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Mini Review

Outpatient Management of Uncomplicated Acute Colonic Diverticulitis: A Narrative Review.

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Abstract

Acute colonic diverticulitis is a common gastrointestinal condition with increasing prevalence among younger populations and in developing countries adopting Western dietary habits. This narrative review explores current evidence and clinical practices surrounding the outpatient management of uncomplicated diverticulitis. Diagnosis relies on clinical evaluation and contrast-enhanced abdominal CT to distinguish between uncomplicated and complicated cases. Conservative treatment—centered on analgesia and dietary modifications— has been shown to be safe and effective, with antibiotics reserved for select patients with comorbidities or worsening symptoms. The role of adjunct therapies such as rifaximin, mesalazine, and probiotics remains uncertain. Surgical intervention should be individualized, based on clinical severity and imaging findings rather than episode count. This review supports a personalized, evidence-based approach to outpatient care, with the aim of reducing unnecessary hospitalizations and optimize long-term outcomes.

Key words: Uncomplicated diverticulitis, Outpatient management, Selective antibiotic therapy, Clinical follow-up, Surgical indications

INTRODUCTION

Colonic diverticular disease is a common gastrointestinal condition traditionally associated with Western countries and older populations. However, recent epidemiological trends show a rising incidence in developing nations adopting Western dietary habits, and increasingly among younger individuals. Symptomatic diverticulitis occurs in approximately 15–25% of patients with diverticulosis, with 80% presenting as uncomplicated and 20% as complicated. The Hinchey classification has long been used to stage acute diverticulitis, but the World Society of Emergency Surgery (WSES) classification has gained popularity due to its clinical applicability and therapeutic implications [1].

REVIEW

Diagnosis and Initial Evaluation

Diagnosis is based on clinical history, physical examination, and elevated inflammatory markers. When diverticulitis is suspected, contrast-enhanced abdominal computed tomography (CT) is the gold standard for confirming the diagnosis and distinguishing between uncomplicated and complicated cases [2].

Patient Management Protocol

Patients presenting to the emergency department undergo surgical evaluation, laboratory testing, and abdominal CT. If uncomplicated diverticulitis is confirmed, the patient may be observed in a short-stay unit for 24–48 hours. Upon discharge, a detailed clinical report and follow-up instructions

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are provided. A surgical outpatient visit is scheduled within 48 hours, and communication between emergency and outpatient teams is essential. Follow-up typically includes three outpatient visits until symptom resolution [3].

Treatment of Uncomplicated Diverticulitis

Analgesia and Dietary Management

Initial treatment focuses on pain control using oral analgesics such as paracetamol, ibuprofen, or oxycodone/naloxone. A liquid diet is recommended until the first follow-up visit (2–4 days post-diagnosis). If improvement is noted, patients may transition to a soft diet and gradually resume normal intake. During the acute phase, typically lasting up to 20 days, patients should avoid cereals, fiber-rich foods, and dried fruits. After symptom resolution, a high-fiber diet is encouraged to reduce recurrence risk. Seed-containing foods are not contraindicated, as evidence shows no increased risk of recurrence [4,5].

Antibiotic Therapy

Antibiotics are not routinely required for uncomplicated diverticulitis. Historically, their use was based on retrospective data and clinical experience. The DINAMO randomized trial involving 480 patients demonstrated that outpatient management with or without amoxicillin-clavulanate did not affect outcomes such as follow-up visits or hospitalizations. Antibiotics may be considered in patients with significant comorbidities (e.g. heart failure, renal failure, liver cirrhosis, COPD, immunosuppressive therapy) or worsening symptoms[6].

Common regimens include:

- Amoxicillin-clavulanate (875+125 mg) every 8 hours
- Ciprofloxacin 500 mg every 12 hours + Metronidazole 500 mg every 8 hours
- Levofloxacin 750 mg daily + Metronidazole 500 mg every 8 hours
- Trimethoprim-sulfamethoxazole every 12 hours + Metronidazole 500 mg every 8 hours

Treatment duration averages 6 days, with adjustments based on comorbidities [7,8]

Other Therapeutic Agents

5-ASA agents (e.g., mesalazine) do not prevent recurrence or improve post-diverticulitis symptoms. The role of rifaximin and pre/probiotics remains unclear and should be individualized based on physician discretion [9,10].

Follow-Up Strategy

Patients showing clinical improvement do not require repeat imaging. Those with worsening symptoms (e.g., pain, fever, intolerance to oral therapy) should be re-evaluated with repeat contrast-enhanced CT to assess disease progression [11].

Recurrence Rates and Outcomes

Recurrence occurs in 16–42% of patients treated medically. Large cohort studies from the UK (United Kingdom) and Canada report low rates of hospital readmission and colectomy. Risk factors for recurrence and surgery include female sex, younger age, smoking, obesity, and complicated initial presentation. Recurrences are generally less severe than initial episodes.

- In a UK study of 65,000 patients, the readmission rate was 11.2%, with 0.9% requiring emergency colectomy and 0.75% elective surgery.
- In a Canadian cohort of 14,000 patients, readmission occurred in 9%, with 1.9% and 1.7% undergoing emergency and elective colectomy, respectively [12,13,14].

Colonoscopy Indications

Colonoscopy is recommended 6–8 weeks after symptom resolution to exclude malignancy, particularly in patients:

- Over 45 years of age
- With atypical imaging or clinical course

Meta-analyses show colorectal cancer detection rates of 8.3–10.8% after complicated diverticulitis, compared to 0.5–0.7% after uncomplicated cases [15].

Surgical Considerations

Previous guidelines recommended surgery after two/three episodes of diverticulitis. Current evidence supports an individualized approach based on clinical severity, radiological findings, and patient preference. According to the American Society of Colon and Rectal Surgeons (ASCRS), surgery should not be based solely on episode count. Postoperative recurrence rates are approximately 6% at one year and 16% at five years, often due to residual or new diverticula or incomplete resection of the rectosigmoid junction [16,17].

DISCUSSION

Outpatient management of uncomplicated diverticulitis is safe and effective in selected patients. Accurate initial assessment and radiological confirmation are essential to exclude complications and guide treatment. Adherence to therapy and structured follow-up contribute to successful outcomes. Colonoscopy is crucial for identifying neoplastic lesions and structural abnormalities. Surgical decisions should be personalized, considering disease severity, symptom persistence, and imaging findings.

CONCLUSIONS

Uncomplicated acute diverticulitis can be managed conservatively in the outpatient setting with favorable

outcomes. Evidence supports a shift away from routine antibiotic use and arbitrary surgical thresholds. A personalized approach to follow-up, colonoscopy, and surgical planning ensures optimal care and minimizes unnecessary interventions.

Abbreviation

CT- computed tomography

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