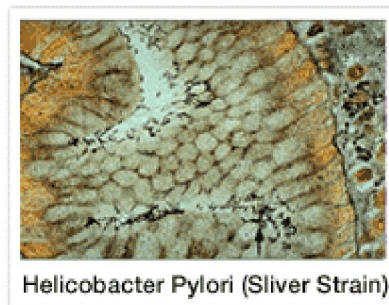
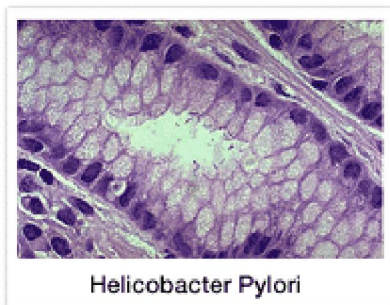


DECISION POINTS FOR THE MANAGEMENT OF HELICOBACTER PYLORI IN PRIMARY CARE

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INTRODUCTION

These evidence based decision points were developed by a representative group of gastroenterologists and GPs from the PCSG. Any comments or feedback are welcome and can be sent by e-mail to pcsg@pcsg.demon.co.uk

INDICATIONS FOR ERADICATION THERAPY

Clinical evidence suggests that H. pylori is associated with the following conditions: duodenal ulcer (except NSAID-induced ulcer) gastric ulcer (except NSAID-induced ulcer) endoscopy-confirmed chronic active gastritis

H. pylori is also associated with MALToma, but this is extremely rare in primary care. H. pylori is not associated with oesophagitis.

TESTING FOR H. PYLORI BEFORE ERADICATION THERAPY

Currently, the most useful pre-eradication test is: the C13 breath test (subject to availability) If this is not available locally, use a laboratory serology test.

NB: Proton pump inhibitor (PPI) therapy should be stopped for 14 days before doing a C13 breath test.

AFTER ERADICATION THERAPY

Testing to confirm successful eradication is the counsel of perfection. In practice it is unnecessary unless: the patient's symptoms recur the patient has a history of ulcer complications (e.g. haematemesis) - he/she should be maintained on an H2-antagonist until eradication has been confirmed.

NB: Following eradication therapy, four weeks must elapse before the C13 breath test gives a reliable result, and six months for a serological test.

TEST AND TREAT STRATEGIES

Patients under the age of 45 with simple ulcer-like symptoms should be tested for H. pylori before investigation or eradication therapy. Present evidence suggests that H. pylori-positive patients under the age of 45 and without alarm symptoms should be referred for endoscopy, followed by treatment as appropriate. Treatment of H. pylori-positive patients without prior endoscopy is an approach often employed in primary care. At present there is no clear evidence for or against this strategy. The most appropriate course of action takes account of the individual patient's circumstances, fears and concerns.

TREATMENT REGIMENS

Evidence indicates that a one week, twice daily, triple therapy, using a PPI + two antibiotics, is the most effective option. The exact choice of regimen depends upon the local level of metronidazole resistance.

NB: PPI therapy should be stopped for 14 days before any course of eradication therapy.

FIRST-LINE REGIMEN (metronidazole resistance high or unknown) PPI b.d.

- amoxicillin 1g b.d.
- clarithromycin 500 mg b.d.

FIRST-LINE REGIMEN (metronidazole resistance low) PPI b.d.

- clarithromycin 500 mg/ 250 mg b.d.
- metronidazole 400 mg b.d.

SECOND-LINE REGIMEN

If symptoms recur, the following regimen has been shown to be successful in most first-line failures: PPI o.d.

- amoxicillin 500mg t.d.s.
- metronidazole 400 mg t.d.s.

CONTRIBUTORY FACTORS FOR HIGH METRONIDAZOLE RESISTANCE

- Patient originates from a developing country.
- Patient has received metronidazole therapy on a previous occasion.
- Patient resides in an inner-city area, or an area of known high metronidazole resistance.
- Patient resides in an area with a significant immigrant community.

NB: These criteria also apply to other nitroimidazoles (e.g.) tinidazole).

SUMMARY OF KEY POINTS

- All patients with GU and DU unrelated to NSAID therapy should be given eradication therapy. Patients with chronic active gastritis should be given eradication if H. pylori-positive.
- The C13 breath test is the most useful test, but has limited availability. The best alternative is a laboratory serology test.
- The best eradication regimen is a one week, twice daily, triple therapy of a PPI plus two antibiotics. Use PPI + amoxicillin + clarithromycin if the local level of metronidazole resistance is high or unknown, or if the patient is in a high-resistance group (e.g. ethnic origins). Use PPI + clarithromycin + metronidazole if the metronidazole resistance is low. Use PPI + amoxicillin + metronidazole as the second-line treatment.
- Best management of H. pylori in primary care balances clinical judgement, common sense and the needs of the individual patient.