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Editorial

Remembering a rare pathology

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This journal issue presents two articles on small bowel diverticula manifested by hemorrhage. Small intestine diverticula can be classified by origin (congenital or acquired), by the wall structure (true or false), and by location (duodenal, jejunal, jejunoileal, and terminal ileal). According to their origin, congenital diverticula are true when their wall includes all the layers of the intestinal wall (mucosa, submucosa, muscularis propria, and serosa); the most typical example is Meckel's diverticulum, described in 1598 by Fabricius V. Hilden, and it was not until 1812 that Johann Friedrich Meckel related it as a remnant of communication with the yolk sac[(1)]. It is present in 2% of the population. Of note is that congenital diverticula are also described, especially in the duodenum and sporadically in the rest of the small intestine. Acquired diverticula are usually false diverticula; their wall comprises the mucosa, submucosa, and serosa layers. They are the majority of jejunoileal and duodenal diverticula.

Their origin lies in pulsion mechanisms with incoordination of the neuromuscular activity of the intestinal wall with dyskinesias, causing high pressures. At the points where the perforating vessels penetrate the intestinal wall at the mesenteric border, progressive herniation of the submucosa and mucosa occurs, forming the false diverticulum; these vessels are more abundant in the proximal jejunum, precisely where these diverticula are more frequent, and are typically multiple[(2)]. The shaped diverticulum allows bacterial overgrowth that triggers malabsorption and possible steatorrhea.

From the perspective of their clinical manifestations, between 60% and 90% are asymptomatic, up to 25% present some symptoms, and 15% develop some complications. Small bowel diverticula can manifest in a chronic form with malabsorption associated with chronic abdominal pain or in an acute form with obstruction, pseudoobstruction, diverticulitis, perforation, or hemorrhage, as the cases reported in this publication[(3,4)]. In chronic manifestations, the diagnosis is made with clinical suspicion, which, due to their rarity, requires the physician's sharpness (incidence in autopsies of 0.06% to 5%). Noble's triad, consisting of diffuse abdominal pain, anemia, and dilation of thin loops[(5)], is described.

Depending on the manifestation, the diagnosis may be incidental to a surgical exploration for another cause or to radiological or endoscopic studies. In acute manifestations, especially those associated with bleeding, an upper or lower source of bleeding is ruled out with esophagogastroduodenoscopy and colonoscopy. At this point, it should be considered that since the highest incidence of diagnosis of diverticula in the small intestine is between 60 and 70 years of age[(6)], it is not uncommon to find associated diverticula in

the colon, hemorrhoidal disease, polyps, vascular malformations, and acid-peptic disease in different degrees of intensity. All these pathologies can distract from the diagnosis of diverticula in the small intestine, and only the persistence or intensity of bleeding makes it necessary to conduct other studies, which, in hemodynamically stable patients, can be capsule endoscopy, enteroscopy, magnetic resonance enterography, or contrast-enhanced tomography. Capsule endoscopy should be avoided in patients with large diverticula due to the possibility of becoming entangled in the diverticula[5].

Due to the intermittent nature of digestive bleeding, studies with radioisotopes allow several measurements to be taken at various times to detect active bleeding even without identifying the anatomical location, which helps the patient receive arteriography therapy[7]. In hemodynamically unstable patients, magnetic resonance angiography, CT angiography, or direct angiography is used. Ten percent of cases with bleeding require surgical management with resection of the diverticulum or the affected intestinal part. In patients with inflammation, it is preferable to resect the segment involved[1,2].

Lastly, we congratulate the authors of the articles on small bowel diverticula published in this issue for their detailed and engaging descriptions of the reported cases.

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