Constipation in childhood

Treatment should be given early

Most doctors who care for children will at some stage confront one with chronic constipation. What promises in its early stage to be a condition easily remedied by increasing the fluid and fibre intake gradually develops into a nightmare for all concerned. A mixture of painful defaecation, deliberate withholding of faeces, overflow faecal incontinence, and parental anxiety—all compounded by a physiological tendency to constipation—leads all too often to an ever increasing use of laxatives and diminishing confidence in the doctor.

Theories from child psychiatrists,1,2 paediatric surgeons,3 and paediatricians4 on the aetiology of chronic constipation have been as varied as the many factors operating in each individual child. Loening-Baucke recently tried to determine which features might predict a good response to treatment.5

Her regimen included the essentials: effective evacuation of retained faeces, maintenance of an empty rectum with oral or rectal medication, strict attention to diet and toilet routines, and a careful explanation of the pathophysiology. As might be expected, she found that those children who had presented with frequent overflow soiling and with faecal masses palpable on abdominal examination were less likely to be free of constipation and off laxatives after one year.

What is the place of specialist investigations? Anorectal manometry has been recommended for severely constipated children to help exclude ultrashort segment Hirschsprung’s disease.6 There seems to be less inhibition of the internal sphincter muscle in response to rectal distension even in

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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