

For consultation and local adaptation

- A **Helicobacter test & treat strategies will benefit patients with ulcer disease, 8% of patients with functional dyspepsia, and reduce future risk of ulcer disease, gastric cancer and risks of long-term PPIs.^{1,2}**
- A **In patients aged 55 years and older, with new unexplained and persistent (over 4-6 weeks) recent onset dyspepsia, an urgent referral for endoscopy should be made.^{3,4}**

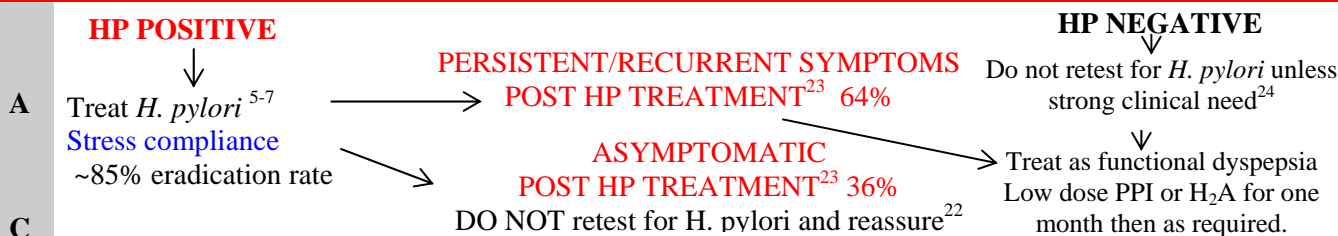
WHO TO TEST AND TREAT FOR HELICOBACTER⁵⁻⁷

- A Patients with uncomplicated dyspepsia unresponsive to lifestyle change, antacids, H₂A or 1 month PPI⁷⁻¹⁰ and without alarm symptoms (for definitions - see references 12 and 13)^{7,11,12}
- Routine testing is **not** recommended in patients with Gastro-Oesophageal Reflux Disease.
- Patients with a past history of gastric ulcer (GU) or duodenal ulcer (DU) who have not previously been tested.
- In chronic NSAID user without ulcer history, HP eradication will reduce peptic ulcers and/or bleeding but will not remove all risk.

WHICH NON-INVASIVE HELICOBACTER TEST IN UNCOMPLICATED DYSPEPSIA¹³

- A **Urea breath test (UBT)^{14,15}** Detects current infection (Prescription-based high cost test)
Most accurate pre and post treatment test (sens & spec 95%)
By prescription (BNF 1.3.1)¹⁶
 - A **Stool helicobacter antigen test** detects current infection.¹⁷ (Medium cost). Pea-sized piece of stool to local lab (check availability of test). (sens & spec 97%)
 - A **Blood serology** in plain bottle.⁵ (Low cost)
Detects antibody to helicobacter and does not differentiate active from past infection. Therefore less accurate than UBT or stool test (sens 85-92%, spec 79-83%)^{19,20} **DO NOT** use in elderly, children or post treatment.^{21,22}
 - A Useful when other tests may be negative Eg in patients with acute GI bleed or on antibiotics.
Near patient serology tests are not as accurate.¹⁵ **DO NOT USE**
- DO NOT perform UBT or stool antigen test within 2 weeks of PPI or 4 weeks of antibiotics as these drugs suppress bacteria and may lead to false negative^{17,18}
- Note: A 100% sensitive (sens) test correctly identifies all patients with helicobacter. A 100% specific (spec) test correctly identifies all patients without helicobacter

WHAT TO DO WITH HELICOBACTER RESULT



TREATMENT REGIMENS

Do not use clarithromycin or metronidazole if used in the past year for ANY infection

First line ^{A+} 7 days BD	Second- line regimens ^{A+} 14 days	Alternative 3 rd line antibiotics on advice of microbiologist or gastroenterologist
lansoprazole 30mg (or other PPI) PLUS clarithromycin 250mg with metronidazole 400mg OR clarithromycin 500mg with amoxicillin 1g	PPI BD PLUS tripotassium dicitratobismuthate 240mg BD PLUS 2 antibiotics not previously used: amoxicillin 1g BD clarithromycin ^{A+} 500mg BD metronidazole 400mg BD tetracycline hydrochloride 500mg QDS	levofloxacin 250 mg BD rifabutin 300mg OD furazolidine 200mg BD

WHEN TO RETEST FOR HELICOBACTER

- D To reassure patients of eradication
 - D Patients with complicated peptic ulcer or MALTOMA
 - Breath test is the most accurate^{A-}
 - Stool antigen test is an alternative^{A-}
 - DO NOT use serology^{A-}
- Wait 4 weeks after treatment

WHEN TO REFER FOR HELICOBACTER CULTURE & SUSCEPTIBILITY TESTING AT ENDOSCOPY²⁵

- D Patients who have had metronidazole & clarithromycin for any infection & are allergic to one of the other antibiotics
 - Patients who have received two courses of antibiotic treatment and are still helicobacter positive
- For advice on antral biopsy specimens and Dent's transport medium, contact the HPA Centre for Infections, London.²⁵

KEY A B C D Indicates grade of recommendation

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http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947328906

We welcome, in fact encourage, opinions on the advice given and future topics we should cover. We would be most appreciative if you could email any evidence or references that support your requests for change so that we may consider them at our annual review.

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