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Summary

When to operate in diverticular disease: The gastroenterologist's and the surgeon's point of view

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This presentation addressed surgical decision-making in diverticular disease, emphasizing individualized treatment based on disease phenotype, with the speaker advocating that uncomplicated first episodes do not require routine antibiotics or surgery, and elective surgery should be reserved for patients with documented disease, inflammatory markers, and meaningful quality-of-life impairment rather than episode count alone.

KEY POINTS

- The speaker stated that first CT-proven uncomplicated diverticulitis in immunocompetent stable patients no longer routinely requires systemic antibiotics; supportive treatment and close follow-up are sufficient, with antibiotics reserved for worsening patients, systemic infection, or significant comorbidities.
- Pericolic free gas does not automatically require surgery; urgent surgery is indicated only to control source of sepsis when conservative management, antibiotics, or percutaneous drainage fail, because urgent surgery has worse outcomes and higher risks than elective surgery.
- The speaker emphasized that simple diverticular symptoms do not equal indication for surgery; alternative diagnoses including irritable bowel syndrome, segmental colitis, inflammatory bowel disease, and colorectal cancer must be excluded before considering surgery.
- For persistent symptoms, the speaker recommended lifestyle modification, soluble fiber, rifaximin 800 mg per day for 7 days cyclically, and consideration of mesalazine and selected probiotics, with anti-spasmodics and neuromodulators for symptom control.
- Elective surgery requires CT-documented disease, raised inflammatory markers, and demonstrated quality-of-life impact; the speaker stated that pain without inflammatory markers is not a surgical indication and may persist after operation.

– The speaker noted anastomotic leak rates of 11 percent, incisional hernia in about 15 percent long-term, and cited the LASER study as showing fewer recurrences with surgery but the same long-term quality of life, cautioning against operating based solely on episode count, patient age, or available robotic technology.

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