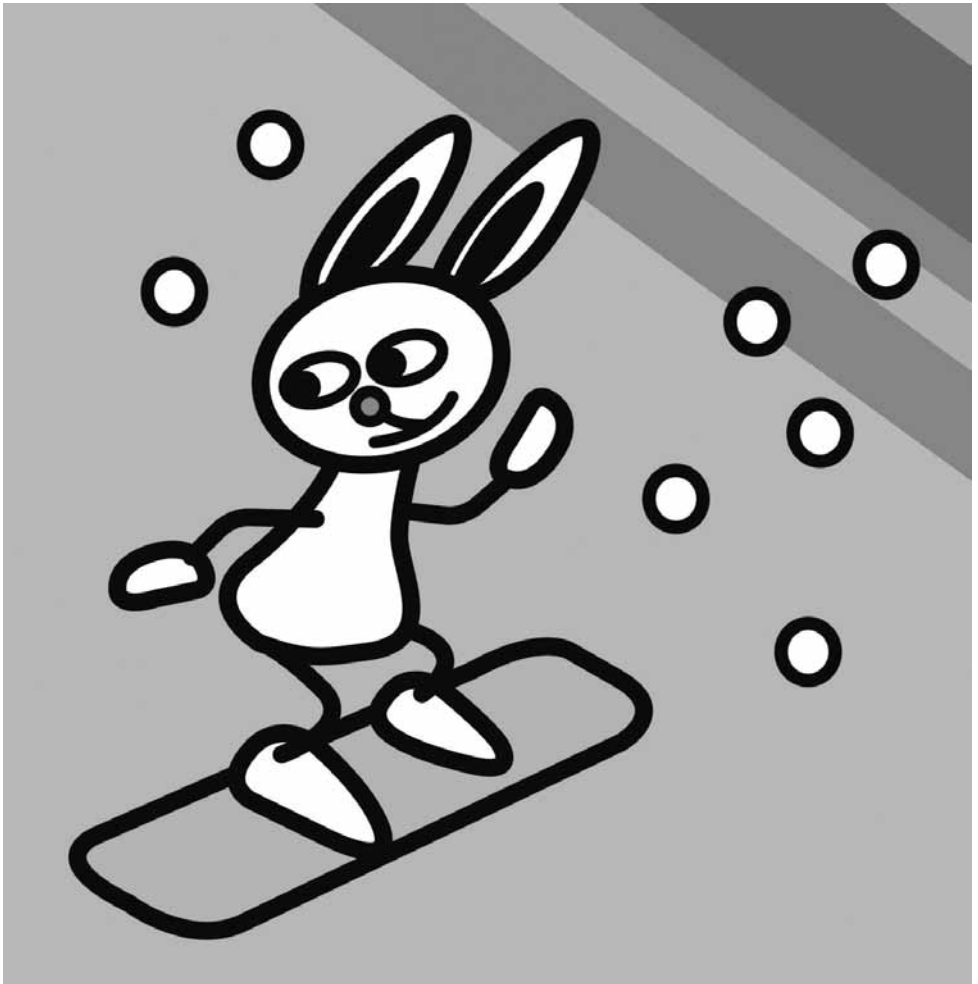


The Children's Hospital

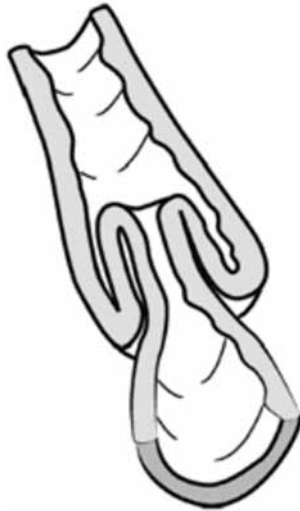
Intussusception and its treatment

Information for parents



What is intussusception?

Intussusception occurs when one part of the bowel slides into another part of bowel, like a telescope, causing the bowel to become blocked. It is the most common tummy emergency in small children, mostly between the ages of 3 months and 2 years. It needs urgent hospital attention. The cause is unknown, but may be linked to infections.



What are the symptoms?

Your child may have spasms of severe tummy pain that comes and goes, with drawing up the legs and inconsolable crying. Your child may vomit, which may become green. You may notice your child passing stools that are loose, mixed with blood and mucous, that may look like redcurrant jelly. You may also notice a lump or swelling on the tummy. If your child is dehydrated they may have fewer wet nappies or may be more sleepy than usual. They need to be seen by a doctor immediately.

How is intussusception diagnosed?

The doctor will ask you questions about the child ('take a history') and then examine your child. An ultrasound scan is done to confirm the diagnosis of intussusception. This is similar to a pregnancy scan and involves no radiation. An X-ray of the tummy may also be done.

How is intussusception treated?

A drip ('cannula') is put into your child's vein, to give fluids and antibiotics. A 'nasogastric tube' is often passed through the nose into the stomach to drain any stomach/bowel contents and get rid of any pressure that may build up due to the bowel blockage.

Air enema treatment

If the ultrasound scan confirms intussusception, the doctors first try a treatment called an 'air enema'. In this procedure air is introduced through a tube passed into your child's bottom while X-ray pictures are taken. The pressure of the air pushes back the telescoping parts of bowel ('reduction'), which can be seen directly on the X-ray images. This treatment is successful in about 8 - 9 out of every 10 patients.

Risks of air enema treatment

There is a small risk of bowel perforation (less than 1 in every 100 patients). There is also a chance (about 5 in every 100 patients) that the intussusception may come back again after successful air enema treatment.

Surgical treatment of intussusception

If air enema is unsuccessful in reducing the intussusception (several attempts may be tried) the child will need an operation. An operation will also be required if the child is very unwell on admission to hospital, or if the doctors suspect that the bowel

has perforated (burst) already. The operation is carried out under general anaesthetic. Your child will be asleep throughout the operation.

Before the operation

The surgeon will describe the operation in more detail to you and talk to you about any concerns you may have. An anaesthetist will also talk to you about the anaesthetic. If your child has any medical problems, such as allergies, please tell the doctor. The surgeon will also ask for your written consent for the operation to go ahead. If there is anything you are unsure about, or if you have any questions, please ask the doctor before signing the consent form.

In the anaesthetic room

A nurse and parent can accompany the child to the anaesthetic room, and stay there until your child is asleep. It may be possible to give the anaesthetic with your child sitting on your lap. Your child can either have anaesthetic gas to breathe or an injection through a cannula (a thin plastic tube that is placed under the skin, usually on the back of the hand). Local anaesthetic cream (EMLA or Ametop, sometimes known as 'magic cream') can be placed on the hand or arm before injections so they do not hurt so much. It works well for 9 out of 10 children.

If the anaesthetic is given by gas, it will take a little while for your child to be anaesthetised. They may become restless as the gases take effect. If an injection is used, your child will normally become unconscious very quickly indeed. Some parents may find this frightening.

Once your child is asleep, you will be asked to leave promptly. Your child will then be taken into the operating theatre to have the operation. The anaesthetist will be with your child at all times.

Anaesthetic risks

In modern anaesthesia, serious problems are uncommon. Risk cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. Throughout the whole of life, an individual is at least 100 times more likely to suffer serious injury or death in a road traffic accident than as a result of anaesthesia.

Most children recover quickly and are soon back to normal after their operation and anaesthetic. Some children may suffer side effects like sickness or a sore throat. These usually last only a short time and there are medicines available to treat them if necessary.

The exact likelihood of complications depends on your child's medical condition and on the nature of the surgery and anaesthesia your child needs. The anaesthetist can discuss this with you in detail at the pre-operative visit.

During the operation

An incision is made to open the tummy and the bowel is exposed. The surgeon gently separates the telescoping segments of bowel. If any bowel tissue has died due to lack of blood supply, or if any obvious cause ('lead point') of the intussusception is found, this affected segment needs to be cut out ('resection'). The two surrounding ends are then stitched back together (this is called 'primary anastomosis').

What are the risks of the operation?

This is a safe operation and the risk of complications is small. However, all operations carry some risks. The doctor will talk to you about the risks in more detail. The following complications have a less than 5 in 100 chance of happening:

Bleeding – very rarely blood lost in the operation may cause your child to require a blood transfusion.

Wound infection – this can be treated with antibiotics.

Recurrence of intussusception – if the bowel has been separated without cutting out the affected part the chance of this is less than 1 in 100 patients.

Adhesions – any abdominal surgery has the risk of adhesions – when the bowel becomes sticky, leading to bowel obstruction. This may occur months to years after the surgery. Signs to look out for are: your child vomiting green bile, swelling of the tummy, and your child not passing stool. If this happens, bring your child back to hospital immediately.

After the operation

Before your child wakes they will be given pain relieving medicine. You will be able to rejoin your child in the recovery room as soon as they are awake. Initially, your child will not be able to have any feeds by mouth, to allow the stomach and intestines to rest. They will receive fluids through an intravenous drip, and their milk feeds will slowly be increased as advised by the surgeon.

Discharge

Your child will be in hospital for several days, and discharged once they are feeding normally. Your child may have a sore tummy for a few days, but can have pain-relieving medicine for this. The stitches used in theatre are dissolvable, so will disappear within a week. Your surgeon will want to see you in clinic in a few months time to check that all is well.

Contacts and telephone numbers

If you have any problems after you get home, please contact your GP. Otherwise, you can phone the ward for advice on:

Tom's Ward **01865 234108** or **234109**

JR Switchboard **01865 741166**

Further information

If you have any questions, or there is anything you don't understand, please ask one of the doctors or nurses.

If you need an interpreter or need a document in another language, large print, Braille or audio version, please call **01865 221473** or email **PALSJR@orh.nhs.uk**

Dr V Sreeharan, Dr Rachel Taggart and Miss Kokila Lakhoo
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Oxford Radcliffe Hospitals NHS Trust
Oxford OX3 9DU
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