Annals of Gastroenterology (2013) **26,** 354

Jejunal diverticulosis

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A 70-year-old patient presented with a 6-month history of bloating, flatulence, diarrhea and foul-smelling retching. He had undergone a Billroth II gastrectomy due to complicated peptic ulcer disease 30 years ago.

Physical examination denoted mild abdominal distention. Laboratory tests revealed macrocytic anemia (Hb: 10.1 g/dL, MCV: 102 Fl) with severe vitamin B12 deficiency (161 pg/mL), although folate levels were elevated (18.7 ng/mL). Upper gastrointestinal endoscopy showed remnant gastritis and Giemsa stain was negative for *Helicobacter pylori*. Ileocolonoscopy was normal. Small bowel enteroclysis demonstrated multiple jejunal diverticula sized up to 4 cm and delayed contrast passage though the ileal loops, possibly related to adhesions (Fig. 1).

The patient was diagnosed with possible small intestinal bacterial overgrowth (SIBO) secondary to jejunal diverticulosis and gastrectomy. He was administered rotating antibiotic courses achieving significant clinical and laboratory improvement.

Jejunal diverticula occur in 1-2% of the population. They are frequently multiple, localized to the proximal jejunum and composed of either mucosa and submucosa or all wall layers. They usually remain asymptomatic although complications (e.g. inflammation, perforation and bleeding) may occur. Their major clinical manifestation is malabsorption due to bacterial overgrowth. Symptoms include abdominal discomfort, bloating, diarrhea, flatulence and weight loss. Barium follow-through and enteroclysis are the diagnostic methods of choice. CT, MRI and enteroscopy may also be used, if indicated [1].

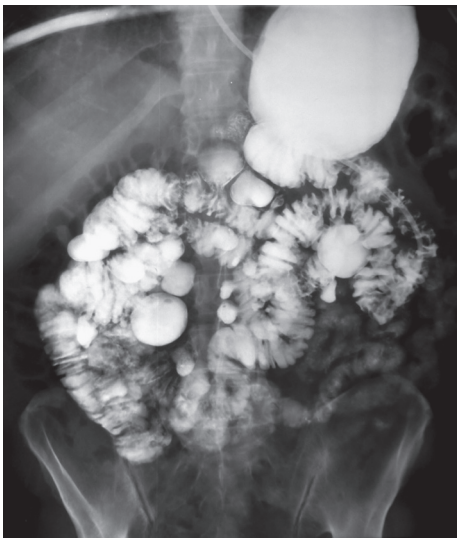

Figure 1 Small bowel enteroclysis in a patient with Billroth II gastrojejunal anastomosis showing multiple jejunal diverticula of various sizes

Treatment of SIBO associated with jejunal diverticulosis consists primarily of antibiotics covering enteric flora. These include rifaximin, metronidazole, amoxicillin/clavulanate, ciprofloxacin, norfloxacin and tetracycline. Antibiotics are usually given initially for two weeks. Repeat courses on a regular basis are needed when recurrent symptoms are present. Rotating regimens prevent resistance development in these patients [2].

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Conflict of Interest: None

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Received 23 April 2013; accepted 29 April 2013

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