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): 2004. doi:10.1016/j.cgh.2018.08.031.

# 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

We thank Drs Chey, Howden, and Leontiadis for their comments. We apologize for the confusion regarding the confirmation of cure; this was only one of many stimuli for the Houston Consensus Conference, which was both planned and completed before the publication of the American College of Gastroenterology (ACG) guideline.[1,2] We were pleased to see that the 2017 ACG version had corrected that error from the earlier ACG guideline.

They also questioned the recommendation in statement 7 that patients who are first-generation immigrants from high-prevalence areas be tested for *Helicobacter pylori* infection. Statement 7 specifically focuses on patients and not universal screening, the latter, however, has become of increased interest as a cost-effective means of eliminating gastric cancer.[3,4] Rather, statement 7 related to the doctor–patient relationship, the likelihood of infection, of transmission within the family, and of the risk of *H pylori*–related disease being similar to that of their region of origin.[2]

The Houston consensus dealt with *H pylori* primarily as an infectious disease and to discussed treatment in terms of the principles of antimicrobial therapy and antimicrobial stewardship. In contrast, the ACG and Toronto guidelines relied on meta-analyses of studies from populations who were not comparable because of differences in resistance patterns, doses, durations of therapy, or proton pump inhibitor potency.[5,6] The ACG guideline even described the continued use of the same failed standard triple therapy for 15 years. Neither the ACG nor the Toronto guidelines acknowledged the issue of antimicrobial misuse and poor antimicrobial stewardship. For example, amoxicillin, clarithromycin, and a third antibiotic combination resulted in all patients receiving at least 1 unneeded antibiotic, leading to an estimated 18 tons of unneeded clarithromycin or metronidazole (class I carcinogen) per 1 million treatments.[7]

## Acknowledgments

Funding

Supported in part by the Office of Research and Development Medical Research Service Department of Veterans Affairs, Public Health Service grant DK56338 (H.B.E.-S. and D.Y.G.), which funds the Texas Medical Center Digestive Diseases Center.

Conflicts of interest

This author discloses the following: David Graham is a consultant for RedHill Biopharma regarding novel *H pylori* therapies and has received research support for culture of *H pylori* and is the principal investigator of an international study on the use of antimycobacterial therapy for Crohn's disease, and is also a consultant for BioGaia

in relation to probiotic therapy for *H pylori* infection and for Takeda in relation to *H pylori* therapies. The remaining author discloses no conflicts.

## References


1. Chey WD, et al. Am J Gastroenterol 2017;112:212–239. [PubMed: 28071659]
2. el-Serag HB, et al. Clin Gastroenterol Hepatol 2018;16:992–1002. [PubMed: 29559361]
3. Lee YC, et al. Gastroenterology 2016;150:1113–1124. [PubMed: 26836587]
4. IARC Helicobacter pylori Working Group. Helicobacter pylori eradication as a strategy for preventing gastric cancer. Leon: International Agency for Research on Cancer, 2014.
5. Fallone CA, et al. Gastroenterology 2016;151:51–69. [PubMed: 27102658]
6. Graham DY. Gut 2017;66:2043–2046. [PubMed: 28935677]
7. Dang BN, et al. Nat Rev Gastroenterol Hepatol 2017;7:383–384.