THE DIAGNOSIS OF CHRONIC INTUSSUSCEPTION IN CHILDREN

WITH AN ACCOUNT OF THREE CASES

BY

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Chronic intussusception in children is uncommon. As a clinical entity it is not well known. Still (1921) gives the clearest account:

'On a particular day the child seemed to have pain in the abdomen and vomited once or twice. During the next few days he occasionally vomited, generally in association with a colicky pain. The vomiting has become less frequent, only once in two or three days, and the pain is only occasional. The bowels, which before were open daily, have since the onset been less regular, aperients have been necessary, but when given have worked well and the stools have been normal; there has been no blood in the stool or at most there has only been a streak once or twice, such as might be seen on the stool of any constipated child. The symptom which has troubled the parents most is the wasting; the child after three or four weeks of these vague troubles is obviously getting thin. The temperature throughout has been normal. Such is the history, and with a duration of some weeks even the finding of a more or less definite lump in the abdomen may hardly raise a suspicion of intussusception, especially when the mother's chief complaint is the wasting. Nevertheless, it is by the detection of the more or less sausage-shaped tumour, and especially by its varying consistency from moment to moment during palpation, that the diagnosis is to be made; to the tactus eruditus also the unnatural emptiness of the right iliac fossa (Dance's sign) may be useful confirmatory evidence, as in the ordinary acute intussusception.'

The purpose of this paper is to describe three cases, which, though conforming to Still's description in some respects, were not diagnosed for a long time, owing to the apparent absence of an abdominal tumour in two of the cases. Previous case reports are given in an appendix.

Case records

CASE 1324. (43). A boy aged seven-and-a-half years was referred to the Radcliffe Infirmary by Dr. W. Stobie on November 12, 1942.

When two-and-a-half years old he was admitted to a hospital in Chester with a sudden attack of severe abdominal pain. No operation was performed and he recovered within two days. In March, 1939, he was admitted to the private ward of the Radcliffe Infirmary with a purpuric rash and

pain and swelling of various joints. Some days previously he had complained of abdominal pain. His bowels were constipated, but there was never any blood in his stools and nothing abnormal was felt in his abdomen. The diagnosis was a purpura of the Henoch-Schönlein type, but its exact etiology was not determined.

After his discharge from hospital he was kept under periodic observation. His general health remained good but he continued to have attacks of abdominal pain. Each attack seemed to follow increasing constipation. It was not accompanied by fever, bruising or purpura, but he was said to look very pale. The pain was of a colicky nature and it usually passed off in the night. These attacks recurred about once a month.

The last attack started five days ago and was characterized by severe abdominal pain, which caused him to scream. The pain was centred around the umbilicus and occurred in spasms about every hour. It was severe for two days and then seemed to subside, but it returned about twelve hours before admission, and his bowels were moved for the first time since the onset of the pain. The motions were normal.

On examination, he was an alert, intelligent and co-operative boy. He looked healthy, but at times was troubled with bouts of pain. His pulse and respirations were normal. There was some resistance in the abdomen to the left and slightly below the umbilicus, which seemed to be due to hardening of the left rectus. The signs were unaltered during the paroxysms of pain. The next day he was much better and in the following ten days he had only one or two spasms of pain. On account of his previous history, various haematological investigations were carried out, but all revealed normal findings. Dr. V. Walker made certain skin tests but no food allergy was detected. A barium meal was advised and this was given on January 19, 1943. The stomach and duodenum were normal, but the follow-through (fig. 1) revealed an intussusception with its apex reaching just beyond the hepatic flexure of the transverse colon. No attempt was made to reduce it. At operation (Mr. D. C. Corry) the intussusception was reduced by manipulation. There were no adhesions, but the gut was swollen and slightly reddened. Appendicectomy was performed and one large mesenteric gland was removed, the histological examination of which did not show any specific lesion.

FIG. 1.

Convalescence was uneventful until February 10, when he was re-admitted with severe intestinal colic of seven hours duration. Laparotomy revealed a loop of small bowel bound down by adhesions. The adhesions were divided and he made a good recovery. Seven months later, his mother reported that he was quite well.

Comment. It is not known for certain how long this boy had had an intussusception, but his history suggests that it first happened when he was two-and-a-half years old, i.e. five years ago. On this occasion, spontaneous reduction must have occurred, for he remained free from symptoms for about two years. Three years ago he had an illness which was in the nature of a toxic reaction of the Henoch-Schönlein type, and there can be little doubt that the intussusception was caused at this time, for thereafter he had attacks of pain about once a month. Despite the long standing illness, the boy's condition remained good and there was no wasting. The true diagnosis was never suspected because no abdominal tumour was palpated even during the paroxysms of pain. The radiological examination gave conclusive evidence of intussusception.

CASE 8340. (43.) R. S., a boy aged eight years, four months, was admitted on April 25, 1943, with the following history:

On March 31, on returning home from school, he collapsed on the sofa. During that night he complained of pain in the lower abdomen, vomited undigested food and passed a loose motion in which there were streaks of blood. The following day his family doctor made a diagnosis of gastro-enteritis. He was kept in bed for three days on a

milk diet, and then as he seemed better, he was allowed to get up. The same evening he had another attack, which was similar to the first, but more severe. On this occasion he was sent to the Victoria Hospital at Swindon. Here, it was found that the right side of the abdomen was tender and that there was some muscular guarding. The pulse and temperature were normal. Among the conditions which were considered were intussusception, tuberculous enteritis and acute appendicitis. At first he was constipated, but on the third and fourth days his bowels opened naturally, abnormally large stools being passed. The tenderness disappeared and the Mantoux tuberculin test proved negative. A consulting physician suggested that as he seemed quite well, he was discharged from hospital (April 18).

On the evening of his return home, he had another attack. Three days later he had yet another, and on this occasion he complained of much pain and six hours later passed about five ounces of blood. Two days later he was admitted to the Radcliffe Infirmary. He was now so pale that his doctor sent him for a blood transfusion.

His mother stated that before the illness began the boy had been a ravenous eater, but recently his appetite had been very poor. She thought that he had lost a lot of weight. He had never been a robust child, but had had no other severe illnesses. His mother's eldest brother died from tuberculous peritonitis, but there was no other case of tuberculosis in the family.

On examination he was a spare, rather sallow boy with a slight malar flush. His rectal temperature was 100° F. There was some slight resistance to palpation, particularly on the right side of the abdomen, but no apparent tenderness. The liver and spleen were not palpable. The rectum was full of soft, normal coloured faeces and there was no blood on the examining finger.

During the first ten days he lay listlessly in bed, sometimes complaining of pain in the left hypochondrium. His appetite was poor and he vomited five times. On May 7 he was seen by Prof. L. Findlay, who noted that the abdomen was full, especially in the left epigastrium and hypochondrium. He detected an indefinite mass running from the left hypochondrium to slightly above the midline just above the umbilicus; it could just be felt on rectal examination. Irritation of the abdominal wall induced peristaltic waves running from left to right along the line of the mass, apparently in the stomach.

Three days later, careful palpation of the abdomen revealed that the lower border of the mass extended from below the costal margin to beyond the midline, just above the umbilicus, and it could be seen bulging the abdominal wall. The upper border was less well defined. The mass was not attached to the abdominal wall and it moved with respiration. It was dull to percussion and continuous with splenic dullness. Later the same day, the tumour changed its position slightly and one of us thought that it could be felt to grow harder and softer. Two days later there was little change.

The diagnosis was not clearly determined. The question of intussusception was considered, but because of the position of the tumour and the route of the peristalsis, it seemed that there might be a tumour affecting the stomach and, for this reason, a

FIG. 2.

barium meal was requested. This was carried out on May 13. The stomach and duodenum were normal, but a follow-through (fig. 2) revealed an intussusception of the ileo-caecal variety, with its apex just beyond the splenic flexure. It was decided to attempt to reduce it with a barium enema under observation with the fluorescent screen. The enema forced the apex of the intussusception backwards into the ascending colon, but the intussusception could not be completely reduced. The boy experienced only slight discomfort from this procedure and until his operation remained quite well.

On May 20 the child was operated upon and found to have an ileo-caecal intussusception. It could not be reduced by manipulation, and the base of the caecum and the appendix had to be excised. No cause was seen. The child made an uneventful recovery, and six weeks later he was quite well.

Comment. On looking back it will be seen that the history was typical. It began with a sudden attack, characterized by collapse, abdominal pain, vomiting and the passage of blood-stained faeces, from which he recovered within three days. Later, there were many other similar attacks and on one occasion he passed a considerable quantity of blood per rectum. The child's appetite failed and he lost a lot of weight. At first no abdominal tumour was recognized and for a long time the diagnosis of intussusception was never seriously entertained. Later, careful palpation disclosed a tumour, but even then the diagnosis was not obvious, for in some respects its physical characters were misleading. On the contrary, the radiological

findings gave conclusive evidence of the true nature of the complaint.

CASE 3. A.G., a boy aged seven years, was admitted to the Radcliffe Infirmary under the care of Dr. A. Cooke on August 31, 1944. He had been perfectly well until two months ago, when after eating gooseberries he complained of a pain in his stomach. The pain came on quite suddenly, but only lasted a minute or two and then passed off. Next day, he was off his food and vomited everything he took by mouth, but he had no further pain. His doctor saw him three days later. He was emaciated and had a tumour running across the epigastrium, downwards and obliquely from left to right. The following day, the sickness had ceased and the tumour had disappeared. He was allowed to resume solid food the next day and on the following day his sickness began again, his temperature rose and the tumour reappeared. He was admitted to a hospital and a week later was discharged. Two days later, the abdominal pain recurred. It came on every two minutes and lasted a second or two. The child described the pain as 'not like a stomach ache but like something pricking him.' He was re-admitted to a hospital and a barium meal and enema were performed which were reported to reveal no evidence of obstruction.

He was in hospital about six weeks and throughout this time he seemed to be getting worse. Fluids were taken and he appeared to improve on them, but if he was given solid food his temperature rose to 102° F. and he began to vomit. Accordingly, his doctor decided to refer the child to the Radcliffe Infirmary for further investigation.

On admission he was found to be undersized and mentally retarded. He had marked generalized muscular wasting, an odd-shaped skull and a curious cardiac murmur suggestive of congenital disease. The abdomen was protruberant but not tender, and no mass was felt. A barium enema was carried out on September 14, 1944, by Dr. B. Mannheimer and this revealed a filling defect in the ascending colon—the appearances being typical of intussusception. There were large amounts of occult blood in the stools. His haemoglobin level was 60 per cent. For several days special efforts were made to improve his general condition. On September 18, he was reported to have vomited his food, but on examination one hour later, no abdominal tumour could be felt. He said he had pain and pointed to the region of his umbilicus. Operation was performed September 23. Preliminary transfusion was unnecessary as his haemoglobin had risen to 76 per cent. The operation (Mr. D. C. Corry) disclosed an intussusception of the ileo-caecal variety reaching as high as the ascending colon. Reduction by manipulation was attempted but several areas of necrosis were revealed so the affected bowel was resected. Examination of the specimen revealed no predisposing causal factor. The child made a satisfactory recovery and was ultimately discharged without complaint, but he was still very emaciated.

Comment. It is probable that this boy had had an intussusception for about three months. At the beginning the story was characteristic and a lump was palpable, but within twenty-four hours of the child being brought under observation, the symptoms

FIG. 3.

subsided and the lump disappeared. The subsequent history is more confusing. The boy suffered from repeated attacks of vomiting accompanied by a rise in temperature. He had some pain but it was never severe. No lump was palpated. The doctor submitted the boy for a gastrointestinal investigation, but gained little help for the barium meal and enema were reported to show no signs of obstruction (it is not known whether the examinations were performed by an experienced radiologist). Since the child made no sustained improvement in health, he was referred to the Radcliffe Infirmary for a further opinion. A second radiological examination (fig. 3) showed the intussusception quite clearly, but though the child was kept under observation for three weeks, no lump was ever detected by ordinary clinical examination. The history was very difficult to analyse on account of the child's mental state, but there is no doubt that he did have some recurrent attacks of central abdominal pain, though except on the first occasion, the pain was never very severe.

No difficulty was experienced in making a correct radiological diagnosis for the intussusception was visualized. (With regard to the findings of the first examination it should be noted that chronic intussusception does not cause intestinal obstruction.)

Discussion

Judging from the reports in the literature, the diagnosis of chronic intussusception in children is

seldom easy. Generally, some weeks or months elapse before the true nature of the condition is realized, and sometimes it is never suspected until revealed by operation or at autopsy. It seems that mistakes arise because the whole clinical picture is not given careful consideration. The significance of repeated attacks of abdominal cramp is not appreciated and too little attention is paid to the physical examination.

Since Still wrote his paper many of the standard textbooks have emphasized the presence of a tumour; for instance: 'A child may have attacks of abdominal pain at hourly intervals for some weeks and on examination a mass is to be found' (Paterson). Again 'only the presence of a tumour leads to recognition of the condition' (Holt and McIntosh). 'The correct diagnosis is arrived at by palpating a sausage-shaped mass, which contracts and expands beneath the fingers' (Pearson and Wyllie).

The question of whether a tumour can be palpated or not is of great importance. Success obviously depends upon the skill of the examiner, the time and conditions under which the examination is carried out, and the position of the mass. Still (1921), in common with many successful paediatricians, believed that the child's abdomen should be palpated during sleep. Clubbe (1906, 1921) who had a very considerable experience of intussusception, said that, 'if there is any distension, or if the child resists or screams, it is quite hopeless

to expect to find a mass in the abdomen, even though there be a large one.' He believed that an anaesthetic 'should always be given for diagnostic purposes whenever you fail to feel a tumour, even though the child did not seem to resist your manipulation in any way.'

No one can seriously doubt the value of a properly conducted clinical examination, yet it seems that it is seldom performed efficiently, for in a series of sixty-two cases collected from the literature, a tumour was detected **at some time** in only forty-seven. In many cases, the child has suffered for months, and in not a single instance was the child examined under an anaesthetic.

Radiology offers another approach to the problem of how to detect the mass. Some experienced workers, notably Nordentoft (1939) in Denmark, believe that radiography is reliable in a high proportion of cases. A barium enema is the usual procedure. Generally, the examination can be made quickly and easily without undue stress to the patient, but it is essential that it should be complete and thorough (for Nordentoft has emphasized that intussusception can never be excluded unless the enema is seen to flow through the ileocaecal valve into the small bowel). Once the intussusception is visualized the diagnosis is not difficult, since the radiographic features are well known and quite distinctive. Occasionally the examination fails because the child will not take a full enema, but in such cases a child may be given an anaesthetic. In about five per cent. of cases the intussusception is of the enteric variety and in such cases a barium enema is negative, but preliminary films of the abdomen may show abnormal gaseous distension of a coil or coils of small bowel, and when necessary, the diagnosis can be confirmed by a barium meal (subject to there being no clinical indication which would render a barium meal inadvisable).

In the light of the experiences reported here it is urged that the only reliable clinical feature is a story of repeated attacks characterized by the sudden onset of gripping abdominal pain. All other symptoms of intussusception may be absent and are unreliable. A suspicious case should be carefully examined until the observer is satisfied

that the whole abdomen has been carefully palpated; if necessary an anaesthetic should be given to secure proper relaxation. Likewise (sometimes in preference to examination under anaesthesia), the child should be submitted for a careful radiographic study of the alimentary canal, preferably begun with a preliminary film of the abdomen and a barium enema, but supplemented, when negative, by a barium meal. The clinician must remember that unless the radiologist has sufficient time to make himself familiar with the clinical picture, the radiological examination is unlikely to prove reliable on all occasions.

Summary

(1) Three cases of chronic intussusception in children are described. In two cases, the condition was not suspected for a long time owing to the apparent absence of a palpable abdominal tumour, and in the third case because the tumour did not persist.

(2) The common features in the histories of these cases were repeated attacks characterized by the sudden onset of central abdominal pain.

(3) Any child who gives a suggestive history should be carefully examined, for owing to the difficulty in securing proper relaxation the tumour can be very easily missed.

(4) Radiological studies should be made whether a tumour is palpable or not, but it is essential that the examination should be thorough.

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APPENDIX
PREVIOUS CASE REPORTS OF CHRONIC INTUSSUSCEPTION

Author	Age	Length of history	Acute onset noted	Abdominal pain	Vomiting	Bowel habit	Blood in faeces	Wasting	Tumour	Remarks
Medical Annotation (1873). <i>Lancet</i> , 1, 709.	$\frac{6}{12}$ yr.	3 wk.	—	N.M.	N.M.	Diarrhoea	—	N.M.	—	Lump felt by mother. None found by doctor. Died
Dr. Chaffey (1888). <i>Lancet</i> , 2, 17.	3 yr.	? 6 wk. ? 10 days	—	+	+	Constipated	+	+	+	
T. A. McGraw (1897). <i>Brit. med. J.</i> , 2, 956.	7 yr	$\frac{4}{12}$	+	+	+	Diarrhoea or regular	+	+	—	
G. A. Wright and K. Renshaw (1897). <i>Brit. med. J.</i> , 1, 1470.	$2\frac{1}{12}$ yr.	4 wk.	—	—	—	Constipated	—	N.M.	—	
Bernard Pitts (1897). <i>Lancet</i> , 1, 1602.	$2\frac{3}{12}$ yr.	$1\frac{1}{2}$ yr.	+	+	+	Constipation or diarrhoea	+	+	+	Recurrent type
F. G. Penrose and T. H. Kellock (1898). <i>Lancet</i> , 2, 261.	$1\frac{4}{12}$ yr.	3 wk.	+	+	+	N.M.	—	—	+	
F. Eve (1899). <i>Clin. J.</i> , 14, 273.	13 yr.	3 wk.	+	+	+	Constipated	+	N.M.	—	'A' tumour is felt in about 50 per cent. of cases
F. P. Connor (1903). <i>Lancet</i> , 2, 600.	9 yr.	1 mth.	+	+	+	Constipated	once	N.M.	—	Diagnosed subacute appendicitis or tuberculous mischief. There was an indefinite resistance on abdominal palpation
R. G. Hogarth (1903). <i>Brit. med. J.</i> , 1, 854.	6 yr.	5–6 wk.	—	+	+	Diarrhoea or regular	—	+	+	Not felt on May 12th in O.P. Felt on admission on May 22nd
C. H. Fagge (1904). <i>Ann. Surg.</i> , 41, 407.	$9\frac{6}{12}$ yr. $2\frac{8}{12}$ yr.	24 days 3 wk.	— —	+	+	Irregular N.M.	N.M. +	— N.M.	+	Despite mass, Tub. peritonitis diagnosed at first. Died $5\frac{1}{2}$ hr. after operation. Felt P.R. only. Treated 3 wk. as dysentery. Died 5 hr. after operation
G. E. Waugh (1911). <i>Lancet</i> , 1, 1492.	$2\frac{1}{12}$ yr. $2\frac{1}{12}$ yr. 3 yr.	2–3 wk. 2 wk. 6 days	— — —	+	+	N.M. Regular ? Regular	— — —	N.M. + N.M.	+	Penile pain Not felt for 5 days. Penile pain Penile pain
T. B. Henderson (1912). <i>Brit. med. J.</i> , 2, 761.	$1\frac{1}{12}$ yr.	6 wk.			—	Diarrhoea			—	? recurrent acute intussusception

J. P. Buckley (1919). <i>Brit. med. J.</i> , 2, 665.	2 yr.	5-6 wk.	N.M.	N.M.	Yes	Diarrhoea	No	+	+	Superimposition of retrograde upon direct intussusception
F. M. Spencer (1920-1). <i>Brit. J. Surg.</i> , 8, 366.	7½ yr.	4 mth.	—	+	+	Constipated at first	+	+	+	Indefinite mass. Treated as abdominal tuberculosis for 6 wk. Still believed to be so at operation; had ascites. Died 36 hr. after operation
G. F. Still (1921). <i>Arch. Pediat.</i> , 38, 174.	1½ yr. 1½ yr. 1½ yr. 3½ yr.	6 wk. 32 days 32 days 21 days	+	+	+	Constipated Loose Regular Regular	Trace Trace Trace Trace	+	+	Only one attack of pain 3 of the 4 cases were previously diagnosed as ? Tub. Peritonitis
H. H. Schlink (1922). <i>Med. J. Austr.</i> , 1, 270.	7 yr.	2 mth.	+	+	+	Diarrhoea	—	+	+	Felt after 5-6 weeks
J. B. Alexander (1923). <i>Brit. med. J.</i> , 1, 508.	4 yr.	12 days	+	+	+	Regular	+	—	+	
R. C. Dun (1923). <i>Brit. med. J.</i> , 1, 107. (10 cases.)	Average yr.	5 4 wk.-2½ yr.	—	N.M.	N.M.	N.M.	2 cases + 8 cases —	N.M.	+ in 6 cases — in 4 cases	Symptoms not discussed
J. Gaymer Jones (1924-5). <i>Brit. J. Surg.</i> , 12, 378.	7 yr. 12 yr. 8½ yr. 1½ yr.	2 wk. 2 wk. 1 mth. 8 days	— — — +	+	N.M. + + —	Normal Normal Diarrhoea and constipation Constipated at first Regular	+	N.M. + + N.M.	+	Due to submucous lipoma supervention of acute on chronic intussusception Tumour in R.I.F., not tender. Possibly intussusception due to appendicitis Not felt one day but felt the next , Acute on chronic
A. W. Owen (1924). <i>Brit. med. J.</i> , 1, 904.	6 yr.	4 wk.	+	+	+	Regular	—	+	+	Not felt for 26 days
H. E. Marsh (1924). <i>Ann. Surg.</i> , 79, 244.	2½ yr. 3 yr.	10 wk. 10 wk.	+	+	+	Constipated Constipated	+	+	—	, Not felt as child was crying
J. S. Stone (1925). <i>Boston med. surg. J.</i> , 192, 210.	3 yr. 2½ yr. 2 yr.	6 wk. 9 mth. 1 mth.	— — —	+	N.M. N.M. N.M.	N.M. Constipated Regular	+	N.M. N.M. N.M.	, Doubtful tumour, + Felt after 1 mth. in hospital	, Intussusception had sloughed off, leaving area of obstruction and ulceration

N.M. = Not mentioned

PREVIOUS CASE REPORTS OF CHRONIC INTUSSUSCEPTION—continued

Author	Age	Length of history	Acute onset noted	Abdominal pain	Vomiting	Bowel habit	Blood in faeces	Wasting	Tumour	Remarks
J. F. H. Stallman (1926). <i>Ann. Surg.</i> , 84 , 735.	$\frac{9}{12}$ yr. 11 yr.	2 mth. 2 mth.	— +	++	++	Normal Diarrhoea in attacks	++	— +	++	
	$\frac{6}{12}$ yr. 5 yr. 7 yr.	$3\frac{1}{2}$ mth. 9 wk. 3 mth.	— — +	++ ++ +	++ ++ +	Constipated Constipated Alternating diarrhoea and constipation	++ ++ —	++ — +	++ ++ +	Tub. peritonitis diagnosed. Post mortem intussusception and general peritonitis
	$\frac{7}{12}$ yr.	5 wk.	—	+	+	Slight diarrhoea	+	+	+	
	$\frac{8}{12}$ yr.	3 wk.	+	+	+	Constipation, later diarrhoea	+	N.M.	—	Tumour not noted in case report
	$\frac{2}{12}$ yr.	2 wk.	+	+	+	Diarrhoea at first	—	—	+	
	2 yr.	3 wk.	—	+	+	Constipation at first, later diarrhoea	+	+	+	
H. B. Epstein (1927). <i>Amer. J. Surg.</i> , 3 , 262.	2 yr.	3 mth.	N.M.	+	N.M.	—	Trace	N.M.	—	
O. B. Markey and K. Kato (1927). <i>Amer. J. Dis. Child.</i> , 34 , 249.	$\frac{3}{12}$ yr.	5 mth.	+	+	+	Constipated	+	+	+	Intussusception prolapsed through anus
E. J. Donovan (1928). <i>Amer. J. Surg.</i> , 5 , 274.	$\frac{15}{12}$ yr.	2 mth.	+	+	+	Constipated	+	+	+	Intussusception protruded at anus
P. W. Beaven (1929). <i>Amer. J. Dis. Child.</i> , 37 , 373.	3 yr. 5 yr.	5 wk. 13 days	++ +	++ +	— —	Regular Constipated	— —	— —	— —	Inverted Meckel's diverticulum Penile pain
D. M. Sutherland (1932). <i>Arch. Dis. Child.</i> , 7 , 191.	3 yr.	2 mth.	—	+	—	Constipated	—	+	+	Original diagnosis tuberculous mesenteric glands
C. W. Mayo (1933). <i>Proc. Mayo Clin.</i> , 8 , 313.	$3\frac{6}{12}$ yr.	5 wk.	—	+	+	Constipated	—	—	+	P.R. mass suspected
J. R. Ryan (1936). <i>Med. J. Aust.</i> , 2 , 331.	$\frac{7}{12}$ yr.	6 wk.	+	+	+	Regular or diarrhoea	+	+	+	Chronic and retrograde intussusception

N.M. = Not mentioned