

INTUSSUSCEPTION

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Most intussusceptions occur between 2 months and 2 years. More than 80% are ileocolic (Figure 17.10), beginning proximal to the ileocaecal valve with an apex in the ascending or transverse colon. Strangulation can progress to gangrene and perforation. The lead point is commonly viral-induced hyperplasia in a Peyer's patch, but a few have a pathological lead such as a Meckel's diverticulum, duplication cyst or a small bowel lymphoma. Pathological leads are found more commonly in those over 2 years and in a recurrence. A previously healthy infant presents with colicky pain, vomiting and drawing up their legs. Between episodes, they initially appear well. Later, they may pass a 'redcurrant jelly' stool. Signs include dehydration, abdominal distension and a palpable right upper quadrant mass. A plain radiograph shows small bowel obstruction, a mass and a paucity of gas in the right iliac fossa. A concentric target sign is seen on an abdominal ultrasound. An air reduction enema is attempted after resuscitation with intravenous fluids, broad-spectrum antibiotics and nasogastric drainage (Figure 17.11). Success is recognised if air flows into the small bowel and symptoms and signs resolve. An air enema is contraindicated if there is peritonitis, perforation or shock. More than 70% are reducible non-operatively . Strangulation and pathological lead points are unlikely to reduce. Colonic perforation during pneumatic reduction is rare. Recurrence occurs in 5% after non-operative reduction. Operative reduction is performed open or laparoscopically . An irreducible intussusception or one complicated by infarction or a pathological lead point requires resection. INTUSSUSCEPTION

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