Summary and Conclusion

Intussusception is a classic topic in pediatric surgery with along and fascinating medical history.

Intussusception is one of the common causes of intestinal obstruction in children in which there is invagination of a proximal bowel segment into an adjacent distal segment of intestine.

It typically occurs in infants and young children between the ages 4 months and 2 years with a peak incidence between 6 and 9 months of age, making it the most common cause of intestinal obstruction in young children.

No intrinsic abnormality is found in 90% of cases (idiopathic intussusception), but there are anatomical predisposing factors which probably may lead to its occurrence.

Clinically, an otherwise healthy infant of 6-9 months of age develops sudden severe colicky abdominal pain with intermittent vomiting; there are periodic episodes of irritability and crying with the infant drawing up both legs onto the abdomen every 20-30 minutes. Between bouts of colic, the young child may initially appear to be comfortable; but, if the intussusception is not reduced, he will become progressively more ill-appearing, demonstrating lethargy, weakness and exhaustion. Vomiting follows and may become bilious. A normal stool may be passed followed by passage of blood from the anus, the form of pink mucous or the typical red currant jelly stools.

A classic triad is often described, consisting of abdominal pain, vomiting, and currant jelly stool.

There is a pathognomonic physical finding in intussusception known as Dance's sign; it is the finding of a sausage shape mass felt anywhere in the abdomen except in the right iliac fossa.

Enemas (both barium and air) are diagnostic with close to 100% accuracy. Enemas also have the added benefit therapeutic reduction**.**

Ultrasonography is used more frequently to diagnose intussusception as it offers several diagnostic advantages as compared to enema, as; there is no radiation exposure, lower cost, in addition, it can some times identify other potential etiologists for the patient's symptoms.

Surgery is not recommended as the primary treatment but non-surgical reduction (NSR) is used, the mainstay of treatment of intussusception in infancy and childhood is initially by non- surgical methods of reduction, while surgical treatment is reserved for use when enema reduction has failed or is contraindicated.

Different contrast media are used for NSR; barium suspension or air with fluoroscopic guidance or saline only or mixed with water-soluble contrast under sonographic guidance has to be used. NSR is an effective technique, being successfully employed in more than 90% of cases.

Operative reduction is necessary, however, for those patients in whom radiologic reduction is unsuccessful, for those where a pathological lead point is suspected, and for those with multiple recurrences.

Recurrent intussusception is a well recognized association with intussusception, aiming to prevent recurrence, many attempts have been made to stabilize the ileocecal region; however no scientific evidence has supported these procedures.

It is concluded that early diagnosis is a must if non-operative methods of reduction will be tried for treatment of intussusception otherwise surgery will be the only method of treatment especially for recurrent cases.