

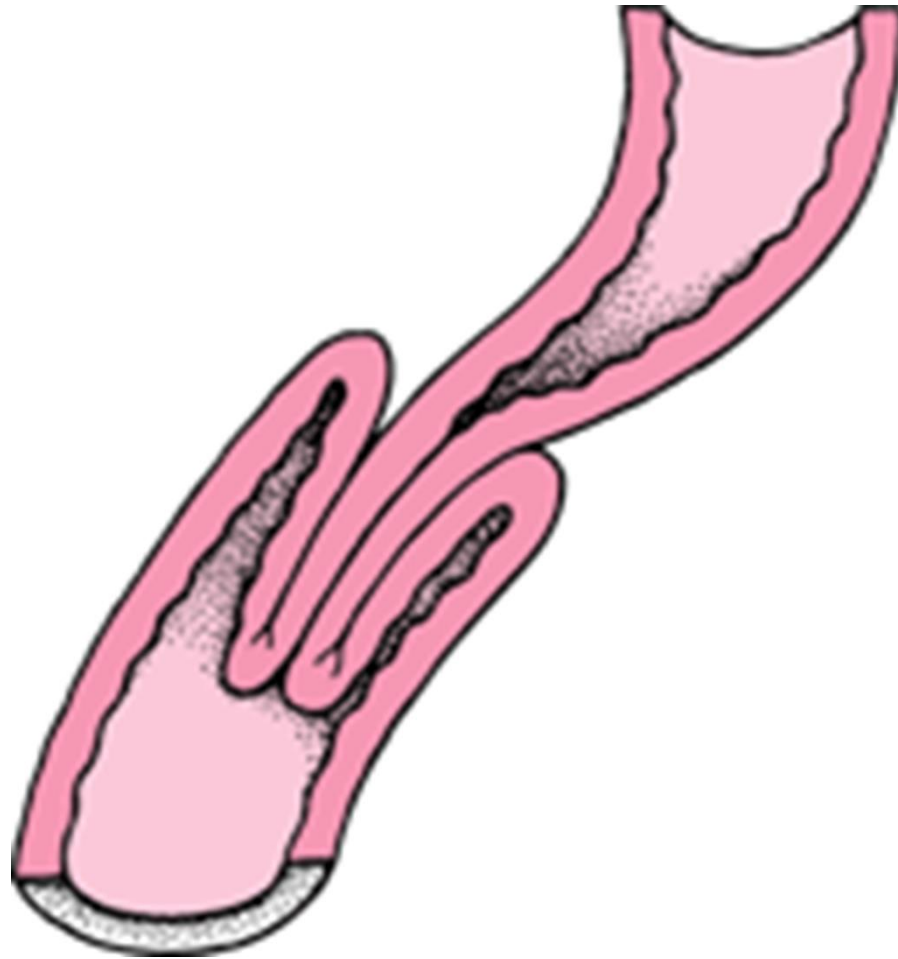
Intussusception

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PEDIATRIC SURGEON**

Intussusception

- Intussusception is the most frequent cause of bowel obstruction in infants and toddlers.
- It is an acquired invagination of the proximal bowel (intussusceptum) into the distal bowel (intussusciens).

PATHOPHYSIOLOGY





Primary Intussusception

- The vast majority(90%) of cases do not have a lead point and are classified as primary or idiopathic intussusceptions.
- The cause is generally attributed to hypertrophied Peyer patches within the bowel wall (upper respiratory tract infection or an episode of gastroenteritis).

Secondary Intussusception

- An intussusception may have an identifiable lesion that serves as a lead point (up to 10%)
- most common lead point is a Meckel diverticulum followed by polyps and duplications.

- Most patients are well-nourished, healthy infants, and approximately two-thirds are boys.
- The highest incidence occurs in infants between ages 4 and 9 months.
- Intussusception is uncommon below 3 months and after 3 years of age.

DIAGNOSIS

- **CLINICAL PRESENTATION:-** The classic presentation is an infant or a young child with intermittent, crampy abdominal pain associated with 'currant jelly' stools and a palpable mass on physical examination(classic triad)





□ VIDEO



- The obstruction progresses and becomes associated with bilious emesis and increasing abdominal distention

RADIOLOGY

- Abdominal Radiography.
- Ultrasonography.
- Computed Tomography
- Magnetic resonance Imaging.



TREATMENT

- NONOPERATIVE MANAGEMENT:-
- An air or contrast enema is first-line treatment.
- Contraindications:- Include intestinal perforation (free intra-abdominal air), peritonitis, persistent hypotension.

- Successful reduction(to 95%).
- OPERATIVE MANAGEMENT:- is needed when nonoperative reduction is unsuccessful or incomplete,, the presence of a lead point, the same contraindications of enema







Thank you