

Diverticulitis

A plain-English guide for you and your family

WHAT IS HAPPENING

Your colon is the long tube that carries leftover food and stool toward the toilet. Over time, tiny pouches called diverticula can push out through weak spots in the colon wall, like little balloons poking through. Most people never know they have them and feel fine. But sometimes a pouch gets plugged up, usually by a hard piece of stool. Pressure builds inside, the pouch swells, and its thin wall can crack or tear. Germs that normally live in your colon leak into the pouch, and infection starts. Your body rushes white blood cells to the spot to fight the germs, and the tissue around the pouch puffs up to wall off the trouble. That's why you feel pain in your lower left belly, where the sigmoid colon sits. You may also get a fever, feel sick to your stomach, and notice your bowel habits change—maybe constipation, maybe diarrhea. If your body's wall holds, the infection stays small and antibiotics can clear it. But if the tear gets bigger or the wall breaks wide open, infected fluid spills into your whole belly, pain spreads everywhere, and you can become very sick very fast. That's why doctors use a CT scan to see how bad the tear is and decide if you need antibiotics alone, drainage of a pocket of pus, or surgery to remove the damaged piece of colon.

What you might feel

- Pain in the lower left belly that gets worse over hours to days
- Fever (temperature above 100.4°F or 38°C)
- Tenderness when you press on the lower left belly (left lower quadrant)
- High white blood cell count (leukocytosis) on a blood test
- Change in bowel habits—either diarrhea or constipation
- Nausea or vomiting
- Blood in the stool (hematochezia)
- Severe belly pain that spreads all over or feels rigid
- Right-sided belly pain in younger or Asian patients

Call the doctor right away if...

- Severe belly pain that spreads everywhere or belly feels hard and board-like (suggests perforation)
- High fever (above 102°F or 39°C) or shaking chills (suggests severe infection or abscess)
- Unable to keep down food or water, or signs of dehydration (dry mouth, dizziness, little urine)
- Large amount of blood in the stool or black tarry stools (suggests significant bleeding)
- Confusion, very low blood pressure, or rapid heart rate (suggests sepsis—infection spreading through the bloodstream)

What the care team will do

- Check vital signs every 2 to 4 hours, especially temperature, heart rate, and blood pressure, and report fever above 102°F (39°C), heart rate above 110, or systolic blood pressure below 90.
- Keep the patient NPO (nothing by mouth) if they have severe pain, vomiting, or signs of complicated diverticulitis, and start IV fluids at the rate ordered by the provider.
- Perform a focused abdominal exam every 4 to 8 hours: look for increasing firmness (rigidity), listen for bowel sounds, gently press all four quadrants, and check for rebound tenderness or guarding.
- Give IV or oral antibiotics exactly on time as ordered, and do not skip or delay doses.
- Monitor intake and output every shift: measure all IV fluids going in and all urine coming out, and report urine output less than 30 mL per hour or 0.5 mL per kilogram per hour.
- Assess and document pain level every 4 hours using a 0-to-10 scale, give pain medicine as ordered, and report pain that suddenly gets much worse or spreads across the whole belly.
- Watch for and report immediately any signs of sepsis: confusion, very low or very high temperature (below 96.8°F or above 101°F), fast breathing (above 20 breaths per minute), or mottled (blotchy) skin.
- Inspect every stool for color, consistency, and blood, and save any bloody stool to show the provider.

Medicines you may be given — and why

Ciprofloxacin

Ciprofloxacin kills bacteria by stopping them from copying their DNA. When bacteria can't copy their DNA, they can't multiply and they die. It works especially well against the gram-negative bacteria (the type with a thin outer wall) that often cause diverticulitis, like *E. coli*.

Metronidazole

Metronidazole kills anaerobic bacteria (bacteria that live without oxygen). These bacteria are common in the colon, and they often join gram-negative bacteria in causing diverticulitis. Metronidazole enters bacterial cells and breaks their DNA strands so they cannot survive.

Amoxicillin-clavulanate (Augmentin)

This is a combination drug. Amoxicillin kills bacteria by breaking down their cell walls so they burst and die. Clavulanate blocks an enzyme (beta-lactamase) that some bacteria make to protect themselves from amoxicillin. Together, they kill both aerobic and anaerobic bacteria that cause diverticulitis.

Piperacillin-tazobactam (Zosyn)

This IV combination is used for severe or complicated diverticulitis in the hospital. Piperacillin kills a wide range of bacteria by destroying their cell walls. Tazobactam blocks the enzymes bacteria use to resist piperacillin. Together, they cover almost all the bacteria that cause serious colon infections.

Ceftriaxone + Metronidazole

This is a two-drug IV combination for hospitalized patients with complicated diverticulitis. Ceftriaxone kills aerobic gram-negative bacteria by breaking their cell walls. Metronidazole (described above) kills anaerobic bacteria. Together, they cover the full range of bacteria in severe colon infections.

Where this information comes from

- American College of Gastroenterology (ACG) 2021 Diverticulitis Guideline
- American Society of Colon and Rectal Surgeons (ASCRS) 2020
- Cochrane Database of Systematic Reviews
- UpToDate (Wolters Kluwer)

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