

# Treatment of intussusception

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In the infant with ileocolic intussusception, after resuscitation with intravenous fluids, broad-spectrum antibiotics and naso gastric drainage, non-operative reduction can be attempted using an air or barium enema. Successful reduction can only be accepted if there is free reflux of air or barium into the small bowel, together with resolution of symptoms and signs in the patient. Non-operative reduction is contraindicated if there are signs of peritonitis or perforation, there is a known pathological lead point or in the presence of profound shock. In experienced units, more than 70% of intussusceptions can be reduced non-operatively. Strangulated bowel and pathological lead points are unlikely to reduce. Perforation of the colon during pneumatic or hydrostatic reduction is a recognised hazard but is rare. Recurrent intussusception occurs in up to 10% of patients after non-operative reduction. Surgery is required when radiological reduction has failed or is contraindicated. After resuscitation, a transverse right-sided abdominal incision provides good access. Reduction is achieved by gently compressing the most distal part of the intussusception towards its origin, making sure not to pull. The last part of the reduction is the most difficult (Figure 78.16). After reduction, the terminal part of the small bowel and the appendix will be seen to be bruised and oedematous. The viability of the whole bowel should be checked carefully. An irreducible intussusception or one complicated by infarction or a pathological lead point requires resection and primary anastomosis.

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