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COMMENTARY

Practice-Changing Pearls From New Diverticulitis Guidelines

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This transcript has been edited for clarity.

Hello. I'm Dr David Johnson, professor of medicine and chief of gastroenterology at Eastern Virginia Medical School in Norfolk, Virginia. Welcome back to another GI Common Concerns.

I wanted to chat with you today about new recommendations for best practice strategies in the management of colonic diverticulitis from the American Gastroenterological Association (AGA), which build upon guidelines from 2015. In this latest update, the authors provide 14 recommendations for changes to common practices that I think are very sensible.

Diverticulitis is a common disease in the United States, accounting for approximately 1.9 million outpatient visits and over 200,000 inpatient hospitalizations, with an economic burden over $5.5 billion annually.

Approximately 12% of patients with incident disease have de novo complications. A subset of 5% of patients who have diverticulitis also have smoldering diverticular disease following continued therapy, with persistent abdominal symptoms and inflammatory changes seen on CT imaging. This is notably different from segmental colitis associated with diverticulosis (or SCAD), which is more like inflammatory bowel disease.

The Best Candidates and Timing for Imaging

The first practice recommendation I'd like to highlight deals with who requires CT imaging.

As the AGA's guidelines stated in 2015, we don't need to jump to CT imaging in everybody, especially as we're now in the era of trying to minimize the risk for radiation exposure. However, early imaging should be considered in patients who have fevers, have ongoing or relapsing symptoms, or are immunosuppressed in order to segmentally document the location of inflammation and confirm the diagnosis.

Regarding colonoscopy, the recommendation still stands that the patient should have an index colonoscopy after the first de novo case. In patients who have established problems with diverticulitis, colonoscopy should be postponed for 6-8 weeks after the acute event or until the resolution of symptoms. That's a little longer than what I previously used, which was 4-6 weeks.

The authors also recommend that if the patient has had a prior high-quality colonoscopy within the past year, they don't need to necessarily have a repeat colonoscopy, which represents a slight change.

Treatment Strategies

The authors recommended to not immediately jump to treatment with antibiotics, but instead reserve them for frail, immunocompromised patients and those who have increased systemic markers such as C-reactive protein values of > 140 mg/L or a white blood cell count of > 15,000.

After the index event, immunosuppressed patients should see a surgeon for a discussion of segmental resection. This is because immunocompromised patients obviously have a higher risk for more progressive disease at a later presentation.

Best Tactics for Reducing Risk

The Mediterranean-type diet or anti-inflammatory diet has been shown in a study using data from the Health Professionals Follow-Up Study to lead to a risk reduction for diverticulitis. A non-Western diet applied in these patients led to a decrease in incidence of approximately 30%.

The authors of these new recommendations also did some myth busting, reiterating that there is no evidence base to support the idea that nuts, seeds, and popcorn increase the incidence of diverticulitis. You can tell your patients that they can be liberal in eating those foods. Although this is now well established in the literature, it's perhaps not as well understood or followed by many of our primary care doctor colleagues.

More vigorous physical activity, weight reduction, nonsmoking, and regular avoidance of nonsteroidal anti-inflammatory drugs (with the exception of aspirin needed for secondary prophylaxis of cardiovascular disease) were the other things the authors noted to be helpful in risk reduction. The other medication to avoid is opiates. The increased incidence of complicated disease in opiate users is notable.

I found the recommendation on genetics very interesting. It's now thought that 40%-50% of diverticulitis has a genetic association, which comes from data looking at twins (monozygotic and dizygotic) and siblings. Overall risk for diverticulitis for siblings is elevated by three times.

That recommendation has changed my discussions with patients with diverticulitis. I now talk to them about their siblings in a similar way to how we do so with colorectal neoplasia and high-risk polyps. We discuss developing some strategies for their siblings to mitigate risk.

The Latest on Prevention and Recurrence

There are no data for the use of mesalamine, or 5-aminosalicylic acid, for the prevention of recurrent diverticulitis. You might recall that the mesalamine prevention trials were really a bust.

There are also no data to support probiotics or rifaximin to prevent recurrent diverticulitis.

Interestingly, the recommendation says that patients should be counseled that if they have a diverticulitis event, the recurrence rate is approximately 8% in the first year and 20% within 10 years. Analogous to what we see with *Clostridioides difficile*, those numbers go up with recurrent episodes. With diverticulitis, after a second episode, the recurrence risk is 18% in the first year and 55% by 10 years. After a third episode, the recurrence risk is 40% within 3 years. So, again, these are numbers that start to ramp up over time.

Individualizing Surgery

Elective surgical referral is something that should be considered but on an individualized basis. Certainly, data show that not everybody needs surgery, even if they have complications like diverticular abscess.

The authors noted studies showing that patients who had surgery had a 15% rate of recurrence at 5 years, compared with 51% for patients who had the standard intervention. Ongoing symptoms following surgery for acute diverticulitis have been reported to be as high as approximately 25% at 5 years, which, although not inconsequential, is dramatically less. Therefore, we must recognize that surgery isn't a cure-all.

Although these recommendations are based on relatively low-quality evidence, I think they have enough application that it changes recommendations in my practice strategy. I encourage you to take a look at them and see what may help you in your discussions with patients who have this very common disease.

I'm Dr David Johnson. Thanks again for listening. See you next time.

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