Unacceptability of Kyoto Global Consensus Report on Helicobacter Pylori Gastritis

Dear Editor,

In the article published recently in the Gut, many experts in the field of H. pylori infection were gathered in Kyoto and agreed to a statement on eradication of H. pylori. The experts concluded that H. pylori infection should be considered as an infectious disease, like tuberculosis and syphilis, and has to be eradicated in all individuals. This recommendation to deal with H. pylori infection can’t be accepted not only in countries like Iran where H. pylori infection is almost universal in the adult population, but also in countries with a low infection rate.

Tuberculosis is beside of its high economic burden for society and the long duration of its treatment, is not a symptomless disease and comparable to the long life silent H. pylori infection disease: in 33 studies, the death rate of tuberculosis ranges between 1.8% to 33.3% during the time period of active treatment of patients. Fetal death occurring in gravid women with asymptomatic syphilis infection in the general population of South America and Africa, where a high prevalence of H. pylori infection exists, is a serious problem. However, H. pylori infection in a large population study in USA, except for gastric cancer, was not responsible for all-cause mortality.

Regarding the eradication of each patient with H. pylori positive dyspepsia, our experiences in Iran were negative: 110 patients with H. pylori positive dyspepsia not responding to previous 4 weeks treatment with antacid were randomized to eradication or symptomatic treatment, the complete or moderate response to treatment after 9 months was the same in both groups. In another recent publication from Iran, with 359 H. pylori positive dyspepsia, the eradication therapy compared with the placebo group was not successful after one year follow-up.

The experiences obtained in other countries were not impressive and the benefit of H. pylori eradication was small; only one out of 14 subjects with non-ulcer dyspepsia had long term responses by a meta-analysis. A better response of eradication therapy in non-ulcer dyspepsia was achieved in China. As the cause of non-ulcer dyspepsia is heterogeneous, then the effect of eradication therapy must be proven in each country. It should be considered that the prevalence of ulcer-like dyspepsia as probable precursor of peptic ulcer disease might be different in various countries.

From the other hand, eradication of H. pylori in the population with no risk for peptic ulcer disease or gastric cancer could be associated with some inadequate consequences, which outweighs the small benefit of eradication even in non-ulcer dyspepsia. In 1997, Labenz, et al. reported the occurrence of reflux-esophagitis in patients with duodenal ulcer within 3 years after H. pylori eradication, compared with those not eradicated. In spite of some controversy, a careful case and control study confirmed this finding. In a meta-analysis with 43 case-control studies and a few cohort studies, this post-eradication sequela was confirmed. The risk of occurrence of esophagitis after H. pylori eradication was greater in Asian than in European countries.

Furthermore, there is now adequate evidence about the inverse association of H. pylori infection with Barrett Esophagus, adenocarcinoma of cardia and distal esophagus, as well as with the occurrence of asthma in the children and adults. Beside these disadvantages of eradication of H. pylori infection, the harmful effect of treatment with two antibiotics on the human intestinal microbiota, which are essential to the health, must not be disregarded.

The cost and side effects of H. pylori eradication in population of a country like Iran is also huge and it is not acceptable when compared with questionable benefit. There are plenty of arguments to avoid H. pylori eradication in all individual with infection not only in countries with high prevalence of H. pylori infection, but even in those with a low infection rate.

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References


