AGA Clinical Practice Update on Medical Management of Colonic Diverticulitis: Expert Review by Cesar Taborda

Presentation

Uncomplicated

- Thickening of the colon wall
- Peri colonic inflammatory changes

Complicated

- 12% of patients
- Abscess, peritonitis, obstruction and/or fistula

Types

Smoldering

- Seen in ~ 5% of patients
- Characterized by abdominal pain and continued evidence of inflammation on CT scan

Segmental

- Diverticular colitis that spares the rectum
- Likely on the spectrum of IBD

Background

Best Practice Advise (BPA)

1. Diagnose
   Consider CT scan to confirm diagnosis and rule out alternative diagnosis (BPA #1)

2. Treat
   Use antibiotics selectively (BPA #6 & #7)

3. Confirm
   Consider colonoscopy to rule out missed malignancy (BPA #2 & #3)

4. Educate
   On risk factors, prognosis, and indications for surgery (BPA #9–#14)

### DIAGNOSE

- **BPA #1**
  - CT → Confirm dx in those w/o prior imaging or confirmed dx and to evaluate for potential complication
  - Also in pts who fail to improve with tx, immunocompromised and those with multiple recurrences

### TREAT

- **BPA # 5, 6, 7, & 8**
  - CLD during acute phase
  - Abx → selective rather than routine in immunocompetent pts with mild uncomplicated diverticulitis
  - Abx→ Pts w/ uncomplicated diverticulitis with comorbidities or are frail, with refractory symptoms or vomiting, or who have a CRP>140 mg/L or baseline white blood cell count > 15 x10^9 cells/L
  - Abx→ complicated diverticulitis or uncomplicated diverticulitis with a fluid collection or longer segment of inflammation on CT scan.
  - Low threshold to get CT and start abx in immunocompromised pts

- **BPA # 2 & 3**
  - Colonoscopy → After an episode of complicated and 1st episode of uncomplicated diverticulitis
  - Delay until 6-8 weeks after symptom resolution
  - Can be done sooner if alarm symptoms present
  - Could be deferred if a recent (within 1 year) high-quality colonoscopy was performed

### CONFIRM

- **BPA #4**
  - In pts with a hx of diverticulitis and chronic sxs, ongoing inflammation should be excluded with both imaging and lower endoscopy
  - If there is no evidence of diverticulitis, visceral hypersensitivity should be considered and managed accordingly

### EDUCATE

- **BPA #9 & 10**
  - Previous hx of diverticulitis → High-quality diet, normal BMI, physical activity, 🚫 tobacco use
  - 🚫 NSAIDs
  - 50% of risk of diverticulitis is due to genetic factors

- **BPA #11 & 12**
  - Avoid mesalamine, probiotics, or rifaximin to prevent recurrent diverticulitis.
  - Complicated diverticulitis→ first presentation of diverticulitis.
  - The risk of complicated diverticulitis decreases with recurrences

- **BPA #13 &14**
  - Discussion of elective segmental resection→ Needs to be personalized to consider severity of disease, patient preferences and values, as well as risks and benefits, including quality of life.
  - Surgery reduces, but does not eliminate, diverticulitis risk, & chronic GI sxs do not always improve with surgery.
  - Elective segmental resection should not be advised based on the number of diverticulitis episodes