Passage of red, currant jelly–like stools (stool mixed with blood and mucus)

Tender, distended abdomen

Palpable sausage-shaped mass in upper right quadrant

Empty lower right quadrant (Dance sign)

Eventual fever, prostration, and other signs of peritonitis

## Therapeutic Management

Conservative treatment consists of radiologist-guided pneumoenema (air enema) with or without water-soluble contrast or ultrasound-guided hydrostatic (saline) enema, the advantage of the latter being that no ionizing radiation is needed (Kennedy and Liacouras, 2016). Recurrence of intussusception after conservative treatment is rare; however this procedure should not be attempted with prolonged intussusception, signs of shock, peritoneal irritation, or intestinal perforation (Kennedy and Liacouras, 2016).

IV fluids, NG decompression, and antibiotic therapy may be used before hydrostatic reduction is attempted. If these procedures are not successful, the child may require surgical intervention. Surgery involves manually reducing the invagination and, when indicated, resecting any nonviable intestine.

### Prognosis

Nonoperative reduction is successful in approximately 65% to 75% of cases (Gourlay, 2013). Surgery is required for patients in whom the hydrostatic enema is unsuccessful. With early diagnosis and treatment, serious complications and death are uncommon.

## Nursing Care Management

The nurse can help establish a diagnosis by listening to the parent's description of the child's physical and behavioral symptoms. It is not unusual for parents to state that they thought something was seriously wrong before others shared their concerns. The description of the child's severe colicky abdominal pain combined with vomiting is a significant sign of intussusception.