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.
Intussusception Care Pathway

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

**Urgent General Surgery consult, start IV and complete blood work**

**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 peritonitis

**Determine type of intussusception**

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

**Air Enema**

- Radiology to notify General Surgery and Emergency MR to discuss ultrasound
- Ensure adequate pain management and IV access
- ED Nurse to accompany patient to Air enema

**Completely reduced?**

- Yes
- No

**Admit to General Surgery**

- Monitor and repeat air enema
- If no enema reduction, proceed with surgical management

**Table 1: Decision to admit/discharge**

Patient should be observed 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

**Ensure follow up with Primary Care Provider/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
- Lives in a more remote location
- Ongoing rectal bleeding
- Lead point found
- Incomplete reduction of intussusceptions

**Intravenous ferric oxide (Ferumoxtran-10)**

**Intussusception caused by post pyloric enteral tubes**

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

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Printable version – Intussusception Management Pathway
Printable version – Tube Related 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>IMMEDIATELY POST-OPERATIVELY</th>
<th>POST-OP DAY #1-2 (to bowel resumption)</th>
<th>POST-OP DAY #3-4 (with bowel resumption)</th>
<th>DISCHARGE: DAY 3 (to bowel resumption) DAY 5 (with bowel resumption)</th>
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</thead>
<tbody>
<tr>
<td>GOALS</td>
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<tr>
<td>• Obtain history  • Complete physical exam  • Assess vital signs  • Complete pain assessment (refer to Pain Assessment Guideline)  • Ensure child has adequate pain control (refer to Pain Management Guidelines)  • Obtain accurate in and out  • Obtain weight and height</td>
<td>• Complete pain assessment every 4 hours  • Ensure child has adequate pain control (refer to Pain Management Guidelines)  • Monitor vital signs as per BP/ER  • Obtain accurate in and out  • Complete wound assessment  • Assess stool color and consistency</td>
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<td>PHYSICAL EXAM</td>
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<td>• Ensure that patient is NPO  • Administer 2000-3000 mL at maintenance  • Normal saline bags as indicated  • Refer to Fluid and Electrolyte Guidelines</td>
<td>• NPO until bowel function present, no abdominal distension, and no nausea/vomiting; then start clear fluids to diet as tolerated  • Administer 1500-2000 mL of 0.9% NaCl at maintenance  • Normal saline bags as indicated  • Refer to Fluid and Electrolyte Guidelines</td>
<td>• NPO until bowel function present, no abdominal distension, and no nausea/vomiting, then start clear fluids to diet as tolerated  • IV to maintenance. TKO once adequate oral fluid intake</td>
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<tr>
<td>DIET &amp; FLUIDS</td>
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<tr>
<td>• NG tube to low intermittent suction only  • Drainage bag clamped  • NG tube to low intermittent suction only  • Drainage bag clamped</td>
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<tr>
<td>LABS &amp; MEDICATION</td>
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<td>• Complete CBC with differential  • Coagulation, electrolytes, type and screen, and Sickie Cell screen (if indicated)</td>
<td>• Labs as clinically indicated  • IV morphine continuous infusion  • Acetaminophen as indicated for pain/fever  • Continue cefoxitin IV for 24 hours post-op then reassess  • Ketorolac every 6 hours for pain management for 48 hours (age appropriate and clinically indicated)  • Amoxicillin/trimethoprim x 7 days if perforated</td>
<td>• Wearn morphine infusion to off (decrease by 5-10 mg every 24 hours)  • If pain/sever, administer acetaminophen as indicated  • Ketorolac/diproprofen every 6 hours as needed for pain</td>
<td>• If needed, provide prescription for oral medication</td>
<td></td>
</tr>
</tbody>
</table>

PRINTABLE VERSION

Related Documents

Care of Patients Receiving Continuous Infusion of Opioids ==>
Care of Patients Receiving Patient Controlled and Nurse Controlled Analgesia ==>
SickKids e-formulary

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

**References**


**Guideline Group and Reviewers**

Guideline Group Membership

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Attachments:

Intussusception final 2021.pdf
Pathway algorithm 2021.pdf