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Diverticulitis in 2021

This is a short update on diverticulitis. I will be giving a talk as part of the Cabrini GP education series on the **20th April at 7:30pm EST** on Zoom (please contact Natalie Lucchinelli on 9508 1194 or email NLucchinelli@cabrini.com.au for details). There will also be a more comprehensive version of this that will be published through ***Australian Doctor*** in their **"How To Treat"** section on the **23rd of April 2021**. I hope this serves as a short refresher on this topic, as well as a primer on some of the controversial aspects in management.

Introduction

Diverticulitis is a well-known differential for abdominal pain. It occurs in patients with diverticulosis, which is incredibly common in the community, with prevalence estimated at 65% of patients over 65 years of age. Approximately 15-20% of these patients are symptomatic. There has been an increasing incidence of diverticulitis with associated hospitalisation (up 25%). This is for reasons not completely clear, but likely related to poor fibre diets, increasing obesity and sedentary behaviour.

Risk Factors

Low fibre diet, obesity, sedentary behaviour. Patients with immunosuppression are at higher risk of complications such as perforation and abscess.

Clinical history and examination

Typically, left lower quadrant pain, accompanied by nausea and vomiting. Patients may have mucus PR discharge and infective symptoms such as fever. Abdominal pain may be elsewhere due to the fact that diverticulitis can occur in any part of the colon, or due to the mobile nature of the sigmoid colon. PR bleeding is rare in acute diverticulitis.

Patients can present with generalised peritonitis from perforation, or alternatively with large bowel obstruction from stricturing due to repeated attacks. Signs are of abdominal tenderness, fever and tachycardia.

Laboratory Tests and Imaging

Markers of inflammation such as WCC and CRP may be raised, although not always. A CT abdomen/pelvis is a mainstay of diagnosis, but mild episodes may not produce the typical inflammatory stranding seen in the mesenteric fat. CT's are very useful at the initial diagnosis, but if the patient has had previous episodes, the pain is typical, and there are no alarm signs (T >38, peritonitis, patient looking 'unwell') then treating empirically without imaging is reasonable.

Rarely, CT is used for resolution of the immediate episode, as patients' symptoms will resolve. Ultrasound can be used, but there is minimal local expertise in using it for the diagnosis of diverticulitis. MRI is generally reserved for those with contraindications to CT such as in pregnancy, although thankfully, diverticulitis is extremely rare in pregnant women.

Controversies

Antibiotic management

Recent randomised control trials have supported not using oral or IV antibiotics for selected cases of diverticulitis. These are essentially patients who had mild diverticulitis on CT (no abscess, phlegmon or perforation), no systemic inflammatory response syndrome and no risk factors such as immunosuppression.

I generally still use antibiotics for patients on their first presentation but make a case-by-case call for patients on their repeat episodes. I still restrict their diet initially to clear fluids whether they are inpatients or not until their pain begins to resolve. If they are not resolving, then antibiotics is usually given (Augmentin DF).

Colonoscopy

The traditional dogma has been that all patients without recent colonoscopy should have one after an episode of diverticulitis. Recent data shows the risk of cancer is elevated in patients who have had complicated diverticulitis (stricture, phlegmon, abscess, perforation) with the rate being 11%. The risk in patients with mild diverticulitis is closer to the population.

If patients are above the age of 40, and have never had had a colonoscopy, I do often recommend a colonoscopy on the basis of bowel cancer screening. However, I do discuss the pros and cons of colonoscopy versus FOBT. In cases of complicated diverticulitis, I am quite insistent on colonoscopy.

Role of surgery

Resection of the affected colon was previously recommended after two episodes to prevent future perforation. Recent data indicates that the first episode is the most likely to result in complications, and subsequent episodes are likely to be uncomplicated. This has caused a pendulum swing against resection. However, there are patients who have their lives impacted by repeat episodes of pain and hospitalisation.

I currently recommend that surgery be considered in the following two instances:

1) Treatment of complications such as peritonitis, stricture, or fistulous disease
2) Repeated episodes causing impact on quality of life. This requires a careful discussion as risks of resection are present.

If you have questions, please email me on raymondjyap@crsurgery.com.au or call on 8376 6429.