children without Hirschsprung's disease who are constipated when compared with those without constipation.⁸ Loening-Baucke also noted that in children with chronic constipation higher rectal volumes were required for maximal anal inhibition and rectal sensation was less. These findings support the theory that the degree of megarectum plays a large part in the persistence of chronic constipation. What remains unanswered is whether the megarectum is present from birth or whether it develops in response to a child's deliberate withholding of faeces for whatever reason.

How does constipation start? Many children become afraid to open their bowels as a response to episodes of painful defaecation. The pain may have been associated with an anal fissure or with rectal prolapse or may have been due simply to the passage of a large hard stool. Care should be taken to avoid a false diagnosis of child sexual abuse—chronically constipated children have good physiological reasons for having anuses with an abnormal appearance—but pain from anal abuse must be considered among the causes of faecal retention.⁹ Another pattern seen in many children is that they begin to avoid defaecation when first coerced to sit on a pot or a lavatory. They seem to assume that it is better to give up defaecation than run the risk of soiling their newly acquired pants and earning dishonour or worse from their parents. Once defaecation becomes associated with distress it is not surprising that they find it difficult to relax their external sphincter muscles.

A tendency to constipation is common in childhood and most children will gain confidence in defaecation as they grow older. If a child has a rectum larger than normal, however, he or she may develop chronic constipation—which in time may

lead to distressing overflow faecal incontinence and major psychological problems. So treatment should be given as a matter of urgency to any child with constipation. The first step is to ensure that the child has sufficient fluid and fibre in the diet. If constipation still occurs then the use of softeners such as docusate sodium, lactulose, or methylcellulose may be sufficient to help. If not, active laxatives such as senna, bisacodyl, or magnesium hydroxide should be used to avoid the vicious cycle of faecal retention and pain. If the constipation has become chronic, and especially if the child is still a baby, investigations should be done to exclude anal anomalies or Hirschsprung's disease. Relapsing or chronic constipation, which may be associated with older childhood disorders, requires a careful liaison between paediatrician, child psychiatrist or psychologist, paediatric surgeons, and the family doctor.

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Intracranial bumps in the night

"Exploding head" syndrome is usually benign

The transition from wakefulness to sleep is often a phase of relaxation. But it may also be a time of intense introspection, awareness of isolation, and fear. Sometimes it is associated with particular sensations or movements, which typically are brief and poorly recalled.

The movements include restless legs associated with deep paraesthesia (creeping sensations), sleep paralysis (a transient state of flaccid immobility), and myoclonic jerks. Jerks on falling asleep commonly affect a limb and are isolated single involuntary movements.¹ All of these conditions are benign.

The sensory events are more varied. Among the commoner feelings is a sense of falling from a height lasting a few seconds. Gowers called this nocturnal vertigo and thought that it was common in healthy people.² He noted that it was sometimes accompanied by a vibratory sound. He also referred to a sudden loud noise that disturbed sleep at its onset.³ Hypnagogic hallucinations are usually visual or auditory. In isolation they have no special links with any physical disorder, but when they are associated with narcolepsy there may also be sleep paralysis and cataplexy (muscular weakness provoked by emotional factors). The narcolepsy syndrome is a rare disorder in which circadian sleep rhythm is disturbed; it is often associated with human leucocyte antigen DR2.

A recent paper by Pearce described 50 patients with "the exploding head syndrome."⁴ They complained of a loud noise in the head during the stage of twilight sleep, describing it as an explosive bang, a crack of lightning, or a loud snap. The event alarmed the victims and might wake them up. The

condition was commoner in women, it covered all adult age groups, and it had often been present for many years. It was rarely familial, and there was no pain. The mechanism remains obscure.

Pearce points out that this symptom is rare in patients seen in a neurological clinic, but it may be elicited by direct questioning—some patients are reluctant to admit it. Most of the people in his series had written to him after reading his initial account of the syndrome.

What should be done for a patient who presents with this condition? The first essential is an adequate history to establish the description, the timing, and the circumstances. Anxiety and stress combined with fear are important components and may aggravate the symptoms. Questions should be asked about background factors, including drugs and alcohol, and the patient should be physically examined.

When the event is divested of overtones it will usually be found to be a purely subjective sensation during twilight sleep; it may then usually be declared benign without further investigation. Reassurance is important. When the symptoms are complex and recurrent further investigation and assessment may be needed.

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