Emergency admission of adults with acute constipation
Patients admitted to surgical unit with a chief complaint of acute "constipation" or obstipation, with or without abdominal pain

Higher risk groups
Older adults
Those taking opiates or other medication known to cause significant constipation
Significant neurological pathology, ie parkinsons/MS
Significantly impaired mobility
Or where there is a history of GI pathology/surgery

Hence importance of:
Abdo and digital recetal exam.
Discussion re treatment escalation plan / ceiling of care.
Imaging: ?AXR, ?CT.
Is there gas all the way to the rectum, or is there a transition point?
Is there the classic 'coffee' bean of volvulus?
+/- flexible sigmoidoscopy with caution?

Differentiation
It is important to differentiate between 1, 2 & 3.
Remember occasionally 1 may lead to 2, ie faecal impaction.
And note, constipation may present as a secondary urinary retention.

1. Functional problem
Often a precipitant: Have they had their simple laxatives?
Often acute on chronic
Sometimes "pseudo-obstruction"
Have they been investigated for slow transit, or obstructed defaecation syndrome, or mega-rectum / mega colon?

Treatment
Enemata? Laxatives?
Treat underlying causes.
Is it appropriate to investigate later for altered bowel habit?
See: NICE CKS Choice of laxatives

2. Mechanical obstruction
Always think of ?
Colorectal tumour
? other stricture or extrinsic compression
? volvulus
? impaction
May still have overflow diarrhoea

3. Toxic megacolon
Remember this may mimic constipation.
Causes include IBD, C Diff, pesudomembranous colitis, ischaemia.

Treatment
This medical and surgical emergency is another topic.

Impaction
Requires manual evacuation, usually in theatre under GA, if fit.

Volvus
Flex sig decompression +/- resection (or PEC tubes) if persistent or recurrent.

Tumour
Resection or stent or stoma.

Other
Other strictures, extrinsic compressions: treatment depends on cause.