Recrudescence of *Helicobacter pylori* after apparently successful eradication: novel application of randomly amplified polymorphic DNA fingerprinting

H X Xia, H J Windle, D G Marshall, C J Smyth, C T Keane, C A O’Morain

**Abstract**

The aim of this study was to find out if reinfection or recrudescence accounted for the recurrence of *Helicobacter pylori* infections after apparent eradication of the bacterium. Three hundred and twenty patients were treated with colloidal bismuth subcitrate (120 mg four times daily for four weeks), metronidazole and tetracycline (400 mg and 500 mg, respectively, thrice daily for the first week). *H pylori* was eradicated four weeks after the end of treatment as assessed by the rapid urease test, histological examination, Gram staining, and culture. However, the infection recurred in 29 (9.1%) of the patients one year after apparent eradication. Pre and post eradication isolates from five patients were available. DNA was extracted and used for restriction endonuclease analysis with *Hind* III and *Hae* III, and for polymerase chain reaction (PCR) based randomly amplified polymorphic DNA fingerprinting with a combination of two 10 nucleotide primers. Sodium dodecyl sulphate polyacrylamide gel electrophoresis was performed also. Randomly amplified polymorphic DNA fingerprinting was unique in that it yielded highly discriminatory fingerprints, which showed that the pretreatment and recurrent isolates obtained from each of the five patients were indistinguishable from one another. This shows that recurrence of *H pylori* infection is probably caused by recrudescence and that the discriminatory power of randomly amplified polymorphic DNA fingerprinting is a practicable and discriminatory typing scheme for *H pylori*.

**Methods**

**Clinical details of the patients and *H pylori* isolates**

Three hundred and twenty Irish patients with confirmed duodenal ulcer were treated with a triple therapy, which included colloidal bismuth subcitrate (120 mg four times daily for four weeks), metronidazole and tetracycline (400 mg and 500 mg, respectively, thrice daily for the first week). *H pylori* was eradicated four weeks after the end of treatment as assessed by the rapid urease test (CLO test, Delta West, Perth, Western Australia), histological examination, Gram staining, and culture (all showed negative results for *H pylori*). Details of specimen preparation and classification criteria for gastritis used in this study have been described elsewhere.\(^1\) Each of the patients had a routine endoscopy one year after apparent eradication of the bacterium, or sooner if symptoms recurred. Recurrence of *H pylori* infection was defined as any one (or more) of the four tests described for *H pylori* being positive. Recurrence of *H pylori* infection was apparent in 29 (9.1%) of the patients. Post eradication *H pylori* was isolated from antral biopsy specimens of 23 of these patients. Both pretreatment and recurrent isolates were, however, successfully recovered from only five of these patients; two isolates were obtained from each of four patients, and three isolates from one patient. The Table gives the clinical details of these five patients and the 11 isolates.

Eradication of *Helicobacter pylori* cures duodenal ulcer\(^1\) and ulcer complications.\(^3 \) An eradication rate of 84.3% is obtained with colloidal bismuth subcitrate (120 mg four times daily for four weeks), metronidazole and tetracycline (400 mg and 500 mg thrice daily for the first week, respectively).\(^4 \) However, recurrence of the infection after apparent eradication has been reported and is associated with the ulcer relapse.\(^7 \) Recent studies have shown that recurrence of *H pylori* is dependent on the efficacy of the treatment regimen. The more effective the treatment, the lower the recurrence rate.\(^9 \) This study was conducted to find out if recurrence of *H pylori* was caused by reinfection or recrudescence by molecular characterisation of the pretreatment and recurrent isolates from patients, who had been treated with the triple therapy, using three fingerprinting techniques. Sodium dodecyl sulphonate polyacrylamide gel electrophoresis (SDS-PAGE) of whole cell proteins, restriction endonuclease analysis (REA) of genomic DNA and polymerase chain reaction (PCR) based random amplified polymorphic DNA (RAPD) fingerprinting technique were used in this analysis.

**Keywords:** *Helicobacter pylori*, DNA fingerprinting, recrudescence.
Recurrent H pylori

Clinical details of the patients before H pylori was apparently eradicated with colloidal bismuth subcitrate, metronidazole, and tetracyline (triple therapy) and after the infection recurred during a period of follow up

<table>
<thead>
<tr>
<th>Patient</th>
<th>Treatment status</th>
<th>Age (y)</th>
<th>Sex</th>
<th>Endoscopic diagnosis</th>
<th>Histological findings</th>
<th>Isolate</th>
<th>Follow up (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Before</td>
<td>32</td>
<td>Female</td>
<td>DU</td>
<td>Mo+Ac</td>
<td>A1</td>
<td>7</td>
</tr>
<tr>
<td>B</td>
<td>After</td>
<td>60</td>
<td>Female</td>
<td>DU</td>
<td>Mo+Ac</td>
<td>A2</td>
<td>8</td>
</tr>
<tr>
<td>C</td>
<td>After</td>
<td>19</td>
<td>Female</td>
<td>DU</td>
<td>Mo+Ac</td>
<td>C1</td>
<td>10</td>
</tr>
<tr>
<td>D</td>
<td>Before</td>
<td>31</td>
<td>Male</td>
<td>DU</td>
<td>Mo+Ac</td>
<td>D1</td>
<td>12</td>
</tr>
<tr>
<td>E</td>
<td>Before</td>
<td>66</td>
<td>Female</td>
<td>DU</td>
<td>Mo+Ac</td>
<td>E1</td>
<td>22</td>
</tr>
</tbody>
</table>

*H pylori* was positive 13 months after eradication, but colonized nine months later; DU, duodenal ulcer; NUD, non-ulcer dyspepsia; Mi+Ac, mild and active antral gastritis; Mo+Ac, moderate and active antral gastritis.

Preparation of bacterial cells

Pre and post eradication isolates of *H pylori* from patients A, B, C, and D for SDS-PAGE. All the isolates were used for RAPD. A reference *H pylori* strain NCTC 11638 was included in all but one of the experiments. Each isolate was recovered from treptomyo sybo broth containing glycerol (20%, v/v) and horse serum (10%, v/v) and stored at -70°C. The recovered isolates were then subcultured either on chocolate agar plates for three to five days in a microaerophilic atmosphere at 37°C, or in a tissue culture flask containing brain heart infusion broth (20 ml) containing horse serum (5%, v/v) and yeast extract (0.25%, w/v) for 24-48 hours, exactly as described previously.

SDS-PAGE

Agar grown bacteria were harvested with phosphate buffered saline (PBS, pH 7.3) and washed twice in this buffer prior to measuring the protein content of each strain by the method of Markwell et al. Bacterial protein (10 μg) in PBS was precipitated by the addition of five volumes of ice cold acetone, followed by incubation at -20°C for 30 minutes. After washing the precipitate once with acetone, the pellet was resuspended in 10 μl sample buffer. The mixture was boiled for four minutes prior to electrophoresis. SDS-PAGE was performed as previously described, using 12.5% acrylamide resolving gels. Molecular weight markers were SDS-PAGE broad range standards (Bio-Rad, CA, USA).

Extraction of genomic DNA

Bacterial cells on chocolate agar (two plates), or liquid medium (15 ml) were washed with PBS (pH 7.3) and 25 mM TRIS-HCl buffer (pH 8.0) containing 10 mM EDTA. The suspension was transferred into an Eppendorf tube and washed twice with TRIS-HCl buffer. DNA was extracted by a phenol/chloroform method similar to the method previously described. Briefly, the pellet of cells was resuspended in 0.5 ml lysis buffer (25 mM TRIS-HCl (pH 8.0), 50 mM glucose, 10 mM EDTA, lysozyme (30 mg/ml)) and incubated at room temperature for 15 minutes. The suspension was treated with SDS, RNase A, and then pronase. DNA was extracted with phenol/chloroform/isoamyl alcohol, precipitated by sodium acetate and cold absolute alcohol, and washed with ice cold alcohol (70%, v/v). The pellet of DNA was finally resuspended in 10 mM TRIS-HCl buffer (pH 7.5) containing 1 mM EDTA. DNA content and purity was determined by measuring the absorbance at 260 nm and 280 nm using a spectrophotometer (Hitachi, U-2000, Japan). All reagents used for DNA extraction were obtained from Sigma Chemical, MO, USA. DNA templates for RAPD were prepared also by the boiling method exactly as described by Mazurier et al.

REA and RAPD

Restriction endonuclease digestion of *H pylori* genomic DNA with Hind III or Hae III was carried out according to the manufacturer’s instructions (Boehringer Mannheim, GmbH, Germany). RAPD fingerprinting was carried out in a final volume of 25 μl containing 3 mM MgCl₂, 20 pmol of each primer, 2-5 U of Taq DNA polymerase (Promega, WI, USA), 250 μM each of dCTP, dGTP, dATP, dGTP (Boehringer Mannheim) in 10 mM TRIS-HCl (pH 8.3) containing 50 mM KCl and Triton X-100 (1%, w/v). The mixture was overlaid with mineral oil and exposed to ultraviolet radiation for 10 minutes. Between 5 and 500 ng DNA template of each isolate obtained by the phenol/chloroform method, or 5 μl cell supernatant fraction prepared by the boiling method was used for PCR. The primers used were a combination of two 10 nucleotide primers, primer 1281 (AAGCCGCGAAC) and primer 1283 (GCGATCCCCA) obtained from the Molecular Medicine Unit, King’s College School of Medicine and Dentistry, London. The synthesis and specificity of these primers has been described previously. A Perkin-Elmer TC480 thermal cycler (Cetus, USA) was used for amplification. The cycling programme was four cycles of (94°C, 5 min; 36°C, 5 min; and 72°C, 5 min), 30 cycles of (94°C, 1 min; 36°C, 1 min; and 72°C, 2 min), and then 72°C for 10 minutes.

Agarose gel electrophoresis

Genomic DNA (20 μl) or digested DNA (20 μl) was mixed with 5 μl loading buffer consisting of 50% (v/v) TBE running buffer (pH 8.0), glycerol (50%, v/v), and bromophenol blue (0.25%, w/v). Loading buffer (5 μl) was added to an aliquot of PCR products and 20 μl of the mixture was electrophoresed. A 0.5% agarose gel was used for genomic DNA, a 0.8% agarose gel for digested DNA, and a 2% agarose gel for PCR products. After electrophoresis, an agarose gel buffer at 70 V, 2 gels were stained in ethidium bromide (0.5 mg/ml) and photographed under ultraviolet light. Hind III digested bacteriophage λ DNA (Sigma) was used as a size marker for genomic DNA in REA; a 100 bp DNA ladder (Gibco, BRL) was used for PCR products.
Results

SDS-PAGE

Patterns of whole cell protein extracts obtained by SDS-PAGE showed 30–40 bands for each isolate with molecular weights of 20 to 120 K. The six major bands of 27, 30, 46, 54, 57, and 64 K were present in the protein profiles of all of the isolates. Although the protein patterns of pretreatment and recurrent isolates from individual patients were very similar it was still possible to distinguish between the profiles of paired isolates from different patients because of minor variations in the expression of some protein constituents, chiefly in the 100–200 K and the 30–37 K regions (Fig 1).

REA

Electrophoresis of undigested genomic DNA showed that the reference strain NCTC 11683 harboured one plasmid of 9·0 kb. Isolates A1 and A2 both harboured two plasmids of the same size (9·6 kb and 5·4 kb). C1 and C2 both had two plasmids of the same size also (15 kb and 8·2 kb). Isolates B1 and B2 shared one plasmid of 25 kb (Fig 2). Hind III digested DNA from all of the three pairs of isolates (Figs 2 and 3), but Hae III only cut DNA from isolate B (Fig 3). Hind III digest profiles of genomic DNA from isolates C1 and C2 were very similar (Fig 3), whereas the REA profiles of isolates A1 and A2 and of isolates B1 and B2 showed considerable similarity, although a number of band differences were apparent in the 8–10 kb regions of the isolates A1/A2 and in the 6–6·5 kb region of the paired isolates B1/B2 (Figs 2 and 3). There were distinct differences in the digest profiles of DNA between the clinical isolates, and between the clinical isolates and the reference strain.

Discussion

In this study we have shown that the DNA fingerprints of five paired pretreatment and recurrent H pylori isolates from five patients were identical. This was accomplished by the application of RAPD fingerprinting to confirm the identity of the paired isolates. Our findings clearly showed that recrudescence, rather than reinfection, accounted for the recurrence of

Figure 1: SDS-PAGE protein profiles of reference strain NCTC 11638 (R) and paired clinical isolates from patients A, B, C, and D. The molecular weight marker proteins (M) were myosin (Mr = 200 000), b-galactosidase (Mr = 116 250), phosphorylase b (Mr = 97 400), bovine serum albumin (Mr = 66 200), ovalbumin (Mr = 45 000), carbonic anhydrase (Mr = 31 000), soya bean trypsin inhibitor (Mr = 21 500), and lysozyme (Mr = 14 400).

Figure 2: Restriction endonuclease analysis. Agarose gel electrophoretic patterns of undigested genomic DNA (left hand side) and Hind III digested DNA (right hand side) restriction fragments of strain NCTC 11638 (R) and paired isolates from patients A, B, and C. The molecular size markers (M) are fragments from Hind III digested bacteriophage λ DNA.

Figure 3: Restriction endonuclease analysis. Agarose gel electrophoretic patterns of Hind III digested (left hand side) and Hae III digested (right hand side) DNA restriction fragments of paired isolates of H pylori from patients A, B, and C. The molecular size markers (M) are fragments from Hind III digested bacteriophage λ DNA.
Recrudescence of *H pylori* infection after apparent eradication with antimicrobial therapy in all five cases examined. Both SDS-PAGE and REA had less discriminatory power when compared with RAPD. To our knowledge, this is the first reported application of RAPD to confirm the identity of paired clinical isolates of *H pylori* obtained from subjects in whom recurrence of the infection occurred after apparent eradication of the organism. The discriminatory power of RAPD fingerprinting represents a potentially practicable and discriminatory typing scheme for *H pylori*.

Several fingerprinting techniques have been used for typing *H pylori*. The numerical analysis of SDS-PAGE protein patterns and restriction endonuclease DNA analysis are sensitive and useful for defining the similarities between isolates. Both techniques are time consuming, however, and scanning the numerous bands for each pattern requires expensive equipment. Ribotyping with *Hae* III and *Hind* III provides a reliable, reproducible, and discriminatory basis for distinguishing one strain from another. However, the DNA of 25% of strains is not cut by *Hae* III. *Hind* III ribotyping patterns are conserved, with several groups of *H pylori* often having the same ribopattern. In this study, DNA from two of three pairs of strains were not cut by *Hae* III.

PCR-based RAPD fingerprinting is a recently developed technique. Its simplicity, versatility, and economy make it an ideal means of genetically fingerprinting isolates. This technique has been used successfully to distinguish clinical isolates of *H pylori* and a combination of the two 10 nucleotide primers used in this study, 1281 and 1283, was found previously to be very suitable for discriminating Irish isolates. In this study, SDS-PAGE protein profiling and restriction endonuclease DNA fingerprinting analysis were applied also, but the electrophoretic patterns were not as easy to compare. In our hands REA yielded less informative data than RAPD. It is interesting to note that other workers using REA found both minor and major band differences between many paired isolates. However, the reasons for the reproducible differences we saw when using REA are not clear. In any event, RAPD yielded very satisfactory fingerprinting profiles. Ready discrimination between the isolates was possible even when the DNA template was prepared by a boiling method.

Recurrence rates of *H pylori* infection from 0–50% have been reported for patients who are followed up for periods of one to seven years. Recurrence rates differ depending on the treatment regimen. We have shown that of 125 one year follow up patients, in whom *H pylori* had been eradicated, the infection recurred in 47% of the patients treated with monotherapy, in 31–8% of those treated with dual therapy, and in 10–9% of those treated with triple therapy. Therefore, the more effective treatment is associated with a low recurrence rate. Furthermore, in a clinical study of 304 patients, who were followed up tri-monthly for 60 months, 19 (6.3%) had *H pylori* recurrence as assessed using a single test, the 14C urea breath test; 17 of which (89–5% of the 19 recurrences) occurred within six months after treatment (1 within three months). None of the patients were ‘reinfected’ with the organism after 24 months. A higher recurrence rate (9–1%) was seen in this study, using four techniques to detect *H pylori*. Although the recurrent isolates from the five patients were cultured between seven and 22 months after the first isolation in this study, the infection might have recurred much earlier as two of these patients did not present until symptoms returned and the other three attended for a one year follow up endoscopy without symptoms.

Previous studies, using SDS-PAGE and REA, have shown that strains of *H pylori* from different patients are genetically distinct from each other, and that the same strains persist in patients for at least two years, even after the patients received antimicrobial therapy. Langenberg et al have also shown that a recurrent strain of *H pylori*, after apparently successful eradication is genetically identical to the pretreatment strain using REA. In our study, the five patients examined were from 29 patients in whom *H pylori* infection recurred after apparently successful eradication. They were selected only on the basis that both their pre and post eradication isolates were available. Thus, these five patients were possibly representative of all the 29 patients. DNA
fingerprints of RAPD showed that the recurrent H pylori strains in each of the five patients were identical to the original strains, which suggests that the nature of H pylori recurrence after eradication is recrudescence rather than reinfection.

The means by which recrudescence arises is equivocal at present. Two possibilities are either incomplete eradication of the bacterium by drug treatment or incomplete elimination of the bacterium from the host. Support for these explanations is provided by several studies. H pylori can live in human gastric pits, where it might avoid the bactericidal activity of antimicrobial agents and recolonise after treatment has finished.23 H pylori can also change its morphology from typical helical to a coccoid form under the hostile conditions found in the gastric environment and can revert to its original shape under favourable conditions.24 Incomplete elimination would most probably occur if the organism inhabited a reservoir other than the stomach. This possibility is strengthened by the findings that H pylori has been found in saliva,25 dental plaque,26 and faeces.27 28 In addition, as it has been found that members within the same family may harbour identical strains,29 there is also a possibility that these patients might have been reinfected with strains from the same reservoir as the pretreatment strains. Other studies, however, have shown that most family members are infected with different strains.19 In conclusion, the findings in this study using a highly discriminatory molecular fingerprinting technique, RAPD, show that the recurrence of H pylori infection after apparently successful eradication is caused by recrudescence rather than reinfection. Thus, the definition of eradication of H pylori currently used may need to be revised. It is suggested that eradication should be defined as the inability to detect H pylori at least six months after cessation of antimicrobial therapy.9 Furthermore, as H pylori urease activity may be undetectable in small numbers of organisms30 or when expression of the enzyme is inhibited by antimicrobial agents or proton pump inhibitors for a period of time after treatment,31 tests that are based on urease activity should be complemented by at least one other technique, such as Gram staining, culture, histological examination or serology when determining the extent of eradication or recurrence of H pylori infection.

The preliminary results of this study were orally presented to the British Society of Gastroenterology in March 1994. (Gut 1994; 35 (suppl 2): S3.) The authors thank the medical and endoscopy staff and research nurses of Meath/Adelaide Hospitals and Professor Jinzhun Zhang of Union Hospital, Wuhan, Peoples Republic of China, for their help, cooperation, and support.


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Gut 1995 37: 30-34
doi: 10.1136/gut.37.1.30