Diverticulitis

Antibiotics are now selective, not automatic · nuts and seeds were never the problem · and colon cancer presents exactly like this

CT the first episode
to exclude the mimics

CLASSIFY IT FIRST *uncomplicated versus complicated decides the entire pathway*

UNCOMPLICATED (the large majority)

Inflammation **with or without phlegmon, but no abscess, perforation, obstruction or fistula**. Left lower quadrant pain, low-grade fever, change in bowel habit, localized tenderness **without peritonism**. This is where the treatment change applies, and most of these patients go home.

⚠ COMPLICATED

Abscess, free perforation, obstruction, or fistula (colovesical is commonest: ask about **pneumaturia or recurrent polymicrobial UTIs**). Peritoneal signs, marked tachycardia or hypotension mean urgent imaging and surgical involvement. **Bleeding is NOT typical of diverticulitis** -diverticular *bleeding* is a separate painless entity, so significant rectal bleeding should prompt a rethink.

ANATOMY MATTERS

Left-sided (sigmoid) disease dominates in Western populations. Right-sided disease is more common in Asian populations, mimics appendicitis, and tends to behave more benignly. **Diverticulosis is not diverticulitis**: it is extremely common with age and only a small minority ever become inflamed, which is worth telling patients alarmed by a colonoscopy report.

DIAGNOSIS *the reason to scan is not to confirm, it is to exclude*

Step	Detail
CT abdomen/pelvis with IV contrast	The test for a suspected **first episode** and whenever complicated disease is possible. It confirms, **stages (abscess, perforation, obstruction, fistula), and excludes the mimics**: **colon cancer, ischemic colitis, IBD, gynecologic pathology, appendicitis**. Clinical diagnosis alone is wrong often enough to matter
When CT can be skipped	Only in a patient with a convincing history of **previously imaged, identical, uncomplicated episodes**. Ultrasound or MRI where radiation matters (pregnancy, young patients, repeated episodes) if local expertise supports it
⚠ Colonoscopy after, never during	**Do not scope during acute inflammation** (perforation risk). Wait **6-8 weeks after resolution**, and scope **after complicated disease, and after any episode in a patient not current with colorectal cancer screening** -because **colon cancer presents exactly as diverticulitis** and is found at above-baseline rates
Raise cancer suspicion further	A mass on CT, persistent unexplained symptoms, weight loss, iron deficiency anemia, or an atypical CT appearance

TREATMENT: WHAT CHANGED *ACP 2022, and the exclusions matter as much as the rule*

Situation	Management
⚠ Uncomplicated: antibiotics	**Initially manage SELECTED patients WITHOUT antibiotics** (ACP 2022): randomized trials showed no difference in symptom resolution, recurrence or need for surgery. **Does NOT apply to: suspected complicated disease, recent antibiotic use, unstable comorbid conditions, immunosuppression, or any sign of sepsis** -those patients are still treated
When antibiotics are used	Cover **Gram negatives and anaerobes**: amoxicillin-clavulanate, or a fluoroquinolone or TMP-SMX *plus* metronidazole. **Short courses (about 4-7 days)** rather than the two weeks once taught
Setting and diet	**Manage most uncomplicated patients as outpatients** when oral intake is tolerated, pain is controlled, comorbidity is stable and follow-up is reliable. **Clear liquids advancing as symptoms improve**; no prolonged bowel rest needed in mild disease. **Reassess at 2-3 days**: failure to improve means re-image and reconsider the diagnosis, not simply extend antibiotics
Abscess	**Small (roughly under 3-4 cm) often resolves with antibiotics alone; larger generally warrants percutaneous drainage**, which frequently **converts an emergency operation into an elective one, or into none at all**
⚠ Free perforation	Peritonitis or generalized sepsis is **emergency surgery**: Hartmann procedure or primary anastomosis with or without diversion, depending on stability and contamination. Fistula and stricture get elective referral once the acute episode settles
Admit rather than discharge if	**Cannot tolerate oral intake, uncontrolled pain, sepsis physiology, immunosuppression, significant comorbidity, complicated disease on CT, failure of outpatient therapy, or inadequate support and follow-up.** Everything else is a candidate for home management with clear return precautions
Return precautions	Give them explicitly: **worsening or spreading pain, fever, inability to keep fluids down, or new urinary symptoms**. A safe outpatient plan is defined by the instructions as much as by the antibiotic decision

HINCHEY CLASSIFICATION (perforated disease)

I pericolic phlegmon or small confined abscess · **II** larger walled-off pelvic, retroperitoneal or distant abscess · **III** generalized **purulent** peritonitis · **IV** generalized **feculent** peritonitis. **I and II are usually managed medically with drainage where the abscess warrants it; III and IV are operative.** The classification is the shared language with surgery, so use it when you call.

WHAT TO TELL THEM ABOUT RECURRENCE

Roughly **a fifth of patients have a recurrence**, and most recurrences are uncomplicated -that reassurance is part of why the automatic-surgery rule was abandoned. **The risk of eventually needing an emergency operation does not climb with each episode the way the old teaching assumed**, and the highest-risk presentation for perforation is often the *first* episode rather than a later one.

PREVENTION AND SURGERY *two pieces of standard advice that are no longer standard*

⚠ RETIRE THE NUTS AND SEEDS RULE

Nuts, seeds, corn and popcorn do not cause diverticulitis: prospective data found no increased risk and if anything an inverse association. **Patients carry this restriction for decades, so lifting it explicitly is part of the visit.** What does help: **dietary fiber, exercise, weight management, smoking cessation**, and **reviewing NSAIDs**, which are associated with higher risk of diverticulitis and its complications. **Mesalamine does not prevent recurrence**; rifaximin and probiotics are not routine.

SURGERY IS INDIVIDUALIZED, NOT COUNTED

The old "two episodes and operate" rule is gone, because most recurrences are uncomplicated and colectomy carries real morbidity. Consider elective colectomy for **smouldering symptoms that do not resolve, complicated features such as fistula or stricture, and immunosuppression** -weighed against quality of life, rather than triggered by an episode count.

PEARLS & PITFALLS

- **The antibiotic decision should be deliberate in both directions.** Reflexively prescribing ignores the evidence; reflexively withholding ignores the exclusion list, which includes the immunosuppressed and anyone with sepsis physiology.
- **Right-sided diverticulitis is an appendicitis mimic**, and the reverse is also true -the CT that sorts them is the same one that excludes cancer.
- **Failure to improve at 48-72 hours is a diagnostic event, not a dosing problem.** Re-image and reconsider before escalating therapy.
- **Ask about pneumaturia** in recurrent or smouldering disease: a colovesical fistula is easy to miss and changes management to surgical.

References: ACP clinical guideline on diagnosis and management of acute left-sided colonic diverticulitis (Ann Intern Med 2022) · ACP clinical guideline on colonoscopy and prevention of recurrence after acute left-sided colonic diverticulitis (2022) · AGA institute guideline on the management of acute diverticulitis · prospective cohort data on nut, corn and popcorn consumption and diverticular disease.