HHS Public Access

Author manuscript

Clin Gastroenterol Hepatol. Author manuscript; available in PMC 2019 December 10.

Published in final edited form as:

Clin Gastroenterol Hepatol. 2018 December ; 16(12): 2005–2006. doi:10.1016/j.cgh.2018.08.035.

Reply

HASHEM B. EL-SERAG, MD, **DAVID Y. GRAHAM, MD**

Department of Medicine, Michael E. DeBakey VA Medical Center, Baylor College of Medicine, Houston, Texas

Thank you for your comments regarding the Houston consensus on testing for *Helicobacter pylori* infection.[1] The Houston Consensus followed the lead of the Kyoto Global Consensus, which was the first to define *H pylori* gastritis as an infectious disease.[2] *H pylori* infection causes lifelong chronic gastric inflammation, alters the gut microbiome, and results in dysregulation of acid secretion and many other conditions such as iron deficiency anemia (especially in children), vitamin B12 deficiency, atrophic gastritis, and dyspepsia. In addition, *H pylori* remains transmissible throughout life and the cumulative risk of a clinical peptic ulcer is approximately 1 in 6. The lifetime risk of an *H pylori* infected individual developing gastric cancer for a man aged 74 years ranges from approximately 0.6% in the United States to 22% among residents of Yangcheng County, China (http://globocan.iarc.fr/). These data underestimate the risk in developed countries such as the United States where the prevalence of *H pylori* infection is now low.

Treatment is usually short and a one-off affair in most cases. While the Consensus supports good antimicrobial stewardship, the lack of an organized program of susceptibility testing and regular updating of treatment recommendations forces clinicians to use empirical therapy, which often requires retreatment. This need to frequently updated susceptibility data was covered in the Consensus conference in Statement 19, which recommended that professional societies provide the research needed to support evidence-based reimbursement decisions for antibiotic susceptibility testing for *H pylori* (100% agree/strongly agree, Grade 1).[1]

We believe that the evidence supports statement 1 that active *H pylori* infection be treated (100% agree/ strongly agree, Grade 1A) with the proviso that competing considerations such as advanced age, comorbid conditions, and so on may preclude it.

Acknowledgments

Funding

The authors are supported in part by the Office of Research and Development Medical Research Service Department of Veterans Affairs, Public Health Service grant DK56338, which funds the Texas Medical Center Digestive Diseases Center.

Conflicts of interest

This author discloses the following: David Y. Graham is a consultant for RedHill Biopharma regarding novel *H pylori* therapies and has received research support for culture of *Helicobacter pylori* and is the PI of an international study of the use of antimycobacterial therapy for Crohn's disease. He is also a consultant for BioGaia in relation to probiotic therapy for H pylori infection and for Takeda in relation to *H pylori* therapies. Hashem B. El-Serag discloses no conflicts.

References

1. El-Serag HB, et al. Clin Gastroenterol Hepatol 2018;16:992–1002. [PubMed: 29559361]
2. Sugano K, et al. Gut 2015;64:1353–1367. [PubMed: 26187502]