Acute Intussusception

Definition
Intussusception is the invagination of proximal bowel into distal bowel, often resulting in bowel obstruction[1]. Mesenteric vasculature is pulled into the intussuscipiens resulting in blood flow obstruction and bowel wall ischemia. There are multiple types of intussusception including ileocolic, and enteroenteric. For the purpose of this guideline, intussusception will refer to the ileocolic type, which is the most common.

Incidence
Intussusception is the most common cause of acute abdominal pain in young children and has an estimated incidence of 35 per 100,000 children and up to 62 cases per 100,000 in certain age groups (26-29 weeks) [2]. Intussusception is the most common cause of bowel obstruction in children and one quarter of abdominal surgical emergencies in those less than 5 years old are attributable to intussusception[3].

The majority of patients are under 1 year of age with a peak seen between 6-8 months[2]. Intussusception is extremely uncommon below 3 months of age[4]. There is a male predominance that increases with age[2]. Although intussusception can quickly progress to disability and death without treatment, with proper resuscitation and management, intussusception has a mortality rate of <1%[2,3,5].

Etiology
The majority of cases (approximately 90%) are idiopathic and may result from lymphoid hyperplasia[1,6,7]. Intussusception may be preceded by viral URI or AGE and has been associated with rotavirus and adenovirus infections[8,9]. Pathologic lead points (PLP) are rare but become more common in the older age groups[6]. There is some evidence that beta lactam antibiotics can increase the risk of intussusception[10]. Post surgical intussusception usually occurs within 2 weeks of surgery[6]. Although any surgical procedure can result in dysmotility and precede intussusception, it is more commonly seen in intra abdominal surgeries where there is extensive manipulation of the bowel[6].

Differential Diagnosis
Appendicitis
Anatomic abnormality causing small bowel obstruction
AGE
UTI
Testicular torsion
Sepsis

Guideline Inclusion Criteria
Patients >3 months and <6 years with clinical symptoms suggestive of intussusception.

Guideline Exclusion Criteria
• Patients with comorbid or complex medical conditions.
• Children with signs of sepsis should be initially cared for with the sepsis protocol.
• Children with recent abdominal surgery (within 1 month) should undergo workup for intussusception but the pediatric surgical service should be notified once intussusception is confirmed and prior to air enema.

Diagnostic Evaluation
The classic triad of abdominal pain, hematochezia, and vomiting occur in only one third of patients and is generally associated with a longer duration of symptoms[9,11].

History of abdominal pain is the most common presenting symptom[11,12]. The addition of one of the following symptoms should prompt a workup for intussusception: bloody stool, vomiting (starts refractory then becomes bilious), or lethargy. A child presenting without abdominal pain but with two of the symptoms above or a history and physical consistent with intussusception should prompt a workup for intussusception.

On physical exam, a sausage shaped mass may be present in up to 30-85% of patients[9,11]. Scaphoid appearance of the right upper quadrant, or Dance sign, is a less common physical exam finding. Abdominal distension may also be noted.

Ultrasound is the diagnostic modality of choice as it has a very high sensitivity and specificity in the diagnosis of intussusception[1].
### Determination of Clinical Severity

Assessment guidelines for symptom severity to be performed by attending physician

<table>
<thead>
<tr>
<th>Level</th>
<th>Criteria</th>
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| Low    | Alert, active, good perfusion  
Stable general condition without signs of severe or moderate criteria |
| Moderate* | Stable appearance with any of the following:  
Duration of symptoms > 48 hours  
Age < 6 months  
Dehydration  
Lethargy  
Concern for small bowel obstruction  
Hematochezia |
| Severe* | Poor appearance with any of the following:  
Signs of shock  
Signs of peritonitis  
Signs of free air |

*Children with moderate and severe severity assessment share features that are associated with increased morbidity and enema failure\(^\text{13-17}\).

### Laboratory Tests

Not routinely recommended for uncomplicated intussusception.

### Critical Points of Evidence

<table>
<thead>
<tr>
<th>Evidence Supports</th>
<th>Evidence Lacking/Inconclusive</th>
<th>Evidence Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prompt diagnosis and intervention</td>
<td>Use of severity criteria</td>
<td>Use of antispasmodics (glucagon)</td>
</tr>
<tr>
<td>The use of fluid resuscitation</td>
<td>Abdominal XR for diagnostic purposes</td>
<td>Use of antibiotics</td>
</tr>
<tr>
<td>The use of ultrasound in the diagnosis of intussusception</td>
<td>The use of anesthesia or sedation</td>
<td>Use of CT for diagnostic purposes</td>
</tr>
<tr>
<td>Use of abdominal XR to rule out free air or small bowel obstruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The use of air contrast enema for reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The use of delayed repeat enema for well appearing children with partial reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge to home after brief observation period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Practice Recommendations and Clinical Management

#### Laboratory Testing

No routine laboratory testing is recommended for patients with uncomplicated intussusception  
\(^\text{Moderate recommendation; Low quality evidence.}\)

A BMP should be obtained if patient appears severely dehydrated to assess for electrolyte abnormalities and kidney function. Acute-phase reactants are not routinely recommended but may be used in conjunction with clinical findings to assess severity. CRP > 10 mg/dL is seen more frequently in moderate to severe cases\(^\text{18}\). Leukocytosis (WBC > 20,000) is seen more frequently in moderate to severe cases and may reflect severity\(^\text{19}\). Bacteremia with septicemia is uncommon and blood culture is not routinely recommended\(^\text{20}\).

#### Imaging

Ultrasound is the diagnostic modality of choice as it has a very high (100%) sensitivity and specificity in the diagnosis of intussusception\(^\text{1,21}\). For children meeting moderate to severe criteria, ultrasound will be performed in the Emergency Department.  
\(^\text{Strong recommendation; Strong quality evidence.}\)

Primary or confirmatory imaging with computed tomography should not be conducted for patients with suspected intussusception\(^\text{1,6}\). Ultrasound is preferred over abdominal computed tomography to evaluate for PLPs\(^\text{1,6}\).  
\(^\text{Strong recommendation; Moderate quality evidence.}\)
Abdominal XR has limited value for intussusception and is not recommended for diagnostic purposes. A soft tissue mass and absence of large bowel gas are suggestive of intussusception but not diagnostic. XR is useful in detecting free air or small bowel obstruction, although even with perforation, free air may not be visualized. Intussusception is less likely if air is visualized in the cecum but false negatives do occur. 

(Moderate recommendation; Moderate quality evidence.)

**Fluid Resuscitation**

IV access should be started and maintained in all children with confirmed intussusception. 

(Strong recommendation; Low quality evidence.)

All children with suspected intussusception meeting moderate to severe criteria should be immediately fluid resuscitated. In low severity criteria, fluid resuscitation can be held until intussusception confirmed. All children should be reassessed frequently to ensure hemodynamic stability prior to reduction procedure.

(Strong recommendation; Moderate quality evidence.)

**Primary Reduction**

Reduction should be attempted by therapeutic air enema. Multiple attempts may be tried at discretion of the Radiologist with up to a 30-minute interlude between attempts. The primary complication of air enema is perforation, which occurs <1% of the time. Contraindications for enema include free air and peritonitis.

(Strong recommendation; Moderate quality evidence.)

The use of smooth muscle relaxants (i.e. Glucagon) has not been found to improve rates of reduction and is not recommended.

(Strong recommendation; Moderate quality evidence.)

There is no strong evidence to support anesthesia or sedation during reduction and it is not recommended.

(Weak recommendation; Low quality evidence.)

There is some evidence to suggest steroid administration may decrease recurrence but more studies are needed before this can be recommended.

(Weak recommendation; Low quality evidence.)

**Surgical Management**

Failure in primary reduction will elicit a surgical services consult. Following surgical services consult, patients will be managed either with delayed repeat enema or surgical intervention off pathway.

(Strong recommendation; Moderate quality evidence.)

**Delayed repeat Enema**

Patients with partial reduction on initial enema attempt are candidates for delayed repeat air enema. These patients will be admitted under the primary surgical team for evaluation and those deemed appropriate will receive further management per surgery.

(Moderate recommendation; Moderate quality evidence.)

**Antibiotics**

Antibiotics are not routinely recommended for uncomplicated intussusception and have not been shown to decrease length of stay or improve outcomes.

(Moderate recommendation; Moderate quality evidence.)

**Antibiotic Management for Peritonitis/Perforation**

Antibiotics are recommended for diagnosis of peritonitis or perforation.

(Strong recommendation; Moderate quality evidence.)

First line therapy:

- Cefazolin (33mg/kg/dose IV q8 hours | Max 2000mg/dose) or ceftriaxone (75mg/kg/dose IV q24 | Max 2000mg/dose) and metronidazole (10mg/kg/dose IV q8 hours | Max 500mg/dose)

**Time to Oral Intake**

No difference has been demonstrated in intestinal perforation, shock, sepsis, LOS, pain, fever, or recurrence in patients who had early PO (<2hours after procedure) vs delayed PO. We recommend starting PO once the child is tolerating oral intake.

(Moderate recommendation; Low quality evidence.)
Early Discharge

Children may be safety discharged after a short observation period (6-8 hours) after air enema. This is a change from the previously admitting this group for 24 hours. Shortened period allows observation for complications of reduction and for tolerance of PO. Most recurrences occur after 48 hours and the vast majority would not be captured in a 24 hour hospitalization. Recurrences may be safely reduced via repeat air enema and readmitted under the pathway.

(Strong recommendation; Moderate quality evidence.)

Consults/Referrals:
- Stat consult pediatric surgical service on patients with clinical signs of peritonitis or free air visualized on XR
- Consult pediatric surgical service for patients who fail primary reduction with air enema
- Stat consult pediatric surgical service for patients with perforation during air enema

The pediatric surgical service should be notified once intussusception is confirmed and prior to air enema in post operative patients

Admission Criteria
Following successful non-surgical reduction of uncomplicated intussusception, children should be admitted for a short observation period to evaluate for complications of enema reduction and ensure adequate PO and hydration prior to discharge.

Discharge Criteria
- Tolerating PO with adequate urine output
- No vital sign instability
- No persistent abdominal pain or emesis
- Barriers to care, including distance of home to hospital and parent comfort level with discharge are assessed

Caregiver Education
(See Addendum 2)

Caregivers should be informed that intussusception carries a 10-12% recurrence rate. The majority of recurrences occur after 48 hours. Recurrences may be safely reduced via air contrast enema. Children should immediately be brought to the Emergency department if they display:
- Colicky or constant abdominal pain
- Persistent emesis
- Lethargy
- Low urine output

Outcome Measures
- Time to initiate diagnostic ultrasound
- Time to initiate air enema
- Readmission rate within 72 hours for non-surgically reduced intussusception
- Emergency Department Revisit rate within 72 hours for non-surgically reduced intussusception

Addendums
- Patient flow and Review of key evidence
- KRAMES caregiver education

Follow-Up Care
With primary care provider in 1-2 days.
Acute Intussusception Emergency Department Pathway
Evidence Based Outcome Center

**Inclusion Criteria**
Patient 3 months to 6 years of age presenting with abdominal pain and at least one following:

**Exclusion Criteria**
- Age < 3 months OR > 6 years
- Children with signs of sepsis
- Underlying medical condition
- Comorbidities
- Recent surgery

**Determination of Clinical Severity by Attending Physician**

**Low Criteria**: Stable general condition Without signs of severe or moderate criteria

**Moderate**
Stable appearance with any of the following criteria:
- Duration of symptoms > 48 hours
- Age 3 to 6 months
- Dehydration
- Lethargy
- Concern for small bowel obstruction
- Hematochezia

- Place IV
- Order NS bolus
- Consider ordering analgesia

**Order STAT Ultrasound**
Consider 2 View Abdominal X-ray if concern for small bowel obstruction

**Ultrasound consistent with intussusception?**
- YES
  - Order air enema
  - Pulse Oximeter & nurse monitoring during transport and procedure
  - Ensure patient is stable and has adequate hemodynamic stability
  - Perfusion?
    - NO
    - Intussusception reduced?
      - NO
      - Manage OFF-Pathway
      - Admit for 6 hour observation
    - YES
    - Admit to Surgical Service
    - Manage OFF-Pathway

- NO

**Severe**
Poor appearance with any of the following:
- Signs of shock
- Signs of peritonitis
- Signs of free air

**Order STAT**
- 2 View Abdominal X-ray
- Ultrasound
  - AND
  - Place IV
  - Order NS bolus

**Peritonitis or free air?**
- YES
  - Manage OFF-Pathway
  - STAT Surgical Consult

**Emergency Department Antibiotic Management**
Combination Therapy:
- **Cefazolin**:
  - 33 mg/kg/dose IV q8 hours | Max 2000 mg/dose
- **Metronidazole**:
  - 10 mg/kg/dose IV Q8 hours | Max 500 mg/dose

OR
- **Ceftriaxone**:
  - 75mg/kg/dose IV Q24 hours | Max 2000 mg/dose
- **Metronidazole**:
  - 10 mg/kg/dose IV Q8 hours | Max 500 mg/dose

**Manage OFF-Pathway**

**Discharge Criteria**
- Tolerating PO
- Adequate urine output
- No persistent abdominal pain
- No persistent emesis
- No vital sign instability

For questions concerning this pathway, Click Here
Last Updated November 2, 2015
ADDENDUM 1

Patient Management Flow

- For all patients in the moderate and severe categories, abdominal ultrasound should occur in the Emergency Department.
- For patients in the low severity category, ultrasound may be performed in the radiology suite; however, if positive, patient should return to the emergency room for monitoring until able to complete air enema.
- For those patients in the low severity category for whom there is a low clinical suspicion for intussusception, PIV placement and bolus administration may be held until after ultrasound confirmation. Once confirmed, if outside of weekday standard working hours, patients should return to the emergency department for PIV placement and bolus administration. During weekday working hours PIV will be placed by the radiology RN.
- In severe patient cases, where there is a clinical concern for peritonitis or free air visualized on 2 view abdominal XR, a stat surgical services consult should be made to the attending surgeon on call.
- If perforation occurs during enema reduction, a stat surgical services consult should be made to the attending surgeon on call.

Early Discharge Following Enema Reduction

Historically, many hospitals have observed patients presenting with uncomplicated intussusception in the inpatient setting for 24-48 hours to monitor for recurrence with a medium length of stay of 2 days following enema reduction. A recent Meta-analysis by Gray et al examined 69 studies of intussusception recurrence in patients aged 0-18. Studies were divided by enema modality and controlled for quality. Overall recurrence rate for contrast enema (CE) was 11.6 (CI 10%-13.3%), 6.9% (CI 5.1%-9%) for ultrasound guided air enema (UGAE), and 7.7% (CI 5.6%-10%) for fluoroscopy guided air enema (FGAE). Recurrence rate in the first 24 hours following reduction was 2.7% (CI 1.2%-4.8%), 0.9% (CI 0.1%-4.8%), and 1.5% (0-6.2%) respectively, suggesting that the majority of recurrences would not be captured in a 24-hour hospitalization. Furthermore, multiple studies support the safety of outpatient management and repeat enema for recurrence. It is therefore reasonable to admit for a short 6-hour observation period following reduction and then discharge to home if meeting discharge criteria.

Pathologic lead points

The majority of intussusceptions are caused by hyperplasia of the lymphoid aggregates in the terminal ileum. In approximately 6% of patients, a pathologic lead point may be present. The presence of PLP increases with age with 5% occurring in ages 0-11 months and 60% occurring in children aged 5-14 years. Children with >1 recurrence or >1 discrete episodes of intussusception have a higher incidence of PLP. The most common PLP is a Meckel’s diverticulum. Other common causes include duplication cysts, intestinal polyp, lymphoma, and Henoch–Schönlein purpura. Ultrasonography is a useful modality to identify PLPs and may detect up to 64% of PLPs. Due to the high prevalence of Meckel’s diverticulum acting as a PLP, a Meckel’s scan is a reasonable imaging modality if PLP is suspected but not confirmed on ultrasound. CT can be a useful imaging study; however, in a study conducted by Daneman et al, CT failed to detect PLPs that had been missed by ultrasound. Further imaging and testing should be tailored to the individual cases.

Delayed Repeat Enema

Historically, children without complete reduction of intussusception following enema have undergone surgical reduction. Although there has been a significant trend away from surgical reduction for intussusception, the rate of operative intervention has been reported to be as high as 51% in some areas of the United States. There is an increasing body of evidence that supports the use of a delayed repeat enema (DRE-a repeat enema several or more hours after initial reduction attempt) to reduce well appearing children who have had a partial reduction with enema. It is felt that the interval time relieves venous congestion and edema thus facilitating the subsequent reduction attempt. In a retrospective cohort study of 4,980 children with intussusception, 502 underwent a DRE while 1,407 children underwent operative reduction. 26.7% of children in the operative group had bowel resections while 11.8% required bowel resection in the DRE group (AOR 2.50, 95% CI 1.83-3.41, p < 0.001). The time interval between initial reduction attempt and DRE has not been rigorously studied. Patient instability, perforation, peritonitis, and failure to move the intussusception are contraindications for DRE. DRE may be attempted for well appearing children with partial reduction of intussusception with coordination between radiology and primary surgical service.
Discharge Instructions for Intussusception

Your child was diagnosed with intussusception. This is a condition where a portion of intestine slides inside another portion. This happens in the same way that parts of a telescope slide inside each other when you close it. Blood supply to part of the intestine could then become blocked. This can cause severe damage if not treated. Intussusception can happen anywhere in the bowel. It is most common where the large intestine and small intestine meet. The cause of intussusception is often unknown.

A fluid or air enema is often used to both diagnose and treat the problem. A flexible tube is used to put fluid or air into the intestine. Then, special X-rays are taken. The force of the fluid or air entering the intestine often straightens it.

Home care

- Allow your child to return to normal activity as soon as he or she feels up to it.
- Watch your child for signs that the condition has returned. Intussusception can sometimes come back.
- Feed your child a normal diet.

Follow-up care

Make a follow-up appointment as directed by our staff.

When to call your child’s doctor

Call the doctor right away if your child has any of the following:

- Pain in the abdomen that comes and goes
- Constant pain in the abdomen that does not improve or seems to be worsening
- Vomiting
- Extreme sluggishness, tiredness, or fatigue
- Dark, mucus-like, bloody stools
- Pale skin color
- A rectal temperature of 100.4°F (38.0°C) or higher in an infant younger than 3 months
- A rectal temperature of 102°F (39.0°C) or higher in a child 3 to 36 months old
- A temperature of 103°F (39.4°C) or higher in a child of any age
- A fever that lasts more than 24 hours in a child younger than 2 years or for 3 days in a child 2 years or older
- A seizure caused by the fever
Instrucciones de alta para una intususcepción

A su hijo le diagnosticaron una intususcepción. Este es un trastorno en el cual una porción del intestino se introduce dentro de otra (se invagina) como las partes de un telescopio cuando se cierra. En consecuencia, el flujo de sangre en esa parte del intestino puede quedar bloqueado. Si se deja sin tratar, podría causar daños graves. Una intususcepción puede ocurrir en cualquier parte del intestino, pero suele ocurrir con mayor frecuencia cerca de donde el intestino grueso se une al intestino delgado. Su causa por lo general se desconoce.

Tanto para tratar como para diagnosticar el problema, suele usarse un enema de líquido o de aire. Se utiliza un tubo flexible para introducir líquido o aire en el intestino. Luego, se toman radiografías especiales. Por lo general la fuerza del líquido o del aire al entrar al intestino lo enderezan.

Cuidados en la casa

- Permita que su niño vuelva a su actividad normal tan pronto se sienta listo.
- Observe a su niño en caso de que haya señales de que su afección ha regresado, ya que a intususcepción a veces puede volver a presentarse.
- Dele a su niño una dieta normal.

Visitas de control

Programe una visita de control según le indique nuestro personal.

Cuándo debe llamar al médico

Llame al médico inmediatamente si su niño presenta cualquiera de los siguientes síntomas:

- Dolor abdominal que aparece y desaparece
- Dolor constante en el abdomen que no se alivia o parece empeorar
- Vómitos
- Lentitud, cansancio o fatiga extremos
- Deposiciones (heces) con sangre, oscuras o con mucosidad
- Palidez de la piel
References

19. Reijn J, C.
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