

SMALL BOWEL DIVERTICULA AND GI BLEEDING

Epidemiology:

- seen in up to 7-1% of patients on autopsy or incidental radiographs
- most asymptomatic
- less than 5% will bleed

Background and Pathogenesis:

- usually pulsion-type pseudodiverticula
- often multiple
- usually diminish in frequency from the ligament of Trietz to the ileocecal valve
- associated with colonic diverticula in about 30-35% of cases
- range in size from 1-25 cm

Presentation:

- most will be asymptomatic
- diverticula can present as pseudo-obstruction likely due to a motility disorder
- can be associated with bacterial overgrowth leading to inflammation
- can cause bleeding, presenting like routine GI bleed, either upper or lower, usually severe

Diagnosis:

- diverticula usually only identified incidentally on barium swallow or with complications
- EGD and Colonoscopy not helpful
- bleeding scan not usually helpful
- angiogram can be helpful at times
- true diagnosis of bleeding site seen in the operating room, or on push enteroscopy into the small bowel
- angiography will show pooling of the extravasated blood in the diverticulum

Differential Diagnosis of patient presenting with GI bleeding

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- Upper GI Bleeding:
 - 1) Duodenal ulcers
 - 2) gastric ulcers
 - 3) acute gastritis
 - 4) Esophageal varices
 - 5) Gastric cancer
 - 6) Mallory-Weiss tear
- Lower GI Bleeding:
 - 1) Diverticulosis
 - 2) AVM

- 3) Colon cancer
- 4) Hemorrhoids
- 5) Inflammatory Bowel Disease
- 6) Ischemic colitis

Treatment:

- embolization of vessels during angiography difficult, site not usually seen
- therefore treatment usually surgical
- first option: local resection of the small bowel diverticula
- limited bowel resection based on previous information of the bleeding site, from angiography, or push enteroscopy
- larger resection of the small bowel

Prognosis:

- even with prompt treatment mortality can be as high as 20%.

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