Clinical features of strangulation

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It is vital to distinguish strangulating from non-strangulating intestinal obstruction because the former is a surgical emer - gency . The diagnosis is clinical but may be aided by CT scanning as long as this does not delay surgical intervention. Summary box 78.8 Clinical features of strangulation - /uni25CF /uni25CF /uni25CF In addition to the features in Summary box 78.8 , it should be noted that: /uni25CF The presence of shock suggests underlying ischaemia. /uni25CF In impending or established strangulation, pain is never completely absent. /uni25CF The presence and character of any local tenderness are of great significance and, however mild, tenderness requires frequent reassessment. /uni25CF Generalised tenderness and the presence of rigidity indi - cates the need for early laparotomy . /uni25CF When pain persists despite conservative management, even in the absence of the above signs, strangulation should be presumed. /uni25CF When strangulation occurs in an external hernia, the lump is tense, tender and irreducible and there is no expansile cough impulse. Skin changes with erythema or purplish discoloration are associated with underlying ischaemia (Figures 78.9 and 78.10) .

Constant pain, severe pain Tenderness with rigidity and peritonism Shock

The classic presentation of intussusception is with episodes of screaming and drawing up of the legs in a previously well male infant. The attacks last for a few minutes and recur repeatedly . During attacks the child appears pale and between episodes may be listless. V omiting may or may not occur at the outset but becomes conspicuous and bile-stained with time. Initially , the passage of stool may be normal, whereas, later, blood and mucus are evacuated – the ‘redcurrant jelly’ stool. Whenever possible, examination should be undertaken between episodes of colic, without disturbing the child. Clas sically , the abdomen is not initially distended; a lump hardens on palpation may be discerned but this is present in only 60% of cases (Figure 78.11). There may be an associated feeling of emptiness in the right iliac fossa (the sign of Dance). On r ectal examination, blood-stained mucus may be found on the finger. Occasionally , in extensive ileocolic or colocolic intussusception, the apex may be palpable or even protrude from the anus. Unrelieved, progressive dehydration and abdominal dis tension from small bowel obstruction will occur, followed by peritonitis secondary to gangrene. Rarely , natural cure may occur as a result of sloughing of the intussusception. Differential diagnosis Acute gastroenteritis Although abdominal pain and vomiting are common in acute gastroenteritis, with occasional blood and mucus in the stool, diarrhoea is a leading symptom and faecal matter or bile is always present in the stool. Henoch–Schönlein purpura Henoch–Schönlein purpura is associated with a characteristic rash and abdominal pain; intussusception may occur.

Sausage-shaped lump. Concavity towards the umbilicus Figure 78.11 The physical signs as recorded by Hamilton Bailey in a typical case of intussusception in an infant.

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