

Multiple Diverticulosis of Whole Colon, Colonoscopy Finding: A Rare Case Report

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Abstract

Colonic diverticulosis, in general, is an acquired disease, developing as mucosal and submucosal herniations through the circular muscle layer at vulnerable weak points of the colonic wall. Diverticula are covered only by serosa. (1) Where the vasa recta penetrate the muscular layer, (2) the presence of anatomic and physiologic changes contributes to the development of diverticula, (3) combined barostat-manometry studies of the entire colon have demonstrated that compliance is lowest in the sigmoid and descending colon and greatest in the transverse and ascending colon. This difference in mechanical properties between the right and left sides might partly account for the left-sided predominance of diverticulosis, (4) low fiber diet increases the chances of intense, more frequent segmentation, thus predisposing to herniation of mucosa.

Key words: Barostat-manometry, Diverticulitis, Peritonitis

INTRODUCTION

Diverticulosis is the formation of numerous tiny pockets, or diverticula, in the lining of the bowel. Diverticula, which can range from pea-size to much larger, are formed by increased pressure on weakened spots of the intestinal walls by gas, waste, or liquid. Diverticula can form while straining during a bowel movement such as with constipation. They are most common in the lower portion of the large intestine (called the sigmoid colon).¹⁻⁵

Diverticulosis is very common and occurs in 10% of people over age 40 and in 50% of people over age 60. Most people will have no or few symptoms from diverticula.

Complications can occur in about 20% of people with diverticulosis. One of these complications is rectal bleeding, called diverticular bleeding, and another is diverticular infection called diverticulitis.⁶⁻⁸

CASE REPORT

Patient name Thukuri Rout, aged about 56 years male Hindu from Jagatsinghpur, Odisha of low socioeconomic status working as a skill labor came to hospital with complaints of pain abdomen, increase frequency of defecation, and passing mucous which was off and on in nature subsiding with medicine for the past 2 years.

The initial assessment of patients with suspected acute diverticulitis comprised a thorough history and physical examination including abdominal, rectal, and pelvic examinations. Such as computed tomography (CT), water-soluble contrast enema, cystography, endoscopy, and ultrasound may be performed. The differential diagnosis of acute diverticulitis should also be considered.

Abdominal ultrasound, with a sensitivity of 84-98% and a specificity of 80-97%, is a noninvasive screening tool with the potential drawback of the interpretation of the study, which may differ from one examiner to another. It is helpful, especially in female patients, to exclude pelvic and gynecologic pathology. CT, with a sensitivity of 69-95%, a specificity of 75-100%, and a low false-positive rate, is generally superior to contrast studies. CT with triple contrast - oral, rectal, and IV contrasts - is being used more frequently as the initial imaging study, especially in the acute setting, particularly whenever

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moderately severe disease or abscess is anticipated. Complicated diverticulitis refers to acute diverticulitis accompanied by abscess, fistula, obstruction, or free intra-abdominal perforation.

Uncomplicated diverticulitis may be managed in the outpatient setting with dietary modification and oral antibiotics for those without fever, excessive vomiting, or marked peritonitis admission is required.^{9,10}

Surgical treatment is required in the following condition.

- Diffuse peritonitis
- Failure of conservative treatment
- Persistent sepsis despite percutaneous drainage
- Very low threshold, immunosuppressed, and immunocompromised patients who are likely to fail medical treatment and present with perforation.

CONCLUSION

- The incidence of diverticular disease, particularly diverticulitis, has increased in industrialized countries.
- Diverticular disease can be classified as symptomatic uncomplicated disease, recurrent symptomatic disease, and complicated disease.
- Conservative or medical management is usually indicated for acute uncomplicated diverticulitis. Indications for surgery include recurrent attacks and complications of the disease.
- Surgical treatment options have changed considerably over the years, along with the development of new diagnostic tools and surgical approaches.
- Indications and timing for surgery of diverticular disease are determined mainly by the stage of the disease. In addition, individual patient risk factors, along with the course of the disease after conservative

or operative therapy, play a significant role in decision-making and treatment.

- In this context, the purpose of this chapter has been to review colonic diverticular disease and its treatment.

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REFERENCES

1. Roberts P, Abel M, Rosen L, Cirocco W, Flesman J, Leff E, *et al.* Practice parameters for sigmoid diverticulitis. The standards task force American society of colon and rectal surgeons. *Dis Colon Rectum* 1995;38:125-32.
2. Thomson HJ, Busuttill A, Eastwood MA, Smith AN, Elton RA. Submucosal collagen changes in the normal colon and in diverticular disease. *Int J Colorectal Dis* 1987;2:208-13.
3. Painter NS, Truelove SC, Ardran GM, Tuckey M. Segmentation and the localization of intraluminal pressures in the human colon, with special reference to the pathogenesis of colonic diverticula. *Gastroenterology* 1965;49:169-77.
4. Fearnhead NS, Mortensen NJ. Clinical features and differential diagnosis of diverticular disease. *Best Pract Res Clin Gastroenterol* 2002;16:577-93.
5. Stefánsson T, Nyman R, Nilsson S, Ekblom A, Pählman L. Diverticulitis of the sigmoid colon. A comparison of CT, colonic enema and laparoscopy. *Acta Radiol* 1997;38:313-9.
6. Cho KC, Morehouse HT, Alterman DD, Thornhill BA. Sigmoid diverticulitis: Diagnostic role of CT - Comparison with barium enema studies. *Radiology* 1990;176:111-5.
7. Painter NS. Diverticular disease of the colon. The first of the Western diseases shown to be due to a deficiency of dietary fibre. *S Afr Med J* 1982;61:1016-20.
8. Schwandner O, Farke S, Fischer F, Eckmann C, Schiedeck TH, Bruch HP. Laparoscopic colectomy for recurrent and complicated diverticulitis: A prospective study of 396 patients. *Langenbecks Arch Surg* 2004;389:97-103.
9. Eggimann T, Küng C, Klaiber C. Right-sided diverticulitis: New diagnostic and therapeutic aspects. *Schweiz Med Wochenschr* 1997;127:1474-81.
10. Rafferty J, Shellito P, Hyman NH, Buie WD; Standards Committee of American Society of Colon and Rectal Surgeons. Practice parameters for sigmoid diverticulitis. *Dis Colon Rectum* 2006;49:939-44.

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