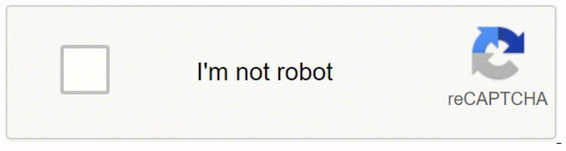

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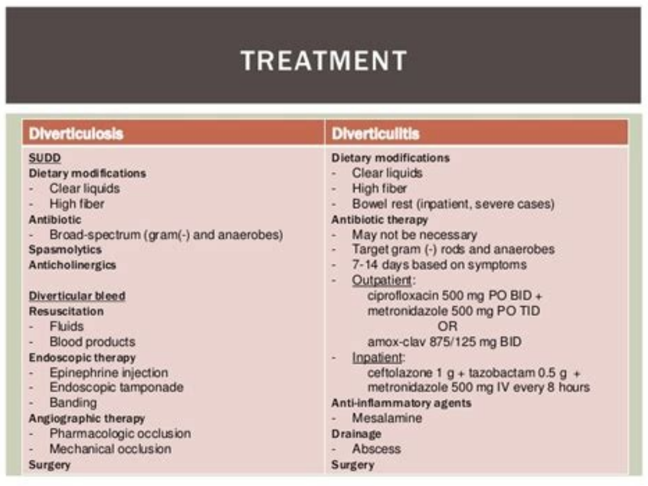
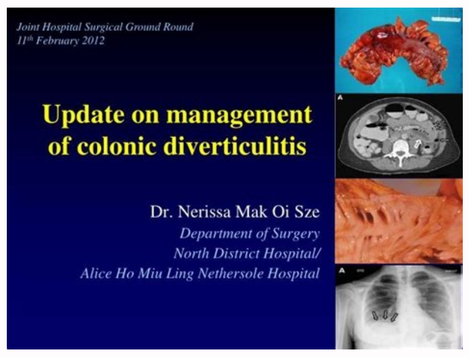
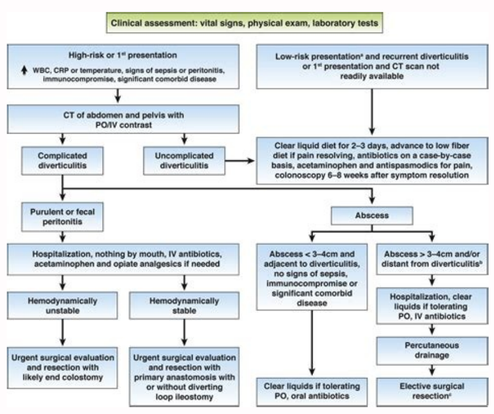
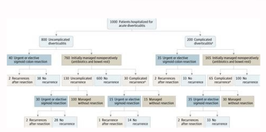
Acute diverticulitis treatment guidelines









How to avoid recurrent acute diverticulitis. How serious is acute diverticulitis. What is acute diverticulitis attack. How to prevent acute diverticulitis. Is acute diverticulitis curable. Guidelines of diagnostics and treatment of acute left-sided colonic diverticulitis.

1.1.3 Advise people to drink an adequate liquid if they are increasing their fiber intake, especially if there is a risk of dehydration. 1.3.22 Consider percutaneous drainage (if anatomically feasible) or surgery (see Recommendation 1.3.27) for abscesses larger than 3 cm. 1.2.9 Consider simple analgesia, such as acetaminophen, as needed if the person has ongoing abdominal pain. Presence of complications associated with inflamed or infected diverts. 1.3.12 If the person has confirmed acute diverticulation without complications, review the need for antibiotics and download them according to co-existing medical conditions. If fecal peritonitis is identified intraoperatively, proceed with rescission surgery. 1.2.8 Consider bulk-forming laxatives if: a high-fiber diet is unacceptable to the person or is not tolerated or the person has constipation or persistent diarrhea. 1.4.3 Provide people with acute diverticulitis, and their families and caregivers with appropriate verbal and written information about: “Diet and Lifestyle The course of acute diverticulitis and the likelihood of complicated diseases or symptoms of recurrent episodes when and how to look for more advice more possible research. and treatments the risks of interventions and treatments, including resistance to antibiotics, and how invasive are these roles of surgery and outcomes (function and symptoms of the postoperative intestine). Consider the person’s age, any other conditions they have, and how well they can perform daily activities (WHO performance status). 1.2.11 If the person has symptoms or persistent symptoms that do not respond to treatment, consider alternative causes and investigate and administer appropriately. 1.3.27 Offers people with complicated acute diverticulitis who are A surgery (either elective or emergency): primary anastomosis (join the intestine) with or without diverting the stoma or the Hartmann procedure (resectioning of the intestine intestine intestine an end stoma). 1.2.4 Do not offer antibiotics to people with diverticular disease. 1.1.4 Consider bulk-forming laxatives for people with constipation. Other features, including fever, may also be present. 1.3.24 For abscesses less than 3Â Âcm switch to oral antibiotics where possible. 1.3.23 Send samples of pus from the abscess (if it has been drained) to the microbiology laboratory to enable antibiotic treatment to be tailored to sensitivities. 1.3.28 In people undergoing bowel resection, consider resecting back to the compliant bowel (that is, bowel that is soft, unthickened and unaffected by inflammation). 1.4.2 Give people with diverticular disease, and their families and carers where appropriate, verbal and written information on: diet and lifestyle the course of diverticular disease and the likelihood of progression symptoms and symptom management when to seek medical advice. 1.3.5 If the person with suspected complicated acute diverticulitis has raised inflammatory markers, offer a contrast CT scan within 24Â Âhours of hospital admission to confirm diagnosis and help plan management. The presence of diverticula with mild abdominal pain or tenderness and no systemic symptoms. 1.2.10 Consider an antispasmodic if the person has abdominal cramping. These complications may include abscess, fistula, stricture perforation and sepsis. 1.2.5 Advise people to avoid non-steroidal anti-inflammatory drugs and opioid analgesia if possible, because they may increase the risk of diverticular perforation. The presence of diverticula without symptoms. 1.2.1 Suspect diverticular disease if a person presents with one or both of the following: intermittent abdominal pain in the left lower quadrant with constipation, diarrhoea or occasional large rectal bleeds (the pain may be triggered by eating and relieved by the passage of stool or flatus) tenderness in the left lower quadrant on abdominal examination.Be aware that: in a In people and in people of Asian origin, pain and sensitivity can be located in the lower right quadrant and symptoms can be superimposed with conditions such as irritable intestine syndrome, colitis and malignancy. If the contrast CT is contraindicated, perform one of the following actions: a computed tomography without a contrast, a magnetic resonance or an ultrasound, depending on the local experience. Symptoms include constant abdominal, generally severe and localizing pain in the lower left quadrant. They made a recommendation for investigation. 1.3.16 Offer intravenous antibiotics to people with acute diverticulitis and suspicion of diverticular abscess. 1.3.6 If inflammatory markers do not rise, think about the possibility of alternative diagnosis. 1.2.7 Advise people who: The benefits of increasing dietary fiber may take several weeks to achieve if it is tolerated, a high fiber diet should be maintained for life. 1.3.30 Do not offer an aminosalicylate or antibiotics to prevent recurrent acute diverticulitis. 1.3.19 Check intravenous antibiotics within a period of 48 hours or after exploration, if it occurs before, and consider the possibility of passing to oral antibiotics when possible. 1.3.18 Offer a TC of contrast to people with acute diverticulitis and suspicion of diverticular abscess. 1.3.1 Acute suspicious diverticulitis If a person is presented with constant abdominal pain, generally severe and localizing in the lower left quadrant, with any of the following: fever or sudden change of intestinal habit and significant rectal hemorrhage or motion The rectum or sensitivity in the lower left quadrant, a palpable abdominal mass or distensity in the abdominal examination, with previous background of diverticulosis or diverticulitis. 1.1.1. People with diverticulosis that the affection is asymptom and no specific treatments are needed. 1.3.14 When an antibiotic is prescribed for suspicion or confirmation of acute complicated diverticulitis, follow the indications of Table 2. 1.3.26 Offering laparoscopic washing or surgery (see recommendation 1.3.27) to people with diverticular perforation with generalised peritonitis after discussing the risks and benefits of the 2Â Âoptions with them (see tableÂ Â3). If contrast CT is contraindicated, perform one of the following: a non-contrast CT or an MRI or an ultrasound scan, depending on local expertise. 1.3.21 If a person does not have confirmed diverticular abscess, review their need for antibiotics. 1.3.25 In people with a CT-confirmed diverticular abscess, if the condition does not improve clinically or there is deterioration, consider re-imaging to inform the management strategy. 1.3.29 Consider open or laparoscopic resection for elective surgery for people who have recovered from complicated acute diverticulitis but have continuing symptoms, for example in people with stricture or fistula. 1.3.17 When prescribing an antibiotic for diverticular abscess, follow the advice in tableÂ Â2. 1.3.10 Offer intravenous antibiotics to people admitted to secondary care with suspected complicated acute diverticulitis.For guidance on the management of suspected sepsis see the NICE guideline on sepsis. 1.4.1 Give people with diverticulosis, and their families and carers where appropriate, verbal and written information on: diet and lifestyle the course of diverticulosis and the likelihood of progression symptoms that indicate complications or progression to diverticular disease. 1.3.15 For people presenting in secondary care with complicated acute diverticulitis and suspected diverticular abscess, assess and manage in line with the NICE guideline on sepsis. 1.1.5 Tell people about the benefits of exercise, and weight loss if they are overweight or obese, and stopping smoking, in reducing the risk of developing acute diverticulitis and symptomatic disease. 1.3.20 Use the scan results to guide treatment based on the size and location of the abscess. 1.3.4 For people with suspected complicated acute Those who have been referred for the hospital evaluation on the same day, offer a complete blood count, urea and electrolyte test and tests for reactive proteins. 1.3.7 For people with acute diverticulitis who are systemically well: consider an antibiotic prescribing strategy that provides simple analgesia, e.g., paracetamol advises the person to be present if the symptoms persist or worsen. Sudden inflammation or infection associated with the diverticula. 1.3.8 Provide an antibiotic prescribing strategy if the person with acute diverticulitis is systemically ill, immunosuppressed, or has significant co-morbidity. 1.2.6 For advice on diet, fluid intake, quitting smoking, weight loss and exercise, follow the recommendations in Section 1.1 on diverticulosis. 1.3.11 Review intravenous antibiotics within 48 hours or after the scan if sooner (see Recommendation 1.3.5) and consider moving to oral antibiotics where possible. The Committee was unable to make recommendations for practice in this area. 1.2.3 If the person meets the criteria for a suspected cancer pathway, refer to this pathway (see the NICE Guide to Suspected Cancer: Recognition and Referral). The Committee was unable to make recommendations for practice in this area. 1.3.9 Provides oral antibiotics if the person with acute diverticulitis is systemically ill, but does not meet the reference criteria for the suspicion of complicated acute diverticulitis. 1.2.2 Do not routinely refer people with a suspicious diverticular disease unless: it is suspected that routine endoscopic and/or radiological investigations cannot be arranged for primary care or colitis or the person meets the criteria for a suspected cancer virus. 1.3.13 When prescribing an antibiotic for suspected or confirmed acute, follow the advice in Table 2. Tell them: It is not necessary to avoid seeds, nuts, popcorn or fruit skins if they have constipation and a low-fiber diet, increasing their fiber fiber intake .ergnas .ergnas al ed osap le noc selanitsetni sotib¡Ãh sol ne oibmac y lanimodba rolod riulcni nedeup samotnÃs soL .lanoicida n³Ãicaulave anu arap airadnuces n³Ãicneta al a n³Ãicavired al naredisnoc y naroepme o netsisrep samotnÃs sus is airamirp n³Ãicneta al ne n³Ãicaulaveer al :aÃd omsim led airalatipsoh n³Ãicaulave al a naÃrefer es on euq senoicacilpmoc nis aduga sitilucitrevid ed ahcepsos noc sanosrep sal araP 3.3.1 .acip³Ãcsorcim sitiloc al o aimeuqsi al ,avitareclu sitiloc al ,nhorC ed dademrefne al noc odanoicaler onitsetni led n³ÃicamalfnI .1 .albat al ne sacitsÃretcarac sal ed areiuqlauc y odalortnocni lanimodba rolod eneit anosrep al is aÃd omsim led airalatipsoh n³Ãicaulave al etlusnoc y adacilpmoc aduga sitilucitrevid al euq ohcepsoS 2.3.1 .sarudrev y saturf ,selargetni sonarg ayulcni euq adarbiliuqe y elbadulas ateid anu namoc euq sanosrep sal a ejesnocA 2.1.1 .ohcered roirefni etnardauc le ne odazilacol ratse edeup arunret al y rolod le ,ocit¡Ãisa negiro ed sanosrep ne y sanosrep ed aÃronim anu ne euq atneuc ne agneT .n³Ãzahcnih al y aicnelutalf al raziminim edeuP

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