Does a 48-Hour Rule Predict Outcomes in Patients with Acute Sigmoid Diverticulitis?

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We read with interest the paper by Evans¹ in which the author demonstrated that a noticeable drop in leucocyte count and temperature over the first 48-h of medical management predicted early discharge on oral antibiotics. We recently undertook an audit of all patients with acute sigmoid diverticulitis, over a 4-month period, which supported these findings.

Our audit reviewed all admissions to the surgical admissions unit of our district general Trust to improve surgical practice and thereby patient care, focussing on management and length of stay. Of all 33 patients admitted, none developed any complications or required surgical interventions. Further, neither intolerance of oral intake, nor opioid need, precluded discharge — despite this, however, mean length of stay was 3 days.

It has been shown that 70–85% of episodes of sigmoid diverticulitis resolve with medical management,¹ and, further, Broderick-Villa et al.² have shown that the risk of recurrent diverticulitis after initial non-operative management

was significantly lower than previous reports. Therefore, this study has important implications for current surgical practice.

There are currently no published guidelines in the UK, and other studies have shown, as has our audit, that there is no consensus between practitioners regarding management.³ Combining the results of Evans' study, current ASCRS guidelines⁴ and our audit, we have written a local guideline to encourage best practice and a reduction in unnecessary inpatient stay. If admission is necessary, then decreasing inflammatory markers within 48-h is an indication for discharge, as complications appearing after this have now been shown to be unlikely.

A 48-h rule should have a significant impact on length of stay of patients with acute sigmoid diverticulitis, with consequent benefits for the patient and substantial financial savings for our Trust.

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