NGN NCLEX 2026 · PEDIATRIC GI EMERGENCY

Intussusception

Telescoping bowel · The pediatric obstruction you cannot miss

System: Pediatric GI | Peak Age: 6-36 mo | ⚡ Surgical Emergency | M > F (4:1)

SOURCE DISCLOSURE

This topic was not covered in your uploaded personal notes. Content compiled from standard NCLEX references: *Saunders Comprehensive Review for the NCLEX-RN (Silvestri, 9th ed.)*, *ATI Nursing Care of Children Review Module*, *Lippincott Pediatric Nursing*, and *American Academy of Pediatrics (AAP) clinical guidelines on pediatric GI emergencies*.

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Definition & Overview

// WHAT IT IS AND WHY IT MATTERS

- **Intussusception** = invagination/telescoping of one segment of bowel (proximal) into the lumen of an adjacent segment (distal) — most commonly the **ileocecal junction** (ileum into cecum).
- **#1 cause of intestinal obstruction** in children 3 months – 6 years of age. Peak incidence: **5–9 months**.
- Most cases are **idiopathic**. In older children, look for a *pathologic lead point* — Meckel's diverticulum, polyp, lymphoma, Henoch-Schönlein purpura, or recent viral illness (adenovirus, rotavirus).
- **Time-critical:** Untreated → bowel ischemia → necrosis → perforation → peritonitis → shock → death.

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Pathophysiology

// STEP-BY-STEP MECHANISM

01	02	03	04	05	06
Bowel segment **telescopes** into adjacent segment →	Mesentery is **dragged in** & compressed →	**Venous congestion** + edema of bowel wall →	Mucus + blood ooze → **"currant jelly" stool** →	Arterial supply cut → **ischemia** →	**Necrosis → perforation → peritonitis → shock**

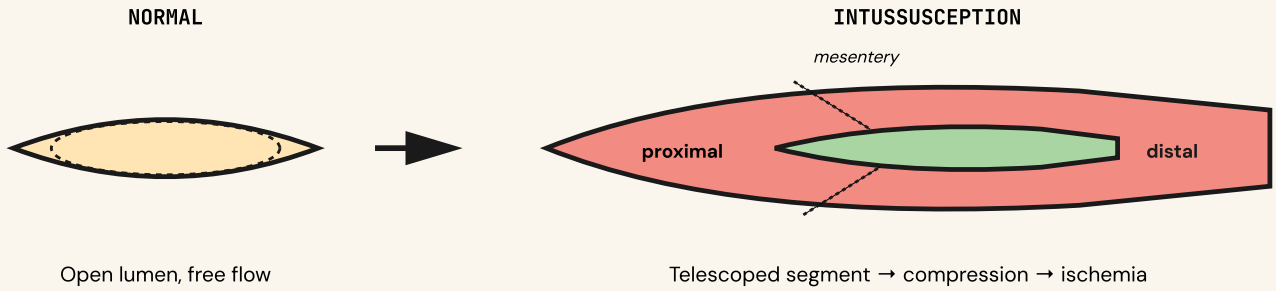

FIG. 1 — BOWEL SEGMENT INVAGINATING INTO ADJACENT LUMEN

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Signs & Symptoms

// THE CLASSIC TRIAD & BEYOND

EARLY · CLASSIC TRIAD

What you see first

- **Sudden, severe, intermittent abdominal pain** — episodes every 15–20 min
- Infant draws **knees to chest**, screams, then becomes quiet/limp between episodes
- **Vomiting** — initially non-bilious, becomes **bilious** as obstruction worsens
- Pallor & diaphoresis during pain episodes

LATE · ISCHEMIA

Red flags — bowel is dying

- **"Currant jelly" stool** — dark red, mucousy blood (LATE sign, indicates ischemia)
- **Sausage-shaped mass** palpable in **RUQ**
- **Dance sign** — empty/flat RLQ on palpation
- Distended, rigid, tender abdomen
- **Lethargy** out of proportion to illness (looks neurological)
- Fever, tachycardia, hypotension → **shock**

CRITICAL PEARL

CURRANT JELLY STOOL IS A LATE FINDING — it means bowel wall is already ischemic and sloughing. Do *not* wait for it to act. Sudden, severe, intermittent pain in an infant + drawing knees up = treat as intussusception until proven otherwise.

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Priority Nursing Interventions

// ABC + SAFETY FRAMEWORK

A Airway

- Position to prevent aspiration if vomiting
- HOB elevated; suction at bedside
- NPO status — **nothing by mouth**

B Breathing

- Assess RR, work of breathing, SpO_2
- Watch for shallow breathing 2° abdominal distension
- Supplemental O_2 if needed

C Circulation

- **IV access** — fluid resuscitation (NS or LR bolus)
- Monitor HR, BP, cap refill, urine output
- Watch for shock — tachycardia + hypotension late

Additional priorities

1. **NPO** — strict; prepare for procedure or surgery.
2. **Insert NG tube** to low intermittent suction for **gastric decompression** and to relieve distension.
3. **Monitor stools** — document every stool (color, consistency, presence of blood/mucus). *Passage of normal brown stool is a key reportable finding* (see Test Traps below).
4. **Pain management** per order — assess using age-appropriate scale (FLACC for infants).
5. **Strict I&O**, daily weight, monitor electrolytes.
6. Continuous abdominal assessment: girth, bowel sounds, rigidity, tenderness.
7. Prepare family and child for **air enema** or **hydrostatic (contrast) enema** — diagnostic AND therapeutic in ~80–90% of cases.
8. Provide emotional support to caregivers — sudden, frightening illness.

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Diagnostics & Treatment

// HOW IT'S CONFIRMED AND REDUCED

DIAGNOSTIC

Confirming the diagnosis

- **Ultrasound** — gold standard; shows classic *"target" or "bull's-eye"* sign
- **Abdominal X-ray** — may show obstruction, air-fluid levels, or absence of cecal gas
- **CBC** — leukocytosis suggests necrosis/perforation
- Stool guaiac — occult blood

THERAPEUTIC

Non-surgical reduction (first line)

- **Air (pneumatic) enema** — preferred; safer, less perforation risk
- **Hydrostatic enema** — saline or water-soluble contrast under fluoroscopy
- Success rate: **80–90%**
- If unsuccessful, perforated, or unstable → **surgical reduction** (manual reduction or bowel resection if necrosis)

✓ SIGN OF SUCCESSFUL REDUCTION

PASSAGE OF NORMAL, FORMED BROWN STOOL after enema = bowel has un-telescoped. *This must be reported and documented immediately* — it is the most reliable bedside indicator of treatment success.

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Pharmacology

// SUPPORTIVE — NO CURATIVE DRUG

DRUG / CLASS	PURPOSE	KEY NURSING CONSIDERATIONS
0.9% NS or LR (IV crystalloid)	Fluid resuscitation; correct dehydration from vomiting/3rd-spacing	Bolus 20 mL/kg; reassess after each bolus; strict I&O
Broad-spectrum antibiotics (e.g., ampicillin + gentamicin + metronidazole)	Prophylaxis if perforation suspected or pre-op	Check allergies; trough levels for aminoglycosides; monitor renal function
Analgesics (acetaminophen IV, morphine, fentanyl)	Pain control	FLACC pain scale; monitor RR & sedation; avoid masking peritoneal signs preoperatively
Antiemetics (ondansetron)	Control nausea/vomiting	Watch QT interval; ECG if multiple doses
Electrolyte replacement (K^+)	Correct losses from vomiting / NG suction	Never IV push K^+; verify urine output before replacement

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NCLEX Test Traps ⚠

// WHERE STUDENTS LOSE POINTS

✗ WRONG ANSWER TRAP	✓ RIGHT THINKING
Waiting for "currant jelly stool" before suspecting intussusception.	Currant jelly stool is a **LATE** sign of ischemia. The earliest cue is **sudden, severe, intermittent abdominal pain with drawing knees to chest**.
"Notify the provider that the child passed a normal brown stool" is unimportant.	Passing a **normal brown stool after an enema = SUCCESSFUL reduction**. This IS the priority finding to report and document.
Confusing intussusception with **pyloric stenosis**.	**Pyloric stenosis**: neonate (3–6 wk), *projectile non-bilious* vomiting, olive-shaped mass RUQ, hungry after vomiting. **Intussusception**: infant 6–36 mo, intermittent pain + knees to chest, currant jelly stool, sausage mass.
Giving the child clear liquids to keep them comfortable.	Maintain strict **NPO** status. Anything by mouth risks aspiration and complicates surgery if needed.
Selecting "administer pain medication" as the first action.	**Airway, breathing, circulation first.** Establish IV access + fluid resuscitation + NPO + NG decompression before analgesia. Don't mask peritoneal signs pre-op.
Assuming lethargy means dehydration only.	**Profound lethargy** in a child with intussusception is an ominous sign — it may mimic a neurological event and can be the *only* presenting symptom in some infants. Escalate immediately.

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Patient & Family Education

// DISCHARGE TEACHING PRIORITIES

RECURRENCE

Watch for return of symptoms

- Recurrence rate is **~10%**, usually within **24–72 hours** of reduction
- Return to ER immediately if: sudden severe crying with knees pulled up, vomiting, bloody stool, lethargy, or refusing to eat
- Most recurrences happen *after* discharge — parents must know the early signs

RECOVERY

Home care after discharge

- Resume **regular diet gradually** — start with clear liquids, advance as tolerated
- Expect **loose or watery stools for a few days** after enema (this is normal)
- Follow-up with pediatrician as scheduled
- Notify provider for fever >101°F, persistent vomiting, abdominal distension, or no stool 24 hr after discharge
- Reassure: most children recover fully with no long-term effects

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Memory Boosters & Mnemonics

// LOCK IT IN FOR TEST DAY

🎯 The 5 P's of Intussusception

- **P** **Pain** — sudden, severe, intermittent, episodic
- **P** **Pallor** — during pain episodes
- **P** **Pulling knees up** — infant draws legs to chest
- **P** **Palpable sausage-shaped mass** — in RUQ
- **P** **Passage of currant-jelly stool** — LATE; blood + mucus

🔭 Telescope analogy

Picture an old hand telescope collapsing into itself — one section slides inside the next. That's literally what the bowel does. The image makes the picture unforgettable on test day.

🥧 Currant jelly = *late*

Jelly is what's *left over* after squeezing the fruit. Currant jelly stool is what's *left over* after the bowel has been ischemic long enough to slough — by then, hours have passed. **Never wait for jelly to act.**

🩺 "Dance sign" — empty RLQ

When the ileum is sucked up into the cecum, the right lower quadrant feels **empty** on palpation. That emptiness "dances" away from your hand — a classic physical exam pearl named after Dr. Dance.

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NCJMM Clinical Judgment Scenario

// 6-STEP NEXT GENERATION NCLEX WALKTHROUGH

CASE

A 9-month-old male is brought to the ED by his mother. She reports that for the past 6 hours he has had episodes of sudden, severe crying lasting about 2 minutes every 15–20 minutes, during which he pulls his knees up to his chest. Between episodes he is quiet and "looks limp." He has vomited 3 times, the last episode green-tinged. T 100.2°F, HR 168, RR 42, BP 78/48, SpO_2 97%. Abdomen distended; a sausage-shaped mass is palpated in the RUQ. The diaper contains dark red, mucus-like stool.

1 RECOGNIZE CUES

What stands out?

Age 6–36 mo · episodic severe pain · knees to chest · bilious vomiting · sausage-shaped RUQ mass · currant jelly stool · tachycardia · hypotension for age · lethargic between episodes.

2 ANALYZE CUES

What do the cues mean?

Classic triad + late ischemic findings →

intussusception with established bowel compromise

. Currant jelly stool indicates the bowel wall is already sloughing. Tachycardia + relative hypotension + lethargy → impending hypovolemic shock from third-spacing and possible perforation.

3 PRIORITIZE HYPOTHESES

Most likely → least likely

① Intussusception with bowel ischemia (most likely). ② Volvulus (similar age range but more sudden, more toxic). ③ Incarcerated hernia. ④ Gastroenteritis with dehydration (does not explain mass or bloody stool).

4 GENERATE SOLUTIONS

What interventions are needed?

NPO · large-bore IV × 2 · NS bolus 20 mL/kg · NG to low intermittent suction · labs (CBC, CMP, type & cross) · abdominal ultrasound (target sign) · notify surgeon & radiology · prepare for air enema vs. surgical reduction · continuous monitoring · pain management once stabilized · family support.

5 TAKE ACTION

In what order?

(1) ABC — position, O_2 if needed. (2) IV access & NS bolus. (3) NPO + NG decompression. (4) Stat labs + ultrasound. (5) Surgical consult + radiology for air enema. (6) Continuous reassessment of VS, abdomen, mental status. (7) Educate mother and obtain consent.

6 EVALUATE OUTCOMES

How will you know it's working?

✓ HR returns to normal range for age (<160) · ✓ BP rises to age-appropriate baseline · ✓ Cap refill < 2 sec · ✓ Urine output ≥ 1 mL/kg/hr · ✓ Pain episodes stop · ✓

Passage of normal brown stool after enema

(key reduction marker) · ✓ Abdomen soft, non-distended · ✓ Tolerating clear liquids before discharge · ✓ Parents verbalize signs of recurrence and when to return.