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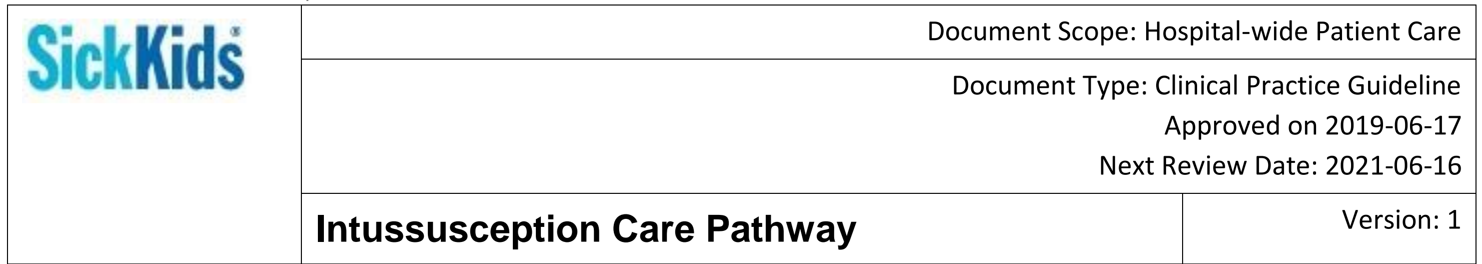

Introduction

The purpose of this pathway is to assist the health care team with clinical decisions regarding the management of a patient with intussusception.

Target Population:

- **Inclusion:** Children age 0-18 years old with no underlying disease or comorbidity who have been diagnosed with intussusception by the General Surgery Team.
- **Exclusion**: to be removed from this pathway if child has significant comorbidities, significant postoperative/post procedure complications (eg. bowel obstruction, bowel perforation, or prolonged TPN therapy) or a change in diagnosis.

Target Users:

- Emergency physicians, radiologists, surgeons, residents, fellows and nurses on the ward.

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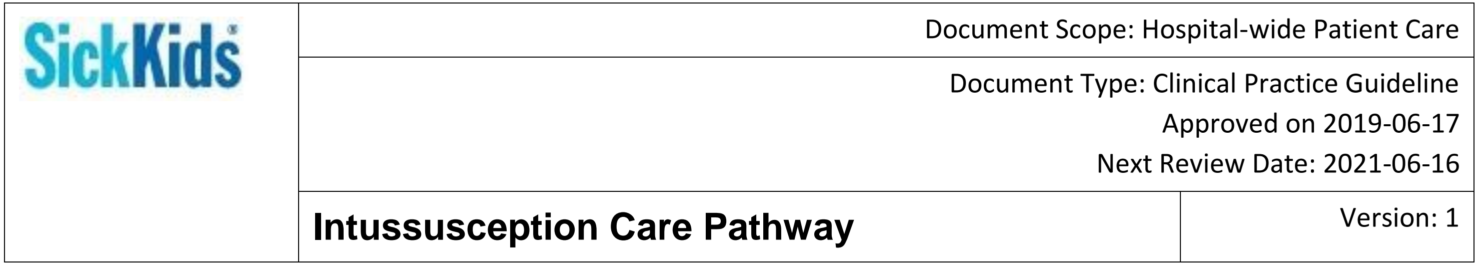

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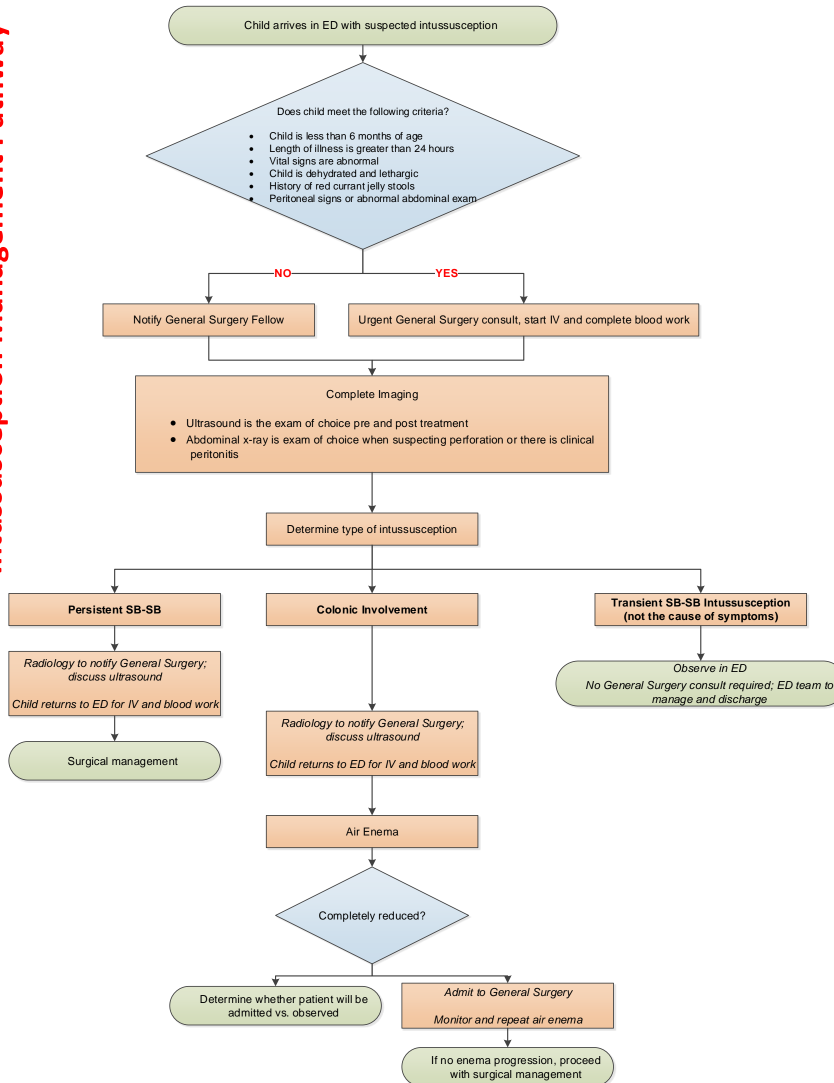

Decision to admit/discharge

Patient should be observed for 2-4 hours in ER and may be discharged if:

- Live close to hospital
- Have a telephone to contact hospital
- Parental reliability
- VSS, Afebrile
- Normal physical exam
- Tolerating diet
- Voiding well
- No pain symptoms
- Idiopathic

***ensure follow up with family MD/pediatrician (follow up with general surgeon if intussusception recurs)*

Patient should be admitted to the hospital when:

- Unwell (persistent obstructive symptoms eg. Abdominal pain, vomiting)
- Presented with bowel obstruction
- Had high WBC count at presentation
- Live in a more remote location
- Ongoing rectal bleeding
- Lead point found
- Incomplete reduction of intussusceptions

Patient should have another ultrasound to rule out recurrent intussusception when they are having:

- Recurrent pain
- Recurrent vomiting

Intussusception caused by jejunal enteral tubes

- Remove jejunal enteral tube
- Reinsert jejunal enteral tube
- Reimage to ensure appropriate tube placement

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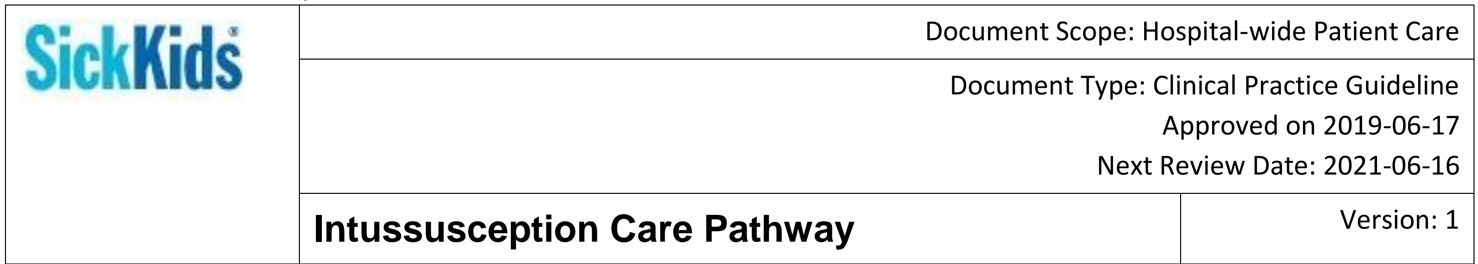

Patients scheduled for surgery typically receive pre and post-surgical care as described below

Intussusception care pathway

Expected Date of Discharge: <3 days if no bowel resection; 3 days if bowel resection

	PRE-OPERATIVE	IMMEDIATELY POST-OPERATIVELY	POST-OP DAY # 1-2 (no bowel resection); DAY # 1-4 (with bowel resection)	DISCHARGE: DAY 3 (no bowel resection); DAY 5 (with bowel resection)
GOALS	1. Hydration maintained 2. Patient prepared for OR 3. Child/family are advised of pre-op bath. Wipes to be used upon arrival. Refer to procedure document 4. Adequate pain control	1. Afebrile 2. Adequate pain control 3. Out of bed 4. Incision intact, no drainage; dry and intact	1. Afebrile 2. Adequate pain control 3. Ambulating 4. Able to tolerate NG to drainage/clamp/remove 5. Incision dry & intact	1. Afebrile 2. Adequate pain control 3. Ambulating 4. Able to tolerate diet 5. Incision dry and intact 6. Child/ caregiver teaching completed 7. Family understands discharge teaching
PHYSICAL EXAM	• Obtain history • Complete physical exam • Assess vital signs • Complete pain assessment (refer to Pain Assessment Guidelines) • Ensure child has adequate pain control (refer to Pain Management Guidelines) • Obtain accurate in and out • Obtain weight and height	• Complete pain assessment every 4 hours • Ensure child has adequate pain control (refer to Pain Management Guidelines) • Monitor vital signs as per BPews • Obtain accurate in and out • Complete wound assessment • Assess stool color and consistency	• Complete pain assessment every 4 hours • Ensure child has adequate pain control (refer to Pain Management Guidelines) • Monitor vital signs as per BPews • Obtain accurate in and out • Complete wound assessment (remove surgical dressing, leave sterístrips) • Assess stool color and consistency	
DIET & IV FLUIDS	• Ensure that patient is NPO • Administer D5W/0.9 NaCl at maintenance • Normal saline bolus as indicated • Refer to Fluid and Electrolyte Guidelines	• NPO until bowel function present, no abdominal distension, and no nausea/vomiting; then start clear fluids to diet as tolerated • Administer D5W/0.9 NaCl with 20mmol KCL/L at maintenance • Normal saline bolus as indicated • Refer to Fluid and Electrolyte Guidelines	• NPO until bowel function present, no abdominal distension, and no nausea/vomiting; then start clear fluids to diet as tolerated • IV to maintenance; TKVO once adequate oral fluid intake	
NG TUBE		• NG tube to low intermittent suction/ straight drain • May put to straight drainage if clinically indicated (decreased output volume, non-bilious, no nausea) • **May remove when tolerate NG to straight drainage or clamp (no nausea/vomiting, no abdominal distention, and no pain)**	• NG tube to low intermittent suction/ straight drain • May put to straight drainage if clinically indicated (decreased output volume, non-bilious, no nausea) • **May remove when tolerate NG to straight drainage or clamp (no nausea/vomiting, no abdominal distention, and no pain)**	
LABS & MEDICATION	• Complete CBC with differential • Coagulation, electrolytes, group and screen, and Sickle Cell screen (if indicated)	• Labs as clinically indicated • IV morphine continuous infusion • Acetaminophen as indicated for pain/fever • Continue cefoxitin IV for 2 hours post-op then reassess • Ketorolac every 6 hours for pain management for 48 hours (age appropriate and clinically indicated) • Ampicillin/gentamicin/metronidazole X 7 days if perforated	• Wean morphine infusion to off (decrease by 5-10 mcg every 24 hours) • If pain/fever, administer acetaminophen as indicated • Ketorolac/ibuprofen every 6 hours as needed for pain	• If needed, provide prescription for oral medication

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Related Documents

Care of Patients Receiving Continuous Infusion of Opioids ==>

Care of Patients Receiving Patient Controlled Analgesia ==>

SickKids e-formulary

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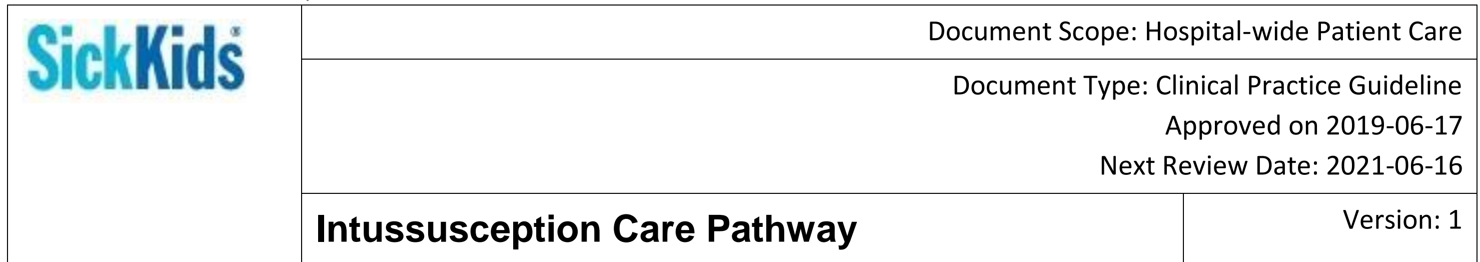

Implementation Plan

- Education and awareness building by General Surgery Program (Surgeons, NPs, fellows, nurse educator) at: fellow orientation (once per year) nursing orientation (every 3 months), and residents orientation (every month).
- Surgeons to communicate any updates in practice to Division of General Surgery and Radiology.
- Radiologists to communicate any updates in practice to Division of General Surgery and Radiology.

Evaluation Plan

- Length of stay (LOS) evaluation

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Guideline Group and Reviewers

Guideline Group Membership

1. Monping Chiang RN (EC), MN, NP General & Thoracic Surgery
2. Fatma A. Rajwani, PT, Clinical Practice Guideline Coordinator

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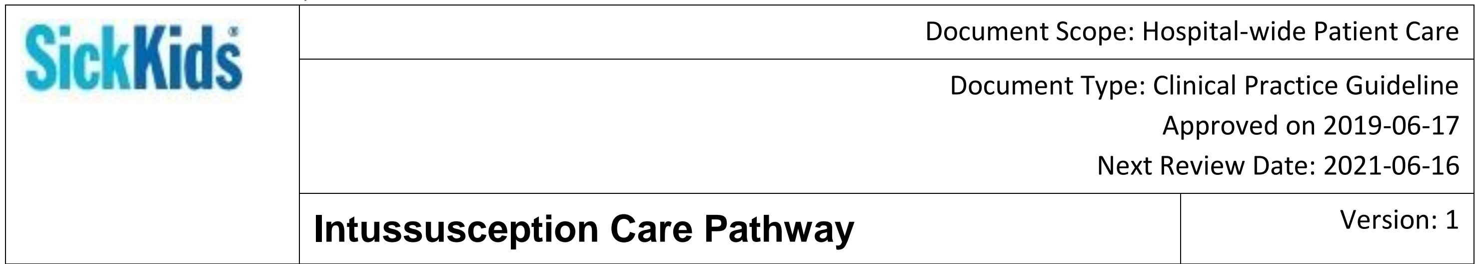

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Internal Reviewers

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2. Bruce Minnes MD Emergency
3. Kelly Keogh MD Emergency
4. Alan Daneman MD Radiology
5. Oscar Navarro MD Radiology

External Reviewer

1. Sharifa Himidan MD North York General Hospital

Attachments:

algorithm_june 2019.pdf

intussusception_final_2019.pdf

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