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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Diving into Diverticular Disease: A Look at Evolving Clinical Insights

Dr. Buch:
Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. And joining us today to talk about the evolving epidemiologic and clinical insights of diverticular disease is returning guest Dr. Brennan Spiegel. Dr. Spiegel is the Director of Health Services Research at Cedars-Sinai and Professor of Medicine at UCLA.

Dr. Spiegel, welcome back to the program.

Dr. Spiegel:
Thanks for having me back.

Dr. Buch:
It is a delight. Let's just jump right in. When can antibiotics be avoided in diverticulitis? And why has this paradigm changed?

Dr. Spiegel:
Well, this is a really important question because traditionally, when patients have diverticulitis, we almost always will use antibiotics to treat it, and that's actually been called into question with the most recent guidelines from the American Gastroenterological Association, and based upon research that's been conducted suggesting that there really isn't always a clear benefit. There's been 2 randomized controlled trials, and now there's been systematic reviews that have actually reported no clear benefit and even question the routine use of antibiotics for acute diverticulitis. Now, this would be, of course, uncomplicated diverticulitis. So if somebody comes in with an abscess or a perforation or a phlegmon or something more concerning, I don't think anyone would question the use of antibiotics. But for sort of run-of-the-mill, uncomplicated acute diverticulitis, based upon these trials, there actually has not been a benefit, either initially or even in longer-term follow-up. So whether or not that's actually going to change practice I think is an open question, but that's what the guidelines most recently say.

Dr. Buch:
So let's follow through a little bit more with that because, again, to the average practitioner out there, you just hit on a very important topic: Will this change practice? What has been your observation in your location whether practitioners are changing practice or not?

Dr. Spiegel:
Yeah. I'm not sure I've seen it change a lot. Now many times these cases are not involving the gastroenterologist—and, of course, I'm a GI doctor like you—and often this will be the primary care decision or the emergency department will be involved or the hospitalists, and we may never really get involved unless there's a concern about needing a colonoscopy, but what I've noticed is that most of these patients are still getting antibiotics, and my sense is that this information about these clinical trials has not really consistently made it to the frontlines. And the knee-jerk reaction that we all learn in medical school is, "Well, they need antibiotics. Let's start them up."

Dr. Buch:
Great. I'll give you an opportunity to talk about colonoscopy under these circumstances.

Dr. Spiegel:
So sometimes we are called in to do colonoscopy in the acute setting of, let's say, inpatient diverticulitis, and generally, our recommendation is to hold off on colonoscopy. Now if there's bleeding, maybe that's different, although in my experience it's quite unusual for acute diverticulitis to present with bleeding. Diverticulosis can bleed, but acute diverticulitis typically doesn't bleed in my experience. In fact, presence of bleeding to me almost suggests something else may be going on, not just run-of-the-mill diverticulitis. But assuming there's no bleeding, we often will sort of hold off on doing colonoscopy initially. You've got a hot colon. It doesn't make a lot of sense to put a whole scope in there, even a flex sig, insufflating and all that, taking a picture of the inflamed tic when a CT scan can show you what you need.

Now that said, there is a role for colonoscopy. The American Gastro Association generally recommends doing a colonoscopy after an episode of acute diverticulitis but waiting a little while, typically around 6 to 8 weeks after resolution of the acute diverticulitis, and the idea is just to make sure there isn't some underlying cancer or advanced polyp that might have grown over a tic and triggered that inflammation because there is some evidence that there's a slightly increased risk of cancer and advanced adenomas in people who do have acute diverticulitis. So if they have not had a recent screening colonoscopy, it's reasonable to consider doing a follow-up colonoscopy.

Dr. Buch:
Thank you for that. And how has the surgical paradigm changed for diverticulitis?

Dr. Spiegel:
Yeah. This has been a work in progress. I'm not a colorectal surgeon, so I would be interested in hearing from them because I think there is some variation even among colorectal surgeons and general surgeons as to the best time to perform colectomy. The issue is that many of us sort of in med school learned various rules like, "Well, if they've had 2 cases, then they need it." But most of those rules that we all learned are not really evidence-based, and the guidelines now from the surgical societies really emphasize that there's no clear reason to do surgery based upon some minimum number of episodes. Most patients don't have a follow-up attack, or if they do, based upon sort of health economic modeling and clinical outcomes, it's still not always necessary to do a colectomy if it's uncomplicated.

Dr. Buch:
Thank you. Now, Dr. Spiegel, should we be recommending prophylactic therapy to prevent further episodes of diverticulitis?

Dr. Spiegel:
Yeah, great question. So therapy can come in different forms. One form that has been studied fairly carefully is the use of 5-ASA or mesalamine, and the idea there is if mesalamine can help reduce ulcerative colitis flares, could it help reduce diverticulitis flares? And the answer is no. So there was an interest in this about 10 years ago. There was a lot of research looking at whether 5-ASA prophylaxis is useful for diverticulitis reduction. It doesn't really seem to make much of a difference.

But there are other approaches people have taken to help reduce cases: for example, use of antibiotics. I'm not really going to recommend routine use of antibiotics, but for people who have had persistent symptoms after an attack, sometimes that is what we call post-diverticulitis IBS, and there is evidence that rifaximin can reduce symptoms in that kind of post-diverticulitis IBS scenario and can reduce the incidence of subsequent diverticulitis; although, the number needed to treat is quite high, like around 50 for that, so it's not all that effective, but it does seem to reduce symptoms, and some people do consider a course of rifaximin in that setting.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Brennan Spiegel about diverticular disease.

Now let's turn to diverticular bleeding, Dr. Spiegel. What's the best treatment for this?

Dr. Spiegel:
Well, this is an interesting area to talk about, because if you were to interview a random sample of experienced gastroenterologists and ask them "How many times have you done an urgent colonoscopy and actually found a bleeding diverticulum that you were able to stop endoscopically?" The answer would be very few; some would say even less than a handful; and that's because it's very hard to find the bleeding tic, and to stop it. Often there's just a colon full of blood. But that said, there is pretty good evidence that early endoscopy is better than delayed endoscopy for diverticular bleeding. And really the key though is, if you're going to do it, you have to clean out that colon as best as you possibly can. And then some people may have a hundred tics, and the idea is it's like finding a needle in a haystack. You have to look very carefully at every diverticulum and try and find the vessel that might be the culprit and treat it, and that can take sometimes well over an hour of work in the endoscopy suite, which is sometimes hard to do, especially if it's a very busy day.

In any event, urgent endoscopy still has a role if you can do an urgent purge and try to find the lesion, but the reality is it can be very hard to find the source and stop it.

Dr. Buch:
Now before we conclude, Dr. Spiegel, are there any other thoughts you would like to share with our audience today?

Dr. Spiegel:
Yeah. I would add that today we've been talking about more sort of acute diverticular complications, acute diverticulitis, or acute diverticular bleeding, but one thing we've come to realize is there are also longer-term consequences. So there's something called SUDD, S-U-D-D, which is symptomatic uncomplicated diverticular disease, and this may be the most common of all forms of diverticular disease, and this is where people have persistent abdominal pain, discomfort; they may have cramping. It looks like they have IBS, but when you look inside, they have tics. And so the question is "Is this IBS with diverticulosis, or is this diverticulosis that looks like IBS?" And there's a whole literature around how to manage SUDD, and there are approaches. I mentioned rifaximin, and even using tricyclic antidepressants and some of the centrally acting approaches that we use for IBS may be useful for SUDD.

So this is a whole other area that I think especially GI doctors need to become more familiar with and recognize that it's not always just about acute diverticulitis. There are also chronic consequences in even post-diverticulitis IBS that have been described in the literature.

Dr. Buch:
Well that was a great discussion, and I want to thank my guest, Dr. Brennan Spiegel, for helping us better understand diverticular disease. Dr. Spiegel, it was a pleasure having you on the program again.

Dr. Spiegel:
Well, thanks again for having me.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening and see you next time.