complicate transurethral catheterization. Augmentation with surgical closure of the bladder neck may be required primarily, or as a secondary procedure in certain rare clinical situations. In this situation, a continent stoma will be required. However, most surgeons prefer to leave the bladder neck and urethra patent as a safety precaution.

## **Continent Stoma**

Augmentation with an additional continent stoma is utilized primarily following failure of previous bladder outlet surgery. It is also advisable when an inability to catheterize transurethrally is likely. An abdominal wall continent stoma may be particularly beneficial to the wheelchair-bound spina bifida patient, who may often have difficulty with urethral catheterization or who is dependent on others to

catheterize the bladder. For continence with augmentation and an abdominal wall stoma, an adequate bladder outlet mechanism is essential to maintain continence.

### **Total Bladder Replacement**

Total bladder replacement in anticipation of normal voiding in children is very rare, as there are infrequent indications for a total cystectomy, with preservation of the bladder outlet and a competent urethral sphincter. This type of bladder replacement is much more common in adult urological reconstruction. Any type of major bladder and bladder outlet construction should be performed in centres with sufficient experience of the surgical technique and with experienced healthcare personnel to carry out post-operative follow-up.

### **Lifelong Follow-up of Neurogenic Bladder Patients**

Neurogenic bladder patients require lifelong supervision and monitoring of renal function is extremely important. Periodic investigation of upper tract changes, renal function and bladder status is mandatory. Repeat urodynamic tests are therefore needed more frequently (every year) in younger children and less frequently in older children. From the urological viewpoint, a repeat urodynamic study is warranted when the patient has a change in symptoms or undergoes any neurosurgical procedure. In the case of any apparent changes in the upper and lower urinary tract or changes in neurological symptoms, a more detailed examination including urodynamics and spinal magnetic resonance imaging is indicated. Renal failure can progress slowly or occur with startling speed in these children.

### **Definitions:**

#### **Levels of Evidence**

**1a** Evidence obtained from meta-analysis of randomized trials

**1b** Evidence obtained from at least one randomized trial

**2a** Evidence obtained from at least one well-designed controlled study without randomization

**2b** Evidence obtained from at least one other type of well-designed quasi-experimental study

**3** Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

**4** Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

#### **Grades of Recommendation**

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial

- B. Based on well-conducted clinical studies, but without randomized clinical studies
- C. Made despite the absence of directly applicable clinical studies of good quality

### **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of supporting evidence is identified and graded for some of the recommendations (see "Major Recommendations" field).

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

- Appropriate diagnosis, treatment, and management of neurogenic bladder in children
- Achievement of continence at appropriate age
- Prevention of urinary tract deterioration
- Prevention of renal dysfunction

### **POTENTIAL HARMS**

The main disadvantage of natural fill cystometry is that it is labour-intensive and time consuming. Especially in children, the recording of events is difficult and there is an increased risk of artefacts, which makes interpretation of the huge amount of data even more difficult.

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

The purpose of these texts is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. European Association of Urology (EAU) guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.

## **IMPLEMENTATION OF THE GUIDELINE**

### **DESCRIPTION OF IMPLEMENTATION STRATEGY**

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means

that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource ([www.uroweb.org/professional-resources/guidelines/](http://www.uroweb.org/professional-resources/guidelines/) & <http://www.urosource.com/diseases/>).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore, many important websites list links to the relevant EAU guidelines sections on the association websites and all, or individual, guidelines have been translated to some 15 languages.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Living with Illness

### **IOM DOMAIN**

Effectiveness  
Patient-centeredness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

Management of neurogenic bladder in children. In: Tekgul S, Riedmiller H, Gerharz E, Hoebeke P, Kocvara R, Nijman R, Radmayr C, Stein R. Guidelines on paediatric urology. Arnhem, The Netherlands: European Association of Urology, European Society for Paediatric Urology; 2008 Mar. p. 34-43. [71 references]

### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

### **DATE RELEASED**

2008 Mar

### **GUIDELINE DEVELOPER(S)**

European Association of Urology - Medical Specialty Society  
European Society for Paediatric Urology - Medical Specialty Society

### **SOURCE(S) OF FUNDING**

European Association of Urology

## **GUIDELINE COMMITTEE**

Not stated

## **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

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## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

All members of the working group submit a conflict of interest form. The information is kept on file in the European Association of Urology (EAU) Central Office database. This guidelines document was developed with the financial support of the EAU. No external sources of funding and support have been involved. The EAU is a non-profit organisation and funding is limited to administrative assistance, travel, and meeting expenses. No honoraria or other reimbursements have been provided.

## **GUIDELINE STATUS**

This is the current release of the guideline.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [European Association of Urology Web site](#).

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This NGC summary was completed by ECRI Institute on November 17, 2008. The information was verified by the guideline developer on December 19, 2008.

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