

As soon as a possible diagnosis of intussusception is made, the nurse prepares the parents for the immediate need for hospitalization, the nonsurgical technique of hydrostatic reduction, and the possibility of surgery. It is important to explain the basic defect of intussusception. A model of the defect is easily demonstrated by pushing the end of a finger on a rubber glove back into itself or using the example of a telescoping rod. The principle of reduction by hydrostatic pressure can be simulated by filling the glove with water, which pushes the “finger” into a fully extended position.

Physical care of the child does not differ from that for any child undergoing abdominal surgery. Even though nonsurgical intervention may be successful, the usual preoperative procedures, such as maintenance of NPO status, routine laboratory testing (CBC and urinalysis), signed parental consent, and preanesthetic sedation, are performed. Children with perforation will require IV fluids, systemic antibiotics, and bowel decompression before undergoing surgery. Fluid volume replacement and restoration of electrolytes may be required in such children before surgery. Before surgery, the nurse monitors all stools.

Nursing Alert

Passage of a normal brown stool usually indicates that the intussusception has reduced itself. This is immediately reported to the practitioner, who may choose to alter the diagnostic and therapeutic care plan.

Post-procedural care includes observations of vital signs, blood pressure, intact sutures and dressing, and the return of bowel sounds. After spontaneous or hydrostatic reduction, the nurse observes for passage of water-soluble contrast material (if used) and the stool patterns because the intussusception may recur. Children may be admitted to the hospital or monitored on an outpatient basis. A recurrence of intussusception is treated with the conservative reduction techniques described earlier, but a laparotomy is considered for multiple recurrences.

Malrotation and Volvulus