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 suspected to have or diagnosed with intussusception.
- **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, nurse practitioners and nurses on the ward.
Child arrives in ED with suspected Intussusception

Does child meet the following criteria?
- Child is less than 6 months of age
- Length of illness is greater than 24 hours
- Vital signs are abnormal
- Child is dehydrated and lethargic
- History of red currant jelly stools
- Peritoneal signs or abnormal abdominal exam

YES

Urgent General Surgery consult, start IV and complete blood work

NO

Complete Imaging
- Ultrasound is the exam of choice pre and post treatment (Comprehensive US vs POCUS 
  [Point of Care Ultrasound])
- Abdominal x-ray is exam of choice when suspecting perforation or there is clinical findings

Determine type of intussusception
- Persistent Small Bowel - Small Bowel Intussusception
- Transient Small Bowel - Small Bowel Intussusception (not the cause of symptoms)
- Colonic Involvement

Admit to General Surgery
Monitor and repeat air enema

Air Enema

If no enema reduction, proceed with surgical management

Patient should be admitted for 2-4 hours in ED and may be discharged if:
- Live close to hospital
- Have a telephone to contact a Primary Care Provider
- Parental reliability
- VSS, Afebrile
- Normal physical exam
- Tolerating diet
- Voiding well
- No pain symptoms
- Idiopathic

Patient should be admitted to the hospital when:
- Unwell (persistent obstructive symptoms eg. Abdominal pain, vomiting)
- Presence of bowel obstruction
- Had high WBC count at presentation
- Lead point found
- Incomplete reduction of intussusceptions

Follow the Management of GJ and Combination G/G Tube-Related Intussusception pathway for guidance

Table 1: Decision to admit/discharge

<table>
<thead>
<tr>
<th>Decision to admit/discharge</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient should be admitted to the hospital when:</td>
<td>Unwell (persistent obstructive symptoms eg. Abdominal pain, vomiting)</td>
</tr>
<tr>
<td>Present with bowel obstruction</td>
<td>Had high WBC count at presentation</td>
</tr>
<tr>
<td>Diagnosed with intussusception</td>
<td>Reduced risk of complications</td>
</tr>
</tbody>
</table>

Intussusception Care Pathway

Printable version – Intussusception Management Pathway
Printable version – Tube Related Intussusception Care Pathway

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## Intussusception Care Pathway

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

<table>
<thead>
<tr>
<th>PRE-OPERATIVE</th>
<th>IMEDIATELY POST-OPERATIVELY</th>
<th>POST-OP DAY #1-2 (to bowel resillation)</th>
<th>POST-OP DAY # 5-4 (with bowel resillation)</th>
<th>DISCHARGE: DAY 3 (to bowel resillation)</th>
<th>DAY 5 (with bowel resillation)</th>
</tr>
</thead>
</table>

### 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.

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Evaluation Plan

- Length of stay (LOS) evaluation

References


Guideline Group and Reviewers

Guideline Group Membership

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Attachments:

Intussusception final 2021.pdf
Pathway algorithm 2021.pdf