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Supplementary Table 3. Summary of the results of the questionnaire and relevant guidelines recommendations or evidence

Question	Answer	Current recommendations/evidence
Q1. Do you think there is a difference in disease severity between right and left colonic diverticulitis?	Right diverticulitis likely to be complicated – 84/195 (43.1%) Left diverticulitis likely to be complicated – 46/195 (23.6%) No difference – 65/195 (33.3%)	Results from a systematic review and meta-analysis[1] "Right-sided acute diverticulitis predominantly affects younger male patients compared with left-sided disease and is associated with favourable outcomes as indicated by the lower risk of complications, failure of conservative management, need for emergency surgery, recurrence and shorter length of hospital stay."
Q2. Do you think that colonic diverticulitis in immunocompromised patients has a poor outcome compared with immunocompetent patients?	Yes – 139/195 (71.3%) No – 56/195 (28.7%)	From AGA Clinical Practice Update on Medical Management of Colonic Diverticulitis: Expert Review[2] "Immunocompromised patients are more likely to present with severe or complicated disease. For these patients there should be a low threshold for cross-sectional imaging, antibiotic treatment, and consultation with a colorectal surgeon."
Q3. What do you think is the most useful (or preferred) tool for diagnosing acute diverticulitis?	Blood tests – 3/195 (1.5%) CT scan – 183/195 (93.9%) Abdominal ultrasonography – 6/195 (3.1%) Colonoscopy – 3/195 (1.5%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "CT is recommended as the first-line investigation in suspected diverticulitis. Ultrasound and MRI are alternatives." From Guidelines for Colonic Diverticular Bleeding and Colonic Diverticulitis: Japan Gastroenterological Association[4] "In addition to physical examination and blood tests, an imaging test (CT or US) is recommended for the diagnosis of colonic diverticulitis."
Q4. Do you think antibiotic treatment is necessary for acute uncomplicated colonic diverticulitis in immunocompetent patients?	Yes – 171/193 (88.6%) No – 22/193 (11.4%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "Patients with acute uncomplicated diverticulitis do not require antibiotics routinely. Antibiotic treatment should be reserved for immunocompromised patients and patients with sepsis." From Guidelines for Colonic Diverticular Bleeding and Colonic Diverticulitis: Japan Gastroenterological Association[4] "Antibiotic therapy has been reported to be unnecessary for colonic diverticulitis without abscess or perforation, but no studies have been conducted in Japan. Therefore, the efficacy of antibiotic therapy among Japanese patients is currently unclear. Antibiotic therapy is considered acceptable in present clinical practice."
Q5. Do you think therapeutic bowel rest and parenteral nutrition are necessary in cases of acute uncomplicated diverticulitis?	Yes – 101/190 (53.2%) No – 89/190 (46.8%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "There is no evidence to support dietary restrictions. An unrestricted diet (when tolerated) ispreferable." From Guidelines for Colonic Diverticular Bleeding and Colonic Diverticulitis: Japan Gastroenterological Association[4] "Dietary restriction and bowel rest are recommended for colonic diverticulitis without abscess or perforation in patients admitted to the hospital with clinical features of inflammatory response and high fever."

Supplementary Table 3. Continued

Question	Answer	Current recommendations/evidence
Q6. In acute uncomplicated diverticulitis, when the patient's pain is moderate, do you generally recommend hospitalization or outpatient treatment?	Recommend hospitalization – 127/189 (67.2%) Treat in outpatient setting – 62/189 (32.8%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "For patients with an adequate social network tolerating oral intake, outpatient treatment of uncomplicated diverticulitis seems to be safe in the absence of sepsis, significant comorbidity and immunosuppression."
Q7. Do you think emergency surgery is necessary for patients with acute colonic diverticulitis with an abscess or a microperforation without panperitonitis?	Yes – 14/189 (7.4%) No – 175/189 (92.6%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "Although the role of percutaneous drainage of abscesses in acute diverticulitis is not completely clear, it may be considered in patients with an abscess larger than 3 cm. Emergency surgery should be kept as last resort for patients failing other non-surgical treatments." "It seems fairly safe to observe immunocompetent haemodynamically stable patients even if there are radiological signs of extraluminal air. Immediate surgery should be considered in haemodynamically unstable or septic patients." From Guidelines for Colonic Diverticular Bleeding and Colonic Diverticulitis: Japan Gastroenterological Association[4] "Antibiotic therapy and bowel rest are proposed when the abscess measures ≤ 3 cm. However, when the abscess is ≥ 5 cm, it is proposed that US- or CT-guided drainage, antibiotic therapy, and bowel rest be instituted. For abscesses measuring 3–5 cm, treatment needs to be individualized based on disease state and feasibility of drainage depending on the availability of human and facility resources."
Q8. Do you think screening for colorectal cancer is necessary for patients ≥ 50 years who have recovered from the acute phase of diverticulitis?	Yes – 179/189 (94.7%) No – 10/189 (5.3%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "Endoscopic follow-up: for patients with symptom-free recovery after a single episode of CT verified uncomplicated diverticulitis endoscopic follow-up remains controversial and may not be necessary. All other patients treated without resection for acute diverticulitis should be followed up with an examination of the colon at least 6 weeks after the acute episode, if not done within the last 3 year." From Guidelines for Colonic Diverticular Bleeding and Colonic Diverticulitis: Japan Gastroenterological Association[4] "Although the association between colonic diverticulitis and colorectal cancer is currently unknown, colonoscopy is recommended at least once to eliminate the possibility of lesions other than colonic diverticulosis as the possible cause of disease."
Q9. Do you think screening for colorectal cancer is necessary for patients < 50 years who have recovered from the acute phase of diverticulitis? (It is the same question as the previous question, but it is a question asking whether treatment is different according to age)	Yes – 135/188 (71.8) No – 53/188 (28.2)	

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Supplementary Table 3. Continued

Question	Answer	Current recommendations/evidence
Q10. If patients who recovered after the acute phase of diverticulitis were taking aspirin or non-steroidal anti-inflammatory drugs (NSAIDs), do you think that these drugs should be stopped to prevent the recurrence of diverticulitis?	Yes – 53/185 (28.6%) No – 132/185 (71.4%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "Commonly used drugs, such as nonsteroidal anti-inflammatory drugs, aspirin, acetaminophen, corticosteroids and opioids increase the risk of diverticular disease, particularly complicated diverticulitis." From AGA Clinical Practice Update on Medical Management of Colonic Diverticulitis: Expert Review[2] "Additionally, patients with a history of diverticulitis should avoid regular use (2 or more times per week) of nonsteroidal anti-inflammatory drugs except aspirin prescribed for secondary prevention of cardiovascular disease."
Q11. Do you administer any pharmacological therapy to patients who have recovered from the acute phase of diverticulitis to prevent recurrence?	Rifaximin – 2/185 (1.1%) Mesalamine – 1/185 (0.5%) Probiotics – 14/185 (7.6%) No pharmacotherapy – 168/185 (90.8%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "From the available medical agents, neither mesalazine, rifaximin nor probiotics can be recommended to prevent recurrent diverticulitis or persistent complaints after an episode of acute diverticulitis."
Q12. Do you think a high-fiber diet should be recommended to prevent recurrence in patients who have recovered from the acute phase of diverticulitis?	Yes – 104/185 (56.2%) No – 81/185 (43.8%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "Although a high-fibre diet may be recommendable for general health purposes, there is little evidence that it can prevent recurrent episodes or persistent symptoms in patients with acute diverticulitis."
Q13. If acute diverticulitis recurs several times, which treatment do you prefer, repeating the medical treatment or treating surgically?	Repeat medical treatment – 42/185 (22.7%) Surgical treatment – 11/185 (6.0%) Individualize – 132/185 (71.4%)	From European Society of Coloproctology: guidelines for the management of diverticular disease of the colon[3] "The goal of elective surgery after one or more episodes of diverticulitis is to improve QoL. The indication should be individualized and based on the frequency of recurrences, duration and severity of symptoms after the attacks and the comorbidity of the patient."
Q14. If acute uncomplicated colonic diverticulitis recurred for the third time, would you recommend elective (or planned) surgery after medical treatment (unless the patient has underlying diseases and is at high risk for surgery)?	Yes – 64/185 (34.6%) No – 121/185 (65.4%)	From AGA Clinical Practice Update on Medical Management of Colonic Diverticulitis: Expert Review[2] "An elective segmental resection should not be advised based on the number of diverticulitis episodes." "A discussion of elective segmental resection for patients with a history of diverticulitis should be personalized to consider severity of disease, patient preferences and values, as well as risks and benefits, including quality of life. Patients should understand that surgery reduces, but does not eliminate, diverticulitis risk, and that chronic gastrointestinal symptoms do not always improve with surgery."
Q15. If acute uncomplicated colonic diverticulitis recurred for the fourth time, would you recommend elective (or planned) surgery after medical treatment (unless the patient has underlying diseases and is at high risk for surgery)?	Yes – 116/185 (62.7%) No – 69/185 (37.3%)	From Guidelines for Colonic Diverticular Bleeding and Colonic Diverticulitis: Japan Gastroenterological Association[4] "Recurrent colonic diverticulitis without abscess or perforation alone is not always an indication for colectomy, but elective surgery may be considered in special cases, such as in immunocompromised patients."

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Supplementary Table 3. Continued

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