

# American Gastroenterological Association Institute Guideline on the Management of Acute Diverticulitis

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This document presents the official recommendations of the American Gastroenterological Association (AGA) Institute on the management of acute diverticulitis. Acute diverticulitis, defined as clinically evident macroscopic inflammation of a diverticulum or diverticula, occurs in approximately 4% of patients with diverticulosis; roughly 15% of those patients will have complicated disease, defined as an abscess, perforation, fistula, or colonic obstruction, and 15% to 30% will experience recurrence. Acute diverticulitis is the third most common inpatient gastrointestinal diagnosis in the United States, costing more than \$2 billion annually, and is a common outpatient and emergency department diagnosis as well. The most recent US gastroenterology society practice guideline on diverticular disease was published in 1999; the literature on this disorder has grown considerably since then, with data challenging some prior traditional recommendations. Given the significant burden of disease and the evolving scientific literature, the AGA has identified acute diverticulitis as a priority for an updated guideline. This guideline does not address other manifestations of diverticular disease, such as symptomatic uncomplicated diverticular disease, diverticular bleeding, and segmental colitis associated with diverticulosis, and does not examine the prevention of incident diverticulitis or the management of complicated disease. Reference to surgical society and international guideline recommendations is made when appropriate.

This guideline was developed by the AGA's Clinical Guidelines Committee and approved by the AGA Institute Governing Board. It was developed using a process described elsewhere.<sup>1</sup> Briefly, the AGA process for developing clinical practice guidelines incorporates Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology<sup>2</sup> and best practices as outlined by the Institute of Medicine.<sup>3</sup> GRADE methodology was used to prepare the accompanying technical review on focused questions and their related specific populations, interventions, comparisons, and outcomes.<sup>4</sup> Optimal understanding of this guideline will be enhanced by reading applicable portions of the technical review. The quality of available evidence on each question was first judged by the technical review panel of content and methodological experts (Table 1). Reasons justifying grading are detailed in the following text when appropriate. The guideline authors,

none of whom have any potential financial or professional conflict of interest on the topic, met with the technical review panel to discuss the evidence. The guideline authors subsequently met privately and drafted recommendations, taking into account the quality of evidence as well as the balance between benefits and harms, patient preferences, and resource utilization. Such pertinent considerations are also detailed in the following text when relevant. The strength of the recommendations was categorized as strong, conditional, or no recommendation according to GRADE terminology (Table 2). The draft recommendations were then opened to public comment, edited, and approved by the Governing Board of the AGA (Table 3).

## Recommendations

**Question 1. Should Antibiotics Be Routinely Used in Patients With Acute Uncomplicated Diverticulitis?**

**The AGA suggests that antibiotics should be used selectively, rather than routinely, in patients with acute uncomplicated diverticulitis. (Conditional recommendation, low quality of evidence).**

Until recently, antibiotics have been the unquestioned cornerstone of treatment of patients with acute diverticulitis, consistently recommended in prior guidelines, textbooks, and expert reviews. The emerging belief that acute diverticulitis may be more inflammatory than infectious as well as increasing concerns about the overuse of antibiotics have led to preliminary investigations into the necessity of antibiotics. Two recent randomized trials and 2 systematic reviews have reported no clear benefit and questioned the

**Abbreviations used in this paper:** AGA, American Gastroenterological Association; CT, computed tomography; GRADE, Grading of Recommendations Assessment, Development and Evaluation; NSAID, nonsteroidal anti-inflammatory drug.

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**Table 1.** GRADE Categories of Quality of Evidence

High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate. The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited. The true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate. The true effect is likely to be substantially different from the estimate of effect.

routine use of antibiotics, as does this guideline, suggesting selective and individualized use. It is important to emphasize that the current data are of low quality, and recommendations could change as further studies are performed. Further, the patients studied were inpatients with uncomplicated disease confirmed by computed tomography (CT); therefore, the results should not be generalized to complicated patients (ie, those with abscesses or fistulas), those with signs of severe infection or sepsis, immunosuppressed patients, or patients with other significant comorbidities. This recommendation is conditional due to the low quality of current evidence. Additionally, outpatient management without antibiotics has not been studied, although we would expect these patients to have generally milder disease and logically equal or better outcomes.

**Table 2.** GRADE Categories of Strength of Recommendation

	For the patient	For the clinician
Strong	Most individuals in this situation would want the recommended course of action and only a small proportion would not.	Most individuals should receive the recommended course of action. Formal decision aids are not likely to be needed to help individuals make decisions consistent with their values and preferences.
Conditional	The majority of individuals in this situation would want the suggested course of action, but many would not.	Different choices will be appropriate for different patients. Decision aids may well be useful helping individuals making decisions consistent with their values and preferences. Clinicians should expect to spend more time with patients when working towards a decision.

### Question 2. Should a Colonoscopy Be Performed After an Episode of Acute Uncomplicated Diverticulitis Confirmed by CT Scan?

**The AGA suggests that colonoscopy be performed after resolution of acute uncomplicated diverticulitis in appropriate candidates to exclude the misdiagnosis of a colonic neoplasm if a high-quality examination of the colon has not been recently performed. (Conditional recommendation, low quality of evidence).**

Observational studies of cohorts of patients with imaging-proven uncomplicated diverticulitis who subsequently underwent colonoscopy detected a small number of colorectal cancers (15 cases/1000 patients) and advanced adenomas (38 cases/1000 patients). Absence of a mass lesion on CT scan does not exclude the possibility of an underlying colonic neoplasm. Evidence of alternative, non-neoplastic explanations for the index presentation, such as inflammatory bowel disease or ischemic colitis, was either infrequently identified or not reported in the systematic review. Although an increased risk of recurrent diverticulitis or colonic perforation is a concern in patients undergoing colonoscopy after an episode of acute diverticulitis, this was not reported as an adverse event in the available literature. Although not directly addressed in the existing studies, factors that may influence a decision to perform a colonoscopy after an episode of acute uncomplicated diverticulitis include (1) timing and completeness of a prior colonoscopy, (2) comorbidities, (3) persistent symptoms of abdominal pain or diarrhea, and (4) patient preferences. The risks of colonoscopy may be higher in patients with chronic diverticulitis, acute recurrent diverticulitis, or complicated diverticulitis. The optimal timing of colonoscopy after an episode of acute diverticulitis is uncertain, but the severity and duration of the episode are relevant considerations. Intervals of 6 to 8 weeks after resolution of acute diverticulitis are commonly followed.

### Question 3. Should Elective Colonic Resection Be Performed After an Initial Episode of Acute Uncomplicated Diverticulitis?

**The AGA suggests against elective colonic resection in patients with an initial episode of acute uncomplicated diverticulitis. The decision to perform elective prophylactic colonic resection in this setting should be individualized. (Conditional recommendation, very-low quality of evidence).**

Approximately 20% of patients with acute uncomplicated diverticulitis experience a recurrent episode of diverticulitis in the following 5 years. The risk of future diverticular complications and need for emergency surgery

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