

key points

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It is important to distinguish between diverticulosis, the

presence of asymptomatic diverticula, and diverticular disease which refers to symptomatic cases which can present with acute or chronic symptoms. Chronic symptoms range from mild intermittent abdominal cramps to the more severe picture of chronic abdominal pain and occasional rectal bleeding. In contrast, acute diverticulitis refers to acute inflammation in the diverticula.

Low dietary fibre intake is reported to increase the risk

of diverticular disease. The highest incidence rates are in the United States, Europe and Australia. In the UK, the prevalence rises from approximately 5% of people in their 40s to almost 50% of those above the age of 80.

It is estimated that 20% of patients with diverticulosis

will develop symptoms at some point in their lifetime. There may be diagnostic difficulty in distinguishing symptoms directly related to diverticular disease from those attributed to irritable bowel syndrome although the latter tends to affect a younger age group.

Diverticular disease can be confirmed radiologically

or endoscopically. Referral of patients with symptomatic diverticular disease to secondary care is not indicated unless: the symptoms affect their quality of life; the pain is not controlled by paracetamol; new symptoms develop which require further investigation; there are concerns about the possibility of an alternative diagnosis or patients develop red flag symptoms. Even in patients with established diverticulosis, a change in the clinical picture with development of red flag symptoms warrants urgent referral to rule out lower gastrointestinal malignancy. New evidence supporting use of an antibiotic-free strategy in uncomplicated diverticulitis is mounting.

Patients with suspected uncomplicated acute

diverticulitis should be assessed according to their level of pain and associated systemic features of sepsis. In those where pain is controlled and there are no signs of systemic sepsis or multiple comorbidities, the patient may be treated in primary care.

For both asymptomatic and symptomatic patients

a high-fibre diet is recommended. Bulk-forming laxatives are suggested but not osmotic laxatives such as lactulose. Probiotics, mesalazine and rifaximin have shown some benefit in patients with diverticular disease, however none of these modalities is yet recommended by NICE.

Patients with recurrent diverticulitis may benefit from

an elective colectomy. The decision to recommend elective colectomy for recurrent diverticulitis should be made on a case by case basis.