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Diverticulitis

Diverticulosis is a weakening or pocket in the colon wall that usually occurs with time but may also occur in younger patients. The weakened area of the colon wall by itself normally does not cause any issues, but the pockets can get inflamed, and this is called diverticulitis. The pockets typically are clustered in the sigmoid colon, and this is also where diverticulitis usually occurs. This typically presents with fevers and left lower quadrant pain. Diagnosis can be suspected by history and exam but is confirmed by CT scan imaging. Acute diverticulitis is often treated with antibiotics although milder episodes may be self-limiting with dietary changes. However, it can sometimes be severe enough to require hospitalization. Surgery to remove the affected portion of colon can be considered in people who have had multiple escalating or difficult to treat episodes that are becoming impactful on quality of life. Diverticulitis can more rarely be complicated by perforation and/or abscess. Colon resection may also be considered in these instances.

Surgery

Surgery to remove the affected portion of colon is ideally performed after the acute episode of diverticulitis has resolved. This strategy reduces the risk of leak, infection, larger incisions, and colostomy. Surgery to remove part of the colon is typically performed laparoscopically (minimally invasive surgery) without placing hands inside the abdomen. Robotic assistance is not needed to perform this surgery and provides no advantage over traditional laparoscopic colon surgery. Regardless of how the operation is performed, the most dangerous complication from surgery is a leak where the colon is put back together. Fortunately, the colon heals remarkably well, and the risk in all cases I have done is only 0.7%. If this were to occur, however, it might require emergent re-operation and colostomy creation. The risk of wound infection is less than 5%. Other risks include, but are not limited to, bleeding, conversion to the larger incision/open technique, incisional hernia, and injury to other surrounding intra-abdominal structures. It is important to understand that this operation does not guarantee that diverticulitis will not occur in other parts of the colon, although this is only about 5%. This operation does require hospitalization of 2-4 days on average.

What to expect the day of surgery

You will choose your surgery date with me. The exact time of your surgery is not specifically known but we will estimate this for you. This is controlled by the hospital and is also determined by the length of preceding cases on that day. I take as much time and attention as is needed for each patient, just as I will for your operation. Please be patient as the hospital will often ask you to arrive well before your actual surgery time. There can sometimes be extended waiting so bring a book or iPad. I will meet with you again before surgery to answer any questions that may have developed. After your surgery I will meet with, or call, your family member. Colon surgery DOES require a mechanical bowel prep to be taken the day prior to surgery so make sure that you have received with over-the-counter instructions or a prescription from my office.

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What to expect after surgery

Medication. The first 2-3 days after surgery are the toughest and typically you will need intravenous pain medication. Prescriptions after discharge for pain and nausea medication will be sent into the pharmacy you requested during registration. You may want to make sure this is a pharmacy that is open 24 hour as you may be discharged from the hospital in the evening or weekend. If you can take Motrin/ibuprofen, it is often helpful to take this with or alternate with the narcotic medication. According to CDC, the likelihood of chronic opioid use increases with use after day 3 and with subsequent refills. Do not combine narcotic medication with alcohol or benzodiazepines. If you have chronic pain management by your primary care or pain clinic, you should notify them of upcoming surgery and may need to arrange post-operative pain management with them. It is normal to still be sore/uncomfortable during the next 1-2 weeks, but improvement should be noted.
I will indicate on your discharge papers when to restart blood thinning medication such as Coumadin, Xarelto, Pradaxa, Plavix, Brilinta, Effient, Eliquis, or aspirin. Typically, these can be restarted after discharge. If there is significant bruising or you are unsure, call before restarting those medication. You will be given antibiotics at the time of surgery but will not need prolonged antibiotics.

Activity. On the first day after surgery, you will begin to mobilize to the chair and if able to begin ambulation. By the second hospital day, you should be ambulating in the hallways. You will have a catheter placed in your bladder during surgery that will remain in place until the morning after surgery. You will also have an elastic abdominal binder that is helpful when you begin to mobilize. Staying active helps prevent blood clots, and pneumonia, and accelerates the return of bowel function. It is most important to stay active after you are discharged from the hospital. The more you walk, the quicker you will recover. The stairs are fine but go slow. Avoid heavy lifting, straining, bending, stooping, squatting. It is difficult to get up from a lying or sitting position at first so try to have some help if you can. You will need to avoid heavy lifting and abdominal straining for 6 weeks. It takes the body this long to maximally strengthen the abdominal incisions. Strenuous core activity before this time may increase your risk of hernia.

Wound care. You will have glue over several small incisions. Your largest incision will be approximately 2-3 inches and will be covered with surgical tape. There are no external sutures or staples. You may shower and wash with mild anti-bacterial soap beginning on the second day after surgery. Avoid submersion under water for two weeks. It can be normal for the area around the incisions to become red or bruised from surgical trauma. In some cases of skin sensitivity, you may also develop an itchy rash from the prep used to sterilize the skin during surgery or from the surgical glue. It is fine to use topical steroid or Benadryl creams. If this does not improve, please notify me.

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Diet/Bowel Function There are diet restrictions after this surgery but nothing long term. If you are not experiencing nausea, you will be given a liquid diet the morning after surgery. Your diet and activity will be advanced slowly in the hospital as your body allows. At discharge you should follow a bland, low residue diet for 2 weeks. You should avoid raw vegetables, fruits with peels, pulps, husks, seeds. At your 2 week follow up appointment, your diet may be advanced to regular as you tolerate. You may take stool softeners by mouth if needed, but do NOT use suppositories or enema.

Symptoms. After a few days you may notice firmness under and around the incisions. This is a normal part of the healing process and will resolve with time. You will be tolerating a diet, ambulatory in the hallways, and having bowel function return before discharge. Your first bowel movements will not be “normal.” It is not uncommon to have blood or loose grainy stools at first. This is normal and will resolve. It does take some time for your body to acclimate, but removal of the sigmoid colon does not affect bowel habits/continence long term. Decreased appetite and fatigue are normal and are usually the last to normalize slowly after surgery/anesthesia.

When to call. Surgery can be stressful so please call if you just forget something, are uncomfortable or unsure. It can be normal to have low grade fevers after surgery and this is usually related to decreased activity after surgery. Please be sure to walk and practice deep breathing to keep your lungs exercised. Persistent fevers over 101 should be reported. Call for nausea that is not well controlled with medication and causing potential issues with dehydration. Pain will not be completely resolved with medication but should be tolerable enough that you can move. If you have pain management concerns, please call during office hours. Narcotic medication cannot be addressed after hours.

Follow up. You will have a follow up appointment approximately 2 weeks after surgery. This is scheduled at the same time you schedule your surgery. If you are not sure, please call to confirm this appointment. At this appointment, I will ask about your diet, appetite, bowel function, discomfort level, and activity. Additional appointments are not usually necessary but can certainly be arranged if needed. You will be provided with your pathology report on that visit.

Return to work. I do recommend taking at least 2 weeks off from work. If you have non physically strenuous job you may return to work as you feel comfortable. If there is no light duty and you have a physically strenuous job, you may need to be off for 6 weeks. You may return to driving when no longer taking pain medication, when you can look over your shoulder without discomfort, and when your reaction time is normal. This is variable, but typically is 3-7 days.

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