

BMJ Open Multicentric randomised study of *Helicobacter pylori* eradication and pepsinogen testing for prevention of gastric cancer mortality: the GISTAR study

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ABSTRACT

Introduction Population-based eradication of *Helicobacter pylori* has been suggested to be cost-effective and is recommended by international guidelines. However, the potential adverse effects of widespread antibiotic use that this would entail have not been sufficiently studied. An alternative way to decrease gastric cancer mortality is by non-invasive search for precancerous lesions, in particular gastric atrophy; pepsinogen tests are the best currently available alternative. The primary objective of GISTAR is to determine whether *H pylori* eradication combined with pepsinogen testing reduces mortality from gastric cancer among 40–64-year-old individuals. The secondary objectives include evaluation of *H pylori* eradication effectiveness in gastric cancer prevention in patients with precancerous lesions and evaluation of the potential adverse events, including effects on microbiome.

Methods and analysis Individuals are recruited from general population (50% men) in areas with high gastric cancer risk in Europe and undergo detailed lifestyle and medical history questionnaire before being randomly allocated to intervention or control groups. The intervention group undergoes *H pylori* testing and is offered eradication therapy if positive; in addition, pepsinogen levels are detected in plasma and those with decreased levels are referred for upper endoscopy. All participants are offered faecal occult blood testing as an incentive for study participation. Effectiveness of eradication and the spectrum of adverse events are evaluated in study subpopulations. A 35% difference in gastric cancer mortality between the groups is expected to be detectable at 90% power after 15 years if 30 000 individuals are recruited. Biological materials are biobanked for the main and ancillary studies. The study procedure and assumptions will be tested during the pilot phase.

Ethics and dissemination The study was approved by the respective ethics committees. An independent Data Safety and Monitoring Board has been established. The findings will be published in peer-reviewed journals and presented at scientific meetings.

Trial registration number NCT02047994

Strengths and limitations of this study

- This is currently the only study in Europe addressing population-based eradication of *Helicobacter pylori* to prevent gastric cancer as recommended by international guidelines (Maastricht V, Kyoto Global Consensus, EU Joint Action Cancer prevention project CanCon).
- Gastric cancer mortality is used as an end-point which corresponds to the requirements of a cancer screening program.
- The strategy of combining population-based *H pylori* eradication to pepsinogen detection with endoscopic surveillance of participants in whom precancerous lesions have been detected has not been evaluated before.
- The study biorepository with a wide range of biospecimen collection will be a great resource to conduct a number of unique ancillary studies.
- However, the large sample size with a long follow-up required to demonstrate a statistical difference in mortality reduction between the two groups is a challenge to the study, with the possibility to increase the sample size even further in case of lower prevalence of *H pylori* infection, higher number of women in the study group and/or lower acceptance rate for the intervention.

INTRODUCTION

Although gastric cancer remains a major cause of death among malignant diseases, its prevention has been neglected in the Western world for decades.¹ Most countries show declining trends in age-specific gastric cancer incidence, but the total number of cases in the world is not expected to decrease in the next decades due to demographic changes including population growth and ageing.²

There are considerable geographical variations in the incidence of gastric cancer, with some of the lowest rates seen in North America and Western Europe and the highest in Eastern Asia, Eastern Europe and South America.³ According to recent estimates from Europe, high rates have been observed in Central and Eastern European regions including Belarus, Ukraine, the Russian Federation and the Baltic States in Northern Europe, including Latvia. For example, gastric cancer incidence rates are the highest in Belarus (age-standardised rate (ASR) of 42.1/100 000 in men and 17.2/100 000 in women) among 40 European countries.^{4,5} These estimates are over threefold higher than those in France or Switzerland.^{4,5} The rates in the majority of the former Soviet Union regions remain high.

Infection with *Helicobacter pylori* is the major aetiological factor responsible for developing gastric cancer.^{6,7} It is estimated that 89% of non-cardia gastric cancers are attributable to this infection.⁸

Searching for and eradicating *H pylori* in healthy asymptomatic adults (the 'search-and-treat' strategy) has been suggested to be cost-effective by considering the reduction of gastric cancer burden as well as other diseases related to this microorganism.^{9–11} The recent global Kyoto conference¹² encouraged the broad application of *search-and-treat*, particularly in high-risk areas. This has been further endorsed by the Maastricht European consensus group.¹³ However, due to the limited data available on target groups, feasibility and population impact of the intervention, a working group convened by the International Agency for Research on Cancer (IARC) in 2013 proposed implementation of the strategy via well-designed implementation studies.¹

H pylori eradication in the general population would lead to high antibiotic consumption, particularly in areas of high prevalence of the infection. Widespread use of the same antibiotics used to treat common diseases, some of them life-threatening, may lead to increased antibiotic resistance of microorganisms other than *H pylori*.¹⁴ An inverse association observed between the occurrence of gastric and oesophageal cancers may suggest potential opposing effects of the related environmental factors, including *H pylori*.¹⁵

The potential risks of these effects in community settings were not considered in the above mentioned cost-effectiveness analyses,^{9–11} and knowledge about the potential adverse effects of *H pylori* eradication on the gut microbiome is scant.

Therefore, the recently published European Guide on Quality Improvement in Comprehensive Cancer Control emphasised the need for additional clinical studies to clarify whether and how to implement population-based *H pylori* screening and eradication programmes for gastric cancer prevention.¹⁶

In addition to the population-based eradication of *H pylori*, detection and treatment of precancerous lesions or early gastric cancer has been proposed as a means to reduce gastric cancer mortality and some countries in the

Western Pacific region have introduced nationwide gastric cancer screening programmes.¹⁷ Pepsinogen testing is currently the best available non-invasive option to identify individuals with precancerous lesions (in particular, gastric atrophy)¹³ who are at increased risk of gastric cancer. However, a recent meta-analysis¹⁸ concluded that pepsinogens exhibit only a moderate diagnostic yield in gastric cancer detection; thus, large-scale and well-designed prospective studies are encouraged, particularly in East, Central and part of Northern Europe and Latin American countries where gastric cancer burden is relatively high and prevention effort is scarce.

Here, we present the design of a clinical trial aimed at investigating the role of *H pylori* eradication combined with non-invasive screening for precancerous lesions in the reduction of gastric cancer mortality in a predominantly Caucasian population in Northern and Eastern Europe (GISTAR).

METHODS AND ANALYSIS

The aim of the study is to search for new intervention strategies to decrease mortality from gastric cancer in high-risk areas in the Baltic States and Eastern Europe. The main study site is Latvia, where the estimated ASR (world) per 100 000 for gastric cancer mortality was 16.2 in men and 6.4 in women in 2011. Other potential sites include the Russian Federation with gastric cancer mortality of 20.8 in men and 8.5 in women, Belarus with 20.2 in men and 7.8 in women and Ukraine with 17.4 in men and 6.6 in women in 2011.¹⁹

The primary objective is to determine if *H pylori* eradication combined with non-invasive screening and follow-up of precancerous lesions (atrophic gastritis or higher) reduces mortality from gastric cancer in a high risk population among 40–64-year-old subjects.

In addition to the above, secondary objectives include analyses of success rates of *H pylori* eradication therapy, resistance rates of *H pylori* to the key antibiotics used in standard therapies (in subgroups), potential adverse effects of population-based eradication (including effects on gut microbiome), optimisation of follow-up strategies as well as search for new biomarkers, including volatile markers.

The key hypotheses of the study are: (1) *H pylori* eradication in middle-aged individuals in a high risk population with endoscopic follow-up of those with evidence of atrophic gastritis prevents gastric cancer mortality; (2) *H pylori* eradication is effective in preventing gastric cancer mortality even after the development of gastric mucosal atrophy; (3) certain population subgroups can derive more benefit from *H pylori* eradication, and therefore could be targeted if general population eradication is not feasible; (4) a combination of biomarker screening and upper endoscopy is an appropriate strategy to prevent mortality from gastric cancer in high incidence areas.

The study protocol (version 4.5, revised on 7 September 2015) was approved by the Ethics Committee of the

International Agency for Research on Cancer (IEC 12–36) as well as the national Ethics Committees in Latvia; the Ethics Committee of Riga East University Support Foundation (No.14-A/13) and the Central Medical Ethics Committee (No. 01–29.1/11). The protocol is registered in the clinicaltrials.gov database (NCT02047994).

Participants

The study aims to enrol men and women at equal proportions at the risk age (40–64 years at inclusion) for developing gastric cancer. The recruitment centres are planned in high gastric cancer risk areas, and predominantly Caucasian origin populations in Europe will be enrolled. The enrolment has been initiated in three study centres in Latvia: Tukums, Dobeles and Rezekne (Caucasian population), with the potential expansion to other locations; more genetically diverse populations would be enrolled when the study is expanded to other sites.

Recruitment centres will be set up reflecting the study requirements. One recruitment centre is expected to randomise 3000 study participants, although in locations with smaller number of inhabitants, fewer than 3000 participants are acceptable. Based on the sample size calculation (see below) at least 10 centres, each recruiting 3000 study participants would be required. The study participants will be contacted by phone and invitation mails through lists that we obtain from the general practitioners (GPs), local primary care medical centres and national medical registration databases, as appropriate, in different locations of the potential recruitment centres. We will pay particular attention to keep the gender balance during recruitment, ensuring at least 50% of the participants are men. To achieve this, we will invite men in priority by direct telephone calls and invitation mails while accept participation of women in case they are the family members of the invited men or express their interest in participating in the study by contacting the study team.

All participants must sign an informed consent and they should be in good health at enrolment, as determined by medical history and physical examination performed by a study physician.

Individuals will be excluded from the trial if they have any of the following: personal history of gastric cancer prior to enrolment; gastric resections due to benign disease (participants with ulcer suturing and vagotomy are eligible); *H pylori* eradication therapy within 12 months prior to inclusion (irrespective of the treatment result); presence of alarm symptoms for digestive or any other diseases; pathological findings at physical investigation suggestive of a serious disease requiring immediate management; factors otherwise limiting the participation according to the protocol; serious psychological conditions/psychiatric disease limiting the possibilities to understand the requirements for diagnostic and/or medical interventions or low expectations on the compliance for the diagnostic work-up, treatment or follow-up.

Interventions

The general study design is illustrated in [figure 1](#).

After being provided detailed information on the study by the study personnel and signing a consent form, individuals with alarm and exclusion symptoms will be identified by a study physician. The remaining participants will complete a detailed lifestyle and medical history questionnaire and then will be randomised online into two groups (50% in the intervention group, 50% in the control group) via central data management system. Randomisation will be stratified by gender, age group and recruitment site.

The intervention group will be tested for pepsinogens (Pg) I and II by a latex-agglutination test-system (Eiken Chemical, Tokyo, Japan). For *H pylori* infection testing IgG group antibodies by ELISA (Biohit, Finland) was initially planned; however, based on the preliminary result from the pilot study which indicated false positivity of serology, ¹³C-urea breath test (UBT) is decided to be used for confirmation of the infection. For participants undergoing endoscopy, histological confirmation will be required for *H pylori* positivity.

The selected cut-off values for pepsinogens characteristic for gastric mucosal atrophy is based on our previous research²⁰; those with pepsinogen PgI/PgII ≤ 2 and PgI ≤ 30 ng/mL will be referred for upper endoscopy with a detailed biopsy work-up according to the updated Sydney system.²¹ Histological assessment of the biopsies collected from the stomach will be independently performed by two experienced pathologists; in the case of discrepant results, the particular slides will be reviewed together to reach consensus.

All participants who are *H pylori* positive will be reinited and offered *H pylori* eradication treatment. The treatment will be chosen according to the Maastricht guidelines,¹³ based on the resistance patterns to clarithromycin in the particular recruitment site as well as the clinical effectiveness of the particular regimen whenever data are available. In low resistance areas (<15%–20%) including Latvia,²² the first choice of eradication treatment will be standard triple therapy for 10 days: esomeprazole 40 mg, clarithromycin 500 mg, amoxicillin 1000 mg, each administered twice a day. Second-line treatment will not be offered within the study; however, study participants requiring it will be referred to their GPs with relevant recommendations. All individuals diagnosed with precancerous lesions during upper endoscopy will be followed up according to the Management of precancerous conditions and lesions in the stomach (MAPS) guidelines.²³

The control group will receive standard care and will not be systematically investigated for *H pylori* or precancerous lesions. As an incentive for participation, both groups will be offered faecal occult blood testing by a laboratory-based immunochemical test (FIT) OC-Sensor (Eiken Chemical), and whenever positive (cut-off at 10 µg/g faeces from a single faecal sample), referred for colonoscopy. Any additional rounds of colorectal

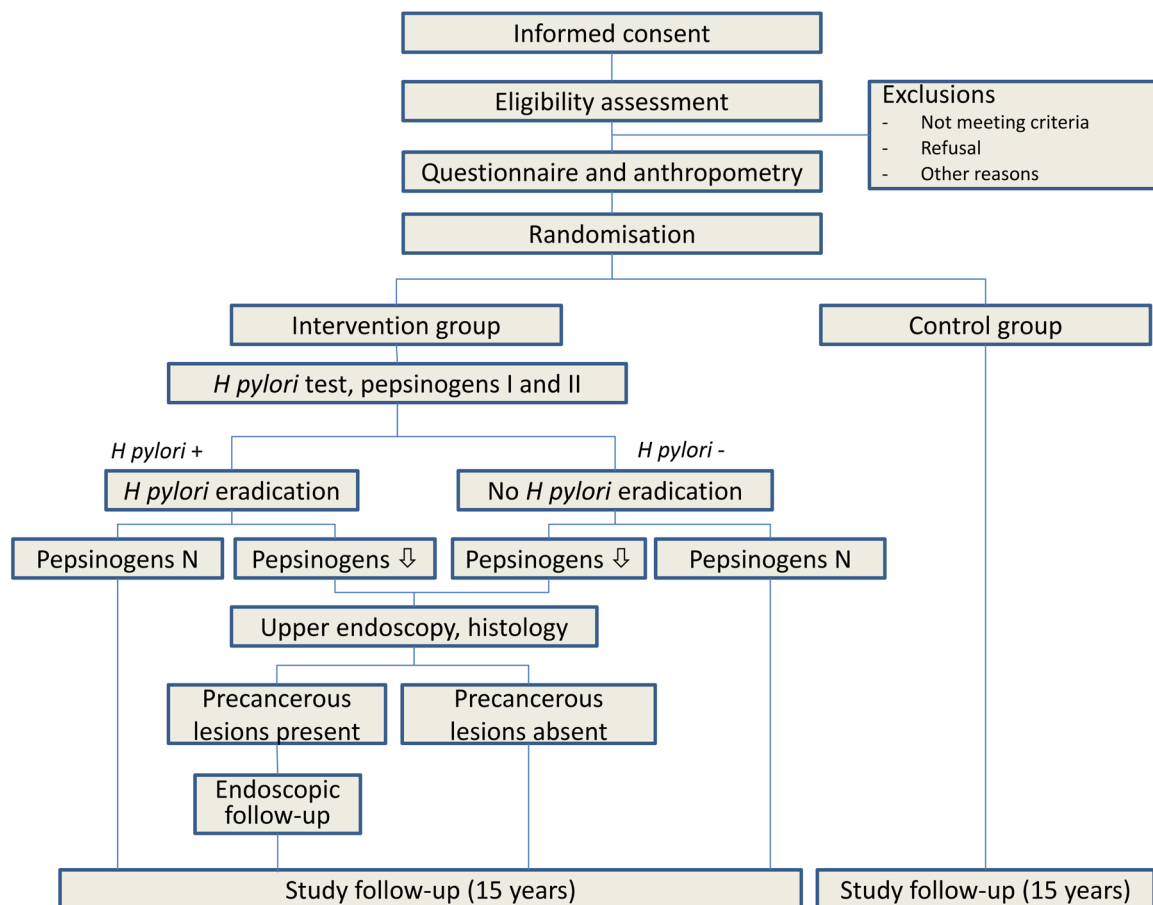


Figure 1 GISTAR general study design.

screening will be provided within the respective national colorectal cancer screening programs.

Biological materials including serum, plasma, DNA as well as stool and biopsies for microbiota analysis will be collected from different groups of participants for biobanking. Plasma/serum samples will be processed immediately after being obtained, stored and transported at -70°C temperature. These materials will provide the unique opportunity to perform ancillary studies including, but not limited to the following: searching for new biomarkers and analysing the impact of wide antibiotic use and presence of precancerous lesions on gut microbiome.

The effectiveness of *H pylori* eradication will be verified in a subgroup of participants ($n=100-150$) from the study centres in Latvia and other centres where resistance patterns are expected to be different based on the available epidemiological data, by using UBT 6–24 months after the treatment. The treatment adherence as well as presence or absence, frequency and severity of adverse events potentially related to the eradication therapy will be actively assessed by telephone interview 45–60 days following the delivery of drugs, and adverse events will be recorded throughout the study. The susceptibility of *H pylori* to commonly used antibiotics in the eradication therapies will be investigated using the pilot study data

from approximately 200 upper endoscopy referrals with evidence of *H pylori* in antral biopsies (proportion of individuals with altered biomarker results and another proportion with normal biomarkers).

The groups will be followed at 5-year intervals by direct or telephone contact or alternative means of communication until the study end-points are reached. Particular attention will be given to collect detailed information on potentially *H pylori* related morbidity and mortality. Whenever possible, we will invite the participants to the study centres to obtain follow-up data including demographic information, socioeconomic status, physical examination as well as biological samples (plasma, serum and stool samples and biopsies for microbiome testing). The new protocol will be developed to update the follow-up data collection. A record linkage will also be made to the national Cancer and Mortality Registry database to ascertain cases of and deaths from gastric cancer.

Data-capture system and centralised biorepository

A centralised multiple-language web-based electronic data-capture system and data management facilities has been developed for the study. The questionnaire and investigation data are recorded in a standardised way and the system provides the primary data source. The system is built using the DotNetNuke content management

platform providing the required conditions for personalised data security. The collected data are stored in a Microsoft SQL Server database. Initially three languages are being used: English, Latvian and Russian. The publicly available information can be viewed at <https://www.gistar.eu>.

A centralised biorepository will be run by the University of Latvia and supervised by IARC. Pathology services and archiving of formalin-fixed and paraffin-embedded material will be handled by the Academic Histology Laboratory in Riga, Latvia.

Trial endpoints and statistical analyses

The primary end-point of the study is mortality difference from gastric cancer between the intervention and control groups at 15 years or when enough cases accumulate to demonstrate a statistically significant difference between the groups. Secondary end-points are the difference in gastric cancer incidence and all-cause mortality between the two groups. The proportion of gastric cancer cases arising in the subgroup with biomarkers indicating high risk (eg, low Pgl/PgII ratio and low Pgl levels) will be compared with the group with normal biomarkers at inclusion. Additional estimates will be made on the incidence and stages of cancers comparing participants under endoscopic surveillance and without it as well as comparing participants having undergone *H pylori* eradication versus those having refused.

The sample size of the study is estimated based on the primary variable of interest, gastric cancer mortality. Estimates of the age-specific and sex-specific mortality rates from gastric cancer were taken from the GLOBOCAN 2008 estimates for Belarus.²⁴ Estimates of the number of deaths from gastric cancer were calculated for 5, 10, 15 and 20 years of follow-up. Censoring due to mortality from other causes was taken into account using mortality rates available on the WHO mortality database for Belarus in the years 2007–2009.¹⁹ In addition, a loss to follow-up of 1% per year was included in the calculations to account for migration and other reasons not related to mortality that may prevent the assessment of the primary outcome.

Based on a significance level of 5% and a target power of 90%, with given number of 30 000 participants, 112 deaths from gastric cancer are expected in the control group, and a 35% reduction in gastric cancer mortality is detectable, corresponding to 73 cases in the intervention group at 15 years of follow-up. The study size may need to be increased if lower prevalence of *H pylori* infection, higher number of women included in the study and/or lower acceptance/compliance to *H pylori* eradication therapy are observed.

Gastric cancer mortality will be compared between intervention and control groups using a log-rank test. The survival curves will also be compared with use of the Kaplan-Meier life-table method and the Cox proportional-hazards model. The stratified randomisation process should ensure that groups are balanced with respect to age and gender. In addition, a multivariate Cox

proportional hazards model will be used to account for confounding factors. The effect of confounding factors on the endpoints will be evaluated using univariate models in the first place. These analyses will be repeated for gastric cancer incidence difference between the two groups.

It is expected that the obtained data will allow running cost-effectiveness ancillary studies on mass-eradication of *H pylori* by considering the costs of the adverse effects as well as on endoscopic surveillance of patients with gastric precancerous lesions in European countries with a relatively high risk.

The study subject recruitment to the pilot phase has just been completed to test assumptions defined for the study including acceptability and adherence to the intervention, and *H pylori* prevalence and to test the appropriateness of the chosen tools and infrastructure for the study. In addition, in this phase the accuracy of biomarkers for detecting atrophy will be evaluated by comparing different alternatives (eg, different manufacturer tests, different cut-off values) against histology.

DISCUSSION

H pylori gastritis has been defined as an infectious disease according to the Kyoto Global Consensus Conference,¹² and once-per-lifetime eradication treatment with antibiotics seems to be a rational and cost-effective approach to prevent gastric cancer as well as other *H pylori*-related diseases, including peptic ulcer and functional dyspepsia.^{12,25} In high-risk countries for gastric cancer, this would mean giving antibiotic treatment to the majority of the population, as is the case for Latvia where *H pylori* prevalence is around 80%.²⁶ The risk of adverse events and increased antibiotic resistance are major concerns; the magnitude of these risks has not been sufficiently investigated in well-controlled studies, and no country has implemented a population-based *search-and-treat* strategy for *H pylori*.¹⁷

Pepsinogens are markers for atrophy of the stomach mucosa²⁷; decreased pepsinogen values have been demonstrated to correlate with increased risk of gastric cancer^{28–30}; furthermore, a combination of pepsinogen testing and *H pylori* detection has been suggested to be the best available non-invasive option for gastric cancer risk stratification.^{13,31} However, the accuracy of pepsinogen tests to identify gastric cancer and even atrophy is imperfect.¹⁸

The current European MAPS guidelines being referred to above are recommending surveillance of patients with precancerous lesions to enable detection of those progressing to high-risk lesions or cancer as a strategy of decreasing gastric cancer related mortality.²³ However, there is still a lack of evidence from randomised control trials of combining once-per-lifetime eradication of *H pylori* and screening for high-risk conditions with blood markers such as pepsinogens for reducing gastric cancer mortality. To the best of our knowledge, this is the first

study evaluating the yield of the above combination, that is, mass-eradication of *H pylori* and surveillance of pepsinogen-detected precancerous lesions as a strategy to reduce gastric cancer mortality.

Pepsinogen tests to identify atrophy have demonstrated a wide range of sensitivity in various studies,¹⁸ indicating that several factors may influence pepsinogen levels in different populations. The GISTAR study will allow us to investigate the role of *H pylori* infection and participants' characteristics on the performance of biomarkers for identifying individuals at high risk of gastric cancer.

A few limitations of the study design should be mentioned. While the randomisation process should ensure that groups are balanced with respect to age and gender, adjustment of proportion between genders might be required if a substantially higher proportion of women or men is recruited into the intervention group. To prevent this, we will make an extra effort to balance the gender ratio by actively inviting men or women required to obtain a balance. However, we acknowledge that our extra effort to balance the male and female ratio to ensure sufficient study power to answer the research questions may influence the generalisability of the study results.

The inclusion of colorectal cancer screening in both groups as an incentive may encourage participation and adherence; however, the general participation may be affected by the fact that only half of the participants are offered *H pylori* eradication and screening for precancerous lesions. Furthermore, we acknowledge that the effect of the intervention would be influenced by participation rates of the target population and acceptance rate of the *H pylori* eradication treatment while participation in and acceptance of endoscopic examinations would affect the yield of endoscopic follow-up. Another limitation of the study is the long-term follow-up that is required to achieve its objectives. We will make multiple efforts to assure compliance and retention within the study, including periodic phone calls and interim visits.

As described, the study design and the organisation of the field work have taken into account the scientific background and contextual conditions for a successful implementation and execution of the trial. If new sites outside Latvia are to be included, study design will be adapted to local conditions for better acceptance and affordability without compromising the scientific objectives.

In conclusion, the study would have major public health implications by providing leads for prevention activities in populations with elevated rates of gastric cancer, particularly in Baltic and Eastern European regions where the public health burden from the disease is substantial.

ETHICS, DATA SAFETY AND DISSEMINATION

The Ethics Committee of IARC has approved the study protocol 26/03/2013 and the relevant protocol updates 02/10/2015. reg. No. IEC 12–36; the Ethics Committee

of Riga East University Hospital Support foundation has approved the protocol 03/10/2013, reg. No. 14-A/13, and the Central Medical Ethics Committee in Latvia has approved the protocol 09/12/2013, reg. No. 01–29.1/11.

All the study participants are required to provide signed consent prior the enrolment.

An independent Data Safety and Monitoring Board (DSMB) has been established for the GISTAR study which involves experts in epidemiology, statistics, clinical trials, gastroenterology and pathology to safeguard the interests of study participants and to ensure the scientific validity of the study.

The findings will be published in peer-reviewed journals and presented at scientific meetings. We anticipate that study results will provide necessary information to be considered in further updates of the European and international guidelines for gastric cancer prevention and *H. pylori* management.

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Contributors ML, JYP, MP and RH have been involved in initial design of the protocol. JYP, SP, ILK, SI, IK, DR, AK, DS, ID and VF committed to developing particular specialised parts of the protocol. RM, IP and RH committed to adjusted version of the initial protocol and MP, JYP and RM to the statistical evaluations and study sample size estimates. ML, JYP and RM wrote the manuscript. All coauthors have participated in improvements to the manuscript and acceptance of it.

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Competing interests ML is a partner in institutions involved in realisation of the project—Digestive Diseases Centre GASTRO and Academic Histology laboratory. ILK and SI are employees of Academic Histology Laboratory, IK—of Digestive Diseases Centre GASTRO. Otherwise, the authors declare that they have no competing interests.

Ethics approval IARC, Central Medical Ethics Committee of Latvia, Ethics Committee of Riga East University Hospital Support Foundation.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement Data from the pilot study are currently being analysed to be presented in further publications. These data are available to the principal investigators, study statistician and Data Management Board members. The results will be disseminated during international and national conferences and congresses, published in peer-reviewed papers.

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