ACG GUIDELINE Highlights

Diagnosis and Management of Diverticulitis

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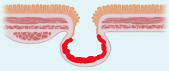
Disease Phenotypes



Uncomplicated Diverticulitis	Chronic or Smoldering Diverticulitis	Complicated Diverticulitis
Localized inflammation of colonic diverticula w/o abscess, perforation, stricture, or fistula	Inflammation that persists for wks to months. Often symptomatically improve partially or completely, but relapse after abx stopped	Diverticular inflammation accompanied by phlegmon, abscess, or perforation; strictures and fistulas may develop as delayed complication

Pearls of Management

Diagnosis

- Clinical evaluation alone is often inaccurate.
- CT at first presentation to confirm diverticulitis, rule out alternative dx, assess severity, and localize disease

Natural History

- Risk of complicated diverticulitis is highest with the first episode and decreases with recurrences.
- Recurrence risk:
  - → 22% after a first episode
  - → 55% after a second
  - → High after 3+ episodes

Elective Surgery

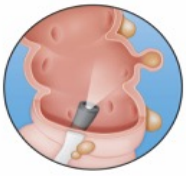
- Recurrent uncomplicated diverticulitis that impacts quality of life = referral to surgery for discussion
- Elective resection lowers, but does not eliminate, recurrence risk.

Colonoscopy

- After complicated diverticulitis—colonoscopy recommended to rule out missed cancer or premalignant lesions.
- After uncomplicated diverticulitis—colonoscopy ONLY if alarm symptoms are present or patient not up to date with colorectal cancer screening.

★ **Alarm symptoms include:**

1. Unintentional weight loss
2. Change in bowel habits
3. Iron-deficiency anemia
4. Bloody stools
5. Persistent abdominal pain



Antibiotics

Acute uncomplicated diverticulitis can be managed without abx in patients who are:

1. Immunocompetent
2. Hemodynamically stable
3. Outpatient
4. Able to tolerate oral intake without SIRS or complicated disease
5. Not medically frail
6. Able to follow up reliably

Abx advised for acute uncomplicated diverticulitis in patients who are:

1. Immunocompromised
2. Frail
3. Medically complex
4. Unable to tolerate oral intake
5. Worsening clinically
6. Have markedly elevated inflammatory markers or higher-risk imaging features
7. Lack reliable follow-up/support

★ **Options for abx for acute uncomplicated diverticulitis (for 4–7 days):**

Monotherapy with:

- Amoxicillin-clavulanic acid 875 mg/125 mg PO q 12 hrs
- Moxifloxacin 400 mg PO daily

Combination therapy with:

- Metronidazole 500 mg PO q 8 hrs **PLUS**
  1. Trimethoprim-sulfamethoxazole (1 DS tablet, 160/800 mg) q 12 hrs **or**
  2. Ciprofloxacin 500 mg PO q 12 hrs **or**
  3. Levofloxacin 500 mg q 24 hrs

Prevention of Diverticulitis

1. Recommend a high-fiber, plant-forward diet
2. Do not routinely avoid nuts, seeds, corn, or popcorn
3. Avoid regular NSAID use when possible
4. Moderation of alcohol use
5. Weight loss if overweight/obese
6. Regular physical activity
7. Encourage smoking cessation

Abx = antibiotics
CRC = colorectal cancer
DS = double strength
Dx = diagnosis
Hrs = hours
NSAIDS = nonsteroidal anti-inflammatory drugs
PO = by mouth/orally
q = every
SIRS = Systemic inflammatory response syndrome
w/o = without
Wks = weeks

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