

Ileocolic Intussusception Clinical Pathway

The following information is only intended as a guideline for the acute management of children with suspected ileocolic intussusception. Management of your patient may require a more individualized approach

Child with Suspected Ileocolic Intussusception

Exclusion Criteria

- Signs of Peritonitis
- Concern for perforation
- Recent abdominal surgery
- Hemodynamically unstable
- < 3 months

Initial Management

- History and Physical Exam
- Assess vital signs
- Mental status
- IV and labs as clinically indicated

Imaging

- Order US Abdomen Limited (Peds Quick List)
 - Ordering provider adds in comments "evaluate for intussusception"

Goals:

- Improve clinical outcomes
- Optimise collaboration and coordination of care
- Minimise pain and optimise patient comfort

Measures:

- Outcomes:
 - % successful reductions
 - % self reductions
 - Pain scores during reduction procedure
- Process:
 - Time from diagnosis to reduction
 - % Use of standardized process
- Balancing:
 - % Admission
 - ED Length of Stay

Ultrasound Negative

- Consider alternative diagnosis
- Further evaluation as indicated

Ultrasound Positive Ileocolic Intussusception

- Radiology
 - Notify ordering clinician
 - Recurrent Intussusception (see page 2)
- Patient returns to ED:
 - Place IV (if not already completed)
 - Order FL Enema for intussusception
 - Consult Pediatric Surgery
 - Order analgesia to be given pre-procedure (Fentanyl 1mcg/kg/dose IV, max 50 mcg)
 - Child life specialist if available

Ultrasound Positive Small bowel Intussusception

- No fluoroscopic enema is indicated
- More likely to reduce spontaneously
- Further work-up, treatment or observation rarely required unless severe pain or unable to maintain hydration
- see page 2 for more details

Perform FL Enema

- ED RN to administer fentanyl 20 minutes prior to procedure and consider second dose if moderate pain during procedure
- ED RN monitor pain scale during procedure
- Consider surgical team at bedside during procedure in high risk patients (<6 months)
- Radiology to notify surgery if concern for pathologic lead point or for perforation

Intussusception Reduced ≤ 2 Attempts*

- Begin PO clears 2 hours post reduction
- Observe 4 hours from reduction
- Consider Admission
 - <6 months
 - Inability to tolerate PO
 - Concern for access to follow-up care

***Attempt definition:** In practice, radiology will perform 2-3 reduction attempts on the same fluoroscopy section, with the patient remaining on the table and breaks between attempt.

Discharge with primary care physician follow up in 24-48 hours

Intussusception Reduced > 2 Attempts (attempts performed under the same fluoroscopy section)

Admit to Pediatric Surgery

Unable to Reduce or Concern for Perforation

Further Management per Pediatric Surgery

Child with Suspected Ileocolic Intussusception

Ileocolic intussusception without pathologic lead point is commonly seen in healthy children aged 6 months to 3 years old. Outside this age range, particularly in children older than 5 years, discussion with the radiologist is recommended to assess the need for further evaluation and the appropriateness of enema reduction.

Recurrent Intussusception

After a third recurrence, there is an increased likelihood of a pathologic lead point. At that stage, a discussion regarding surgical evaluation should be considered. Similarly to age above 5 years old, attending to attending discussion may be needed in such cases.

Small Bowel Intussusception

- Generally, a benign process
- Often found incidentally, associated with conditions that cause bowel inflammation and hypermotility (e.g., gastroenteritis, HSP)
- Management differs from ileocolic intussusception as small bowel intussusception is less likely to respond to nonoperative reduction and more likely to reduce spontaneously, provided that the intussusceptum is short and is isolated to the small bowel.
- Further work-up, treatment or observation/admission rarely required unless long segment involved, severe pain or child unable to maintain hydration.
- In one series of patients with isolated small bowel intussusception, all cases in which the intussusceptum was < 3.5 cm resolved spontaneously, children who required surgery had a mean intussusceptum length of 7.3 cm (95% CI 4.8-9.7 cm)