Uncomplicated Diverticulitis

Management of acute diverticulitis, as mentioned previously, is largely decided by the severity of disease at presentation. Modified Hinchey Stage 0 and 1a disease is typically treated with bowel rest with a liquid or low-residue diet and oral antibiotics over 7-10 days in stable patients with no significant comorbidities or immunosuppression. In patients with significant comorbidities, or those with significant physical finding and symptoms, hospitalization with an NPO regimen, IV fluids and antibiotics is recommended until abdominal pain has subsided and bowel function returns, usually within several days. If signs of obstruction or ileus are present, a nasogastric tube is also placed. Once the signs and symptoms of active disease have subsided, a contrast study or colonoscopy may be done to evaluate the extent of the disease, about 6-8 weeks after the attack. However, in those patients who fail to respond after 72 hours or clinically deteriorate after conservative treatment, urgent surgical resection is usually necessary. In fact, an estimated 15-30% of patients admitted with acute diverticulitis will require surgical management during their admission. This may be achieved with a single-stage operation and primary anastomosis in most circumstances.

The natural history of diverticulitis as reported in older literature demonstrates a recurrence rate of around 30%, with a rate of complication upon recurrence as high as 60%. Therefore, after a second episode, elective resection has been traditionally recommended to prevent the increased morbidity and mortality of possible future episodes. This opinion has recently come under attack; one study demonstrated that after a first acute diverticulitis episode 71% of patients had no recurrent episodes. In addition, of the patients with subsequent episodes, none required emergent surgery or died of complicated disease. Chapman et al showed that the most dangerous complication, free perforation, which carries a mortality rate of 21.6%, occurs most commonly during the first ever presentation of diverticular disease. Furthermore, prophylactic colectomy has been associated with mortality risk as high as 2.5%, a risk which is higher than the mortality risk associated with some forms of complicated diverticulitis, excluding perforation. Elective resection continues to be recommended for those patients younger than 40 since this population is believed to have more virulent disease and the risk of recurrence is higher given their longer residual life-span.

References: