Diverticular disease: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
28/06/2019 to 09/08/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Organisation name	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	General	General	We note the document does not consider endoscopy after an episode of acute diverticulitis. We do think it would be helpful for NICE to have a position on this.	Thank you for your comment. Follow-up investigations for people who have had an episode of acute diverticulitis was not included as a scope topic.
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	General	General	We were also wondering about the evidence for probiotics (if any) and also if there might be an emphasis on ambulatory care of those with uncomplicated acute diveticulitis.	Thank you for your comment. We found no evidence on probiotics. Please see chapter H. The majority of patients are treated in primary care. For those reaching secondary care for potential ambulatory management we have tried to emphasise the need for early diagnosis and discharge.
Association of Coloproctology of Great Britain and Northern Ireland – Patient Liaison Group	Guideline	General	General	The 5 members of the ACPGBI PLG (Patient Liason Group) who read the document felt that whilst diverticulosis *per se* is asymptomatic it does have the capacity to perforate so cannot be viewed as always without consequence.	Thank you for your comment. We have highlighted throughout the guideline that diverticulosis may be progressive. We have added the possibility of perforation to the introduction of Chapter A.
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	003	002	Would it be worth adding "Smoking cessation" and possibly "avoidance of NSAIDS" to Recommendation 1.1	Thank you for your comment. We have added stopping smoking to recommendation 1.1.5. We have moved the recommendation on NSAIDS to the top of the section on management and advice of section 1.2 diverticular disease.
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	006	009 - 012	Recommendation 1.3.2. Table 1. The fistula is to the bladder – is it worth emphsising this?	Thank you for your comment. We have added fistula into the bladder or vagina for completeness.
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	007	011 - 016	Recommendation 1.3.5. The Association accepts that not all units are able to perform a CT scan within 24 hours, but feel that this is the standard they should be aspiring to, rather than the 48 hours in the guideline.	Thank you for your comment. We recognise that 24 hours is achievable for the majority of units. We have edited the recommendation in accordance with your suggestion.
Association of Coloproctology of Great Britain and	Guideline	011	002 - 004	Recommendation 1.3.23. Is there a time frame for re-imaging?	Thank you for your comment. No evidence was identified to inform a recommendation on the timing of re-imaging. In the experience and opinion of the committee the timing is variable

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Northern Ireland					and dependent on a number of different factors. They were therefore unable to make a consensus recommendation.
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	011	001	Table 3 describing laparoscopic lavage. The point that "water or solution" is required should be removed.	Thank you for your comment. We have deleted 'water or solution'.
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	012	006	Recommendation 1.3.25. ACPGBI believe that any patient undergoing a primary resection with restoration of continuity in the acute setting should have their surgery performed by an individual with a declared colorectal interest who performs such surgery regularly, electively. In addition the guidelines do not allow for the patient who is very sick and simply has a defunctionning stoma pulled up proximal to the diverticular segment.	Thank you for your comment. We have added this information to the committee's discussion of the evidence in evidence report M. We have also added text on a defunctioning stoma to evidence report M. There was insufficient evidence for the committee to make a specific recommendation on this.
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	013	008 - 012	Recommendation 1.3.27. The benefits of laparoscopic surgery are well known. We would favour this approach over open surgery in patients undergoing and elective resection for ongoing symptoms.	Thank you for your comment. In evidence report K we have expanded the discussion on the potential benefits of laparoscopic surgery. Benefits have been shown in people with cancer but they have not been demonstrated in people with complicated acute diverticulitis.
Association of Coloproctology of Great Britain and Northern Ireland	Guideline	014	003 - 015	On page 14 at paragraph 1.4.1 a bullet point should be added after line number 8 On page 14 at paragraph 1.4.2 the bullet point should be altered at line 15	Thank you for your comment. Unfortunately, we are unclear what sections of the guidance you are referring to.
British Society of Gastroenterology	Guideline	General	General	Under symptoms or signs of Sepsis perhaps we should not be limited to no urine OP. Perhaps it should so no or poor urine output ie less than 0.5ml/kg/hr. It also mentions low tympanic temperature. Perhaps it should mention fever or high tympanic temperature as well. I realise fever is in the acute diverticulitis bit but it should still be mentioned).	Thank you for your comment. The indications are consistent with the NICE guideline on Sepsis (NG51). We now cross-refer to this guideline in the table. These indications were thoroughly discussed by the sepsis guideline committee.

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British Society of Gastroenterology	Guideline	General	General	Perhaps 'terms used in this guideline' should be presented at the very start of the document as definitions of this kind help frame subsequent discussion	Thank you for your comment. The majority of people access the document electronically. The terms will hyperlink to the entries in the section 'terms used in this guideline'. Research conducted by NICE has shown that readers prefer the recommendations are presented first followed by any supporting text.
British Society of Gastroenterology	Guideline	General	General	There is discussion of the lack of evidence for the use of antibiotics to prevent recurrent diverticulitis- but there is no clear discussion of the role of antibiotics to treat recurrent episodic diverticulitis. This is a strategy often employed in primary care in my experience thus an explicit statement about this linked to evidence would be helpful in the avoidance of antibiotic use in this circumstance	Thank you for your comment. No evidence was identified on the treatment of acute episodic diverticulitis. The treatment should be at the discretion of the clinician.
British Society of Gastroenterology	Guideline	General	General	Overall this is an excellent document and the committee should be commended to produce a very clear guideline	Thank you for your comment.
British Society of Gastroenterology	Guideline	006	013	RE Table 1 Symptoms and signs that suggest a complication of acute diverticulitis (1.3.2)	See comment below
British Society of Gastroenterology	Guideline	007	008 - 010	In 1.3.4 RE Secondary care U&Es should also be tested as well in view that this patient might go on to have a CT scan with contrast or be offered antibiotics that might impair renal function. This may aid the decision as to whether it is safe to offer contrast in the acutely ill patient.	Thank you for your comment. We have added urea and electrolytes to recommendation 1.3.4.
British Society of Gastrointestinal Abdominal Radiology (BSGAR)	Guideline	General	General	As is so often the case, the tariffs for diagnostic imaging and image-guided therapeutic procedures do not reflect the true cost of providing the service, particularly in hard-pressed departments where consultants may only be able to provide services by diverting from other timetabled commitments, resulting in outsourcing of less imperative diagnostic work (i.e. routine reporting) with the additional cost involved. While NICE can do nothing directly about this, we should take every opportunity to point this out.	Thank you for your comment. The committee were aware that scanning of patients suspected of having complicated diverticulitis might be difficult for some hospitals. However, they concluded that the benefits of early scanning justified the potential increase in workload. We have referred this to the NICE implementation team.
British Society of Gastrointestinal	Guideline	General	General	No mention of diverticular haemorrhage in this document. This seems to me to be a major omission.	Thank you for your comment. Diverticular haemorrhage was not included as a topic in the scope.

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Abdominal Radiology (BSGAR)					
British Society of Gastrointestinal Abdominal Radiology (BSGAR)	Guideline	007	011 - 016	Section 1.3.5 says : "If the person with suspected complicated acute diverticulitis has raised inflammatory markers, offer a contrast CT scan within 48 hours of hospital admission to confirm diagnosis and help plan management. If contrast CT is contraindicated perform a non-contrast CT if indicated. If CT is contraindicated, consider MRI or ultrasound scan depending on local expertise. This only suggests using MR if CT is contraindicated, I think this is too strong - it is reasonable to use MR according to site preference if there are contraindications to CE-CT. Although there are no head-to-head studies it is highly likely that CE-MRI is at least as, if not more sensitive than unenhanced CT. Same argument for 1.3.16 - if you suspect a diverticular abscess then it will be far easier to prove this on MRI than unenhanced CT where the lack of contrast may make it hard to diagnose an abscess if no gas in it. I think they should rephrase so that unenhanced CT, MRI and US are all options if contrast CT is (relatively) contraindicated.	Thank you for your comment. We agree with your suggestion and have edited recommendations 1.3.5 and 1.3.18 so that unenhanced CT, MRI and US are all options if contrast CT is contraindicated.
British Society of Gastrointestinal Abdominal Radiology (BSGAR)	Guideline	019	007	Page 19, line 7 - they should use the correct terminology of CT colonography (rather than CT virtual colonoscopy)	Thank you for your comment. We have edited this and now refer to CT colonography.
Department of Health - Northern Ireland	Algorithm	009	General	• Recommendation for Cefalexin as an alternative first choice antibiotic if penicillin	Thank you for your comment. We understand that only about 0.5–6.5% of penicillin-sensitive patients will also be allergic to cephalosporins. From the SPCs, cefalexin is not contraindicated in people with penicillin allergy, and can be used with caution. IV

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				allergic The Northern Ireland Primary Care Antimicrobial Guidelines advise that patients who have a type 1 allergic reaction with penicillins (e.g. urticaria, laryngeal oedema, bronchospasm, hypotension, angiodema) should not be prescribed any beta-lactam agents – this includes cephalosporins such as Cefalexin. Penicillin hypersensitivity is associated with rashes and anaphylaxis and can be fatal. Patients with a history of immediate hypersensitivity to penicillins may also react to cephalosporins and other beta-lactam antibiotics. If a beta-lactam antibiotic such as Cefalexin is required in an individual with a history of immediate hypersensitivity to penicillin then our guidance suggests that specialist advice from a microbiologist / infectious disease specialist should be sought on hypersensitivity testing or using a beta-lactam antibiotic with a different structure to the penicillin that caused the hypersensitivity. As such, I cannot support this recommendation as it stands, as there is a risk to patient safety in recommending the use of a beta lactam agent in patients with a true penicillin allergy. • First-choice intravenous antibiotics for suspected or confirmed complicated acute diverticulitis This section needs to make clear that Co-Amoxiclav, Amoxicillin and Cefuroxime should only be used in patients who are not allergic to penicillin.	cefuroxime can be used with caution in penicillin allergy, but is contraindicated in people with immediate hypersensitivity to penicillin. The clinician would use their judgement as to whether a cephalosporin can be used in someone with a penicillin allergy. We have added 'caution in penicillin allergy' after 'cefalexin'. We have not made reference to penicillin allergy in the IV antibiotics part of the table as this would make it hard to read if 'not in penicillin allergy' was added to each relevant entry.
Guts UK	Guideline	General	General	Need for precise definition of diagnostic entities throughout the documentation.	Thank you for your comment. The diagnostic entities used in the guideline are defined in the section 'terms used in this guideline'. The terms will hyperlink to the entries in this section.

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Guts UK	Guideline	005	006	This recommendation regarding fibre may be challenging for patients and practitioners, as we receive daily feedback from patients that a high-fibre diet worsens their symptoms. It may be beneficial for both parties if further, specific information on the types of fibre (soluble & insoluble) was provided to patients as dietary advice, or signposting to further support.	Thank you for your comment. We have added 'if tolerated' to recommendation 1.2.7 to acknowledge that high fibre diets may worsen symptoms. In the experience of the committee, people respond differently to different types of fibre and in the absence of evidence were unable to make a more detailed recommendation. The committee has made a research recommendation on how to manage diverticular disease.
Guts UK	Guideline	003 – 004	General	We are concerned that there is no precise definition of diagnostic entities between diverticulosis and diverticular disease. This will have important implications for diagnostic coding, future epidemiological studies and future studies on the pathogenesis of colonic disorders including through genetics. The reason is that large numbers of screening colonoscopies are uncovering incidental diverticulosis, yet this is frequently being conflated in medical records systems (and coding) with the term diverticular disease.	Thank you for your comment. The diagnostic entities used in this guideline are defined in the section 'terms used in this guideline'. When the term appears in the short guideline it will hyperlink to the relevant entry in this section.
Royal College of General Practitioners	Evidence review A: Prevention of diverticular disease in patients with diverticulosis	007	011	The guideline refers to the prescribable probiotic VSL#3, however we can no longer prescribe this https://www.medicinesresources.nhs.uk/en/Medicines-Awareness/Guidance-and-Advice/Drug-Prescribing/Probiotics-VSL3-and-Vivomixx-have-been-removed-from-the-Drug-Tariff-following-review-by-Advisory-Committee-on-Borderline-Substances-ACBS-/	Thank you for your comment. We have removed VSL#3 from table 2.
Royal College of General Practitioners	Guideline	General	General	The guideline uses multiple terms including diverticulosis, diverticular disease and diverticulitis. The committee should consider defining the terms within the text rather than in the summary at the end to prevent confusion to the reader. Page 20, line 19 specifically states that the aim of the guidance is to reduce confusion in primary care and including the definitions within the text will help mitigate this confusion which currently exists in the document.	Thank you for your comment. The majority of people access the document electronically. The terms will hyperlink to the entries in the section 'terms used in this guideline'. The diagnostic entities used in the guideline are defined in this section. Research conducted by NICE has shown that readers prefer the recommendations are presented first followed by any supporting text.
Royal College of General Practitioners	Guideline	003	009	Can the committee consider adding popcorn to the list of foods that should not be avoided as this is a common misconception.	Thank you for your comment. We have edited recommendation 1.1.2 and now refer to popcorn.
Royal College of General Practitioners	Guideline	004	005 - 008	Can the committee highlight that the symptoms described for diverticular disease have significant crossover with irritable bowel syndrome as well as malignancy (that is covered) and highlight that	Thank you for your comment. We have edited recommendation 1.2.1 and now refer to symptoms overlapping with IBS and malignancy in a 'Be aware' statement. We have also mentioned

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				even in young adults (18+) we should still consider diverticular disease/ diverticulitis with these symptoms	this in the rationale section.
Royal College of General Practitioners	Guideline	004	015	Diverticular disease can easily be managed in primary care in most instances. Can the committee consider adding specific reasons to refer to secondary care. E.g. Follow the routine referral pathways to secondary care *If* primary care investigations are not available or if non urgent complications of diverticular disease require further investigation or treatment	Thank you for your comment. We have edited 1.2.2 to make it clear that people with suspected diverticular disease do not need to need to be referred routinely. We have covered the non-urgent and urgent management of acute diverticulitis in the separate sections with specific recommendations on this.
Royal College of General Practitioners	Guideline	007	020	Watchful waiting in primary care with no antibiotic prescribing for acute diverticulitis is recommended appropriately but can the committee consider adding to the statement: a. The use of simple analgesia as a treatment option? (The AVOD study in 2012 and a Cochrane review showed IV fluid with as effective as IV antibiotics concluding simple analgesia should be first line with uncomplicated diverticulitis) Although secondary care based, the AVOD study could be extrapolated to stable primary care populations. b. Appropriate safety netting. By ensuring safety netting this will ensure if the persons symptoms progresses or they become unwell they seek further medical review.	Thank you for your comment. The AVOD study was included in the evidence review for non-surgical management of acute diverticulitis and at the time the committee interpreted the results as demonstrating no clinically important difference between IV fluids and IV antibiotics. Based on this and following further discussion with committee members, we have added two bullet points under recommendation 1.3.7 to refer to simple analgesia and safety netting as suggested.
Royal College of General Practitioners	Guideline	013	002	Can the committee consider adding "with de-functioning colostomy" to the term Hartman's procedure. This is a term understood by surgeons but not by lay people or health care professionals without surgical experience.	Thank you for your comment. We now explain the terms anastomosis and Hartmann's procedure in recommendation 1.3.27.
Royal College of Surgeons	Guideline	004	012 - 015	1.2.2 I am a little confused about the recommendation that patients should be investigated for diverticular disease (defined as diverticula + symptoms). This group is, in essence, people with IBS symptoms and diverticula. We really do not want these in the colorectal clinics that are sinking with 2 WW referrals. Surely the key point is that patients with bowel symptoms that might be due to cancer or IBD should be investigated. Is there a place to discuss FIT in here?	Thank you for your comment. We have added a 'be aware' recommendation to recommendation 1.2.1 highlighting the overlap with irritable bowel syndrome, colitis and malignancy. The role of FIT is still ill-defined in this patient group and was not prioritised as a scope topic. We will highlight your comment to the surveillance team for when any update is considered.
Royal College of Surgeons	Guideline	006	003	P 6 line 3 "mucous" is an adjective "mucus" is a noun	Thank you for your comment. We have edited the spelling in accordance with your suggestion.
Royal College of Surgeons	Guideline	006	016	Is "rebound tenderness2 really reliable? It's a poor sign at best and is always extremely unpleasant for the patient. I would like to see	Thank you for your comment. We have removed 'rebound tenderness' as suggested. The indications are consistent with

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				this removed, it really does not add anything to the assessment of guarding. Why not just specify low temperature? Is there something special about the ear?	the NICE guideline on Sepsis (NG51). These indications were thoroughly discussed by the sepsis guideline committee.
Royal College of Surgeons	Guideline	007	020 - 021	1.3.7 this sentence is horrible, it's a grammatical monster. It needs revision "Consider conservative treatment with analgesia and observation for systemically well people with acute diverticulitis." @You deal with antibiotic indications in the next bullet	Thank you for your comment. We have edited this sentence and now use separate bullet points for recommendation 1.3.7.
Royal College of Surgeons	Guideline	007	031	Page 7 line 31 48 hours for a CT scan? The average routine outpatient wait for a CT in he US is less than 8 hours. This looks like a stone age recommendation. Could you be less specific about time and simply say that CT is required to confirm or refute the clinical diagnosis. If you are going to put a time limit on then make it 24 hours. 48 is too long I think. P 7 line 14 Delete "if indicated" it's tautologous.	Thank you for your comment. We have amended the recommendation to 24 hours. We have deleted 'if indicated' from recommendation 1.3.5.
Royal College of Surgeons	Guideline	008	008 - 010	1.3.12 Couldn't you be stronger here? There is no good evidence that antibiotics are required for uncomplicated diverticulitis? Shouldn't you be recommending that antibiotics should not be used here?	Thank you for your comment. We now refer to stopping antibiotics in the rationale and impact section for this recommendation.
Royal College of Surgeons	Guideline	010	008 - 012	1.3.16 This reads oddly, surely we need to CT scan to make the diagnosis of complicated DD. Should this not be separated .. Antibiotics for sepsis. CT for source identification. If no sepsis then CT to make the diagnosis, then antibiotics for pericolic sepsis?	Thank you for your comment. We have removed 'complicated' from recommendation 1.3.18 as we agree it is not possible to make a diagnosis until the CT scan has been performed. We now have separate recommendations on following the sepsis guideline (1.3.15) and on antibiotics (1.3.16).
Royal College of Surgeons	Guideline	013	008 - 012	1.3.27 Do you really mean this? Surgery for stricture I can understand but "symptoms" seems very vague to me. Can we be more specific here?	Thank you for your comment. We have added 'for example people with fistula or stricture' to the recommendation and to the committee's discussion of the evidence in evidence report K. The symptoms are very broad and we thought it was more helpful to identify the population this recommendation relates to.
Royal College of Surgeons	Guideline	013	006 - 007	1.3.26 what do you mean by "compliant" bowel, Do you mean soft, unthickened, unaffected by inflammation, healthy? I note that you do explain this later in the text, I'm not sure that people will necessarily go looking for this, it might be better to find some other word that is more familiar to clinicians.	Thank you for your comment. We now define what we mean by compliant bowel in the recommendation (1.3.28). We have used the definition from the ACPGBI Position Statement on Elective Resection for Diverticulitis. Fozard et al (2011)

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Royal College of Surgeons	Guideline	015	020	P 15 line 20 .. Given that we need a CT to diagnose complicated diverticulitis how is this going to be treated by antibiotics in primary care?	Thank you for your comment. We have deleted the word complicated from the recommendation.
Royal College of Surgeons	Guideline	016	025	P 16 line 25 This sentence is a tautology delete "inpatients with known diverticulosis"	Thank you for your comment. We have deleted the end of the sentence in accordance with your suggestion.
Royal College of Surgeons	Guideline	017	013	P 17 line 13 including should be inclusion	Thank you for your comment. We have changed this to 'inclusion' as suggested.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*