Complicated Diverticulitis

Management of diverticulitis complicated by abscess, stage 1b or 2, may be treated in various ways depending on the size of the abscess. For instance, small abscesses less than 3-4cm might not be amenable to CT-guided drainage and treatment with antibiotics may be sufficient in these cases. For larger abscesses percutaneous drainage provides a bridge to elective surgical resection so that an emergent two-stage procedure may be avoided. It is not advisable to simply drain a large abscess and treat with antibiotics as these patients may have worse outcomes with higher recurrence rates compared to patients with smaller abscesses that are treated conservatively. Drainage followed by elective resection allows for decreased morbidity and mortality. Perforated diverticulitis requires an emergent surgical resection as the risk sepsis and shock are imminent. Diverticular fistulas, such as colovesical or colovaginal fistulas, are a rare indication for urgent surgical intervention. In the majority of cases an elective one-stage resection and primary anastomosis, with repair of the adjacent organ is feasible, however if there is extensive inflammation a two-stage procedure may be necessary. In a small subset of patients with contraindications to surgery and no signs of urinary tract obstruction, observation and antibiotics was shown safe in avoiding renal failure or urinary sepsis. Obstruction from stricture formation may occur as a result of the chronic inflammation associated with recurrent diverticulitis. These patients may present with acute obstruction and thus require urgent surgical treatment, or they may present with symptoms of chronic obstruction that may be treated with an elective procedure. Obstruction is rarely complete and allows for proper bowel preparation, with resection and primary anastomosis; however, if bowel preparation is incomplete, a colostomy is required. It is important to consider occult malignancy in patients with fistulous disease and obstruction and perform an adequate diagnostic evaluation. Bleeding as a complication of diverticular disease occurs in about 30% to 50% of cases, however diverticulitis very rarely presents with bleeding, unlike diverticulosis. Management is consistent with the standard treatment of any GI bleed and includes resuscitation, initial assessment, localization of bleeding, and diagnosis of the etiology of the bleed. Therefore one would start by placing two-large bore IVs and administering saline solutions while cross-matching the patient’s blood. The patient’s hemodynamic stability may be assessed by their vital signs, blood pressure and pulse. An upper GI origin must be excluded, as profuse bleeding above the ligament of Treitz may result in rectal bleeding, by placing a nasogastric tube and performing a lavage. If a strong suspicion of lower GI source is present given the patient’s history and physical exam, then the appropriate diagnostic work-up should be begun. Colonoscopy affords the ability to localize the site of bleeding and permits therapeutic intervention, however is not very helpful in an unprepared colon in which poor visualization limits evaluation. Once the etiology is determined the need for operative management is assessed on the basis of the degree of bleeding and how the bleeding responds to resuscitation. Bleeding in the setting of diverticulitis is managed by resection and primary anastomosis in around 70% of patients.
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