How should *Helicobacter pylori* negative patients be managed?

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**Summary**

Dyspepsia is a digestive syndrome distinct from (although frequently overlapping with) gastro-oesophageal reflux disease (GORD) and irritable bowel syndrome (IBS), which is characterised by various combinations of painful and non-painful symptoms arising from the epigastrium. Dyspepsia can be secondary to a variety of diseases, but in most instances it is idiopathic. *Helicobacter pylori* infection is responsible for the majority of peptic ulcers and of other diseases potentially associated with dyspepsia. Nevertheless, a causal role for *H pylori* infection in symptom occurrence has not been established. Experimental data indicate that *H pylori* eradication does not improve symptoms in the majority of dyspeptic patients. It has been proposed recently that *H pylori* negative patients should be managed according to their clinical presentation. Some reports suggest that taking into consideration the most relevant or “predominant” symptom may help to identify distinct subgroups among dyspeptic patients with different underlying pathophysiological abnormalities and different responses to treatment. Well designed and conducted prospective studies are needed to verify whether treatment of *H pylori* negative dyspeptic patients based on the predominant symptom actually is a cost effective approach.

**Introduction**

Doctors and investigators have been puzzled by dyspepsia for decades. Two factors have recently occurred to stimulate further their interest in this field: understanding of the pathogenic role played by *H pylori* in gastrointestinal diseases potentially associated with dyspeptic symptoms; and the squeeze on health care budgets which prompts scrutiny of diagnostic and therapeutic decisions.

Organic diseases are rare among young *H pylori* negative dyspeptic patients without alarm features and non-invasive *H pylori* testing has been proposed to decrease referrals for upper gastrointestinal endoscopy without significantly increasing the risk of missing dangerous diseases. Both European and North American guidelines suggest that all young patients who are found to be *H pylori* positive by breath test or serology should be treated, whereas endoscopy should be performed only in patients with alarm features or non-responders to treatment. Young *H pylori* negative patients should be treated with antisecretory drugs or prokinetic agents.

*H pylori* plays a pathogenic role in the production of dyspeptic symptoms, a large scale eradication strategy should be associated with a remarkable decrease in dyspepsia in the population, but this does not seem to be the case. Despite effective healing of ulcer craters, *H pylori* eradication fails to control dyspeptic symptoms in over 30% of patients with ulcers, and the effect of *H pylori* eradication on symptoms in patients with functional dyspepsia is even more disappointing. Unfortunately, many of the available eradication studies are flawed because endoscopy is not always performed in patients with functional dyspepsia and therefore are difficult to interpret. Even the most recent studies with appropriate follow up periods have produced conflicting results: patients with symptom improvement after *H pylori* eradication ranging between 0% and 86%. Furthermore, recent evidence suggests that *H pylori* might be associated with the onset of GORD, although conflicting results have also been published. Altogether these figures indicate that approximately 70% of young patients with uninvestigated dyspepsia would remain symptomatic if a large scale eradication programme was undertaken (fig 1). Management of dyspepsia, therefore, will be largely independent of the *H pylori* status of affected individuals. We propose a hypothetical management strategy based mainly on clinical features and summarise the current literature that may substantiate the proposed plan.

**Management of *H pylori* negative patients**

Figure 2 shows a hypothetical algorithm for the management of uninvestigated dyspepsia. Factors other than *H pylori* status should initially guide clinical decisions. Patients with late onset dyspepsia should be evaluated to identify a specific etiology.

**Abbreviations used in this paper:** GORD, gastro-oesophageal reflux disease; IBS, irritable bowel syndrome.
Uninvestigated dyspepsia

Alarm features (and/or ≥45 y)

- No alarm features
- 4 weeks of therapy based on predominant symptom

Endoscopy

Treat accordingly

Responders

- Non-responders/early relapses

$^{13}$C-UBT/serology

$H$ pylori positive

- Eradication

$H$ pylori negative

Therapy based on predominant symptoms (increased doses, combination therapies)

Figure 2. Management of uninvestigated dyspepsia. Short courses of medical treatment tailored to the predominant symptom should be prescribed initially. $H$ pylori investigation and treatment of infected individuals should be considered for non-responders or in the case of frequent recurrences. UBT, urea breath test.

Do $H$ pylori infected and uninfected dyspeptic patients respond differently to symptomatic treatment?

Due to the scarce (if any) symptomatic effect of $H$ pylori eradication, one may anticipate that treatment of dyspepsia should be unrelated to $H$ pylori status. Whether $H$ pylori negative and positive dyspeptic patients respond differently to symptomatic treatment has not been properly investigated. We will briefly compare demographic, pathophysiological, and clinical features of the two subgroups.

**Demographic features**

When using non-invasive tests to identify $H$ pylori status, infected and uninfected dyspeptic patients show very similar demographic features. Both groups are characterised by the prevalence of male sex and have similar smoking and eating habits; $H$ pylori negative patients, however, are younger, more frequently involved in non-manual working activities, and less often have a positive family history of peptic ulcer disease.
**PATHOPHYSIOLOGICAL FEATURES**

**H pylori/gastric acid hypersecretion**

The role of acid in the development of dyspeptic symptoms has not been clarified. Both basal and pentagastrin stimulated acid secretion are normal in patients with functional dyspepsia, regardless of their H pylori status.\(^\text{20}\) Conversely, patients with H pylori infection and otherwise unexplained dyspepsia have gastrin releasing peptide stimulated gastric acid secretion that is lower than that of H pylori positive patients with duodenal ulcer, but higher than in H pylori negative controls.\(^\text{37}\)

**H pylori/gut dysmotility**

Gastrointestinal dysmotility is a complex function characterised by myoelectrical smooth muscle activity, movement of the gut wall, intraluminal phasic and tonic pressure changes, and movement of intraluminal contents. No single technique is available to measure all of these events simultaneously and we have only fragmentary information both in health and disease. Regardless of the technique adopted, gastroduodenal motor abnormalities have been detected in the vast majority of studies on functional dyspepsia.\(^\text{31}\) Nevertheless, their relation with symptoms and H pylori infection has only been partially explored. Testoni et al manometrically recorded decreased fasting and postprandial antral motility in H pylori infected dyspeptic patients, compared with both healthy controls and H pylori negative patients,\(^\text{38}\) but this motor abnormality was not modified by H pylori eradication.\(^\text{39}\) Pieramico and colleagues\(^\text{40}\) confirmed previous data by showing lower antral contractile activity in dyspeptic patients and failed to detect significant differences between H pylori positive and negative patients, but reported normalisation of interdigestive motility in H pylori positive patients after eradication. In keeping with these findings, preliminary data\(^\text{41}\) reported increased antral contractility after eradication. Several studies investigating scintigraphic gastric emptying and H pylori status failed to detect any difference in gastric motility between H pylori positive and negative dyspeptic patients. However, recent studies done using appropriate methods, showed a higher prevalence of motility disturbances among uninfected patients.\(^\text{35} \text{36}\) Indeed, these two putative mechanisms of dyspepsia do not seem to interact as H pylori eradication does not influence gastric emptying.\(^\text{37} \text{38}\)

**H pylori/hypersensitivity**

Dyspeptic patients as a group have gastric\(^\text{41} \text{42}\) and duodenal\(^\text{41}\) hypersensitivity which is not influenced by sex or age.\(^\text{40}\) The gut wall contains three kinds of neural receptors: chemoreceptors, in the mucosa, which respond to chemical stimuli; mechanoreceptors, in the smooth muscle layer, which respond to stretch or compression; and nociceptors, the most numerous receptors, which are commonly silent, but can be “recruited” by any stimulus that is strong enough to induce pain.\(^\text{43}\) H pylori infection has not been shown to be involved in the aetiology of gastric\(^\text{41}\) or duodenal hypersensitivity\(^\text{42}\) in patients with functional dyspepsia.

**CLINICAL FEATURES**

Whether H pylori negative patients have a peculiar symptom profile has not been established yet. A low prevalence of H pylori was observed in a group of patients with strictly selected functional dyspepsia whose predominant symptom was postprandial fullness.\(^\text{44}\) In keeping with these findings, epigastric pain and heartburn were the symptoms most frequently associated with H pylori infection, as detected by breath test\(^\text{45}\) or serology\(^\text{46}\) in separate studies from Northern Italy, whereas the prevalence of infection in subjects complaining of postprandial fullness was lower and similar to that of asymptomatic subjects. Histological H pylori status, gastric acid secretion, gastrin concentrations, cutaneous electrogastrography, and gastric emptying were evaluated in 144 Japanese patients with functional dyspepsia.\(^\text{47}\) All the parameters were similar among the dyspepsia subgroups, with the exception of gastric emptying which was more frequently delayed in patients with dysmotility-like and reflux-like dyspepsia, whereas no association was detected between H pylori and symptoms. Hovelius et al explored the relation between serologically evaluated H pylori status and dyspeptic symptoms among patients seen by general practitioners in Sweden. H pylori positive patients presented with ulcer-like symptom scores significantly higher than H pylori negative patients.\(^\text{27}\)

**Conclusions**

H pylori infection certainly plays a limited role in symptom generation in patients with functional dyspepsia and, therefore, treatments other than H pylori eradication are needed to control dyspeptic symptoms in most patients. It has been proposed that dysmotility-like dyspepsia should be distinguished from the ulcer-like form according to the predominant symptom, and that the two subgroups should be treated with prokinetic agents and antisecretory drugs, respectively. The validity and cost-effectiveness of this hypothesis have still to be explored fully. Furthermore, it is necessary to clarify whether and to what extent H pylori negative and positive patients respond differently to symptomatic treatment. Nevertheless, testing for and treatment of H pylori infection is a possible option in patients who fail to respond to appropriate courses of symptomatic treatment or who have heard of the “bug” and want to get rid of it.

Management of H pylori negative patients


8 Bregante JF, Caellebert A, Barthelemy P. The course of symptoms after eradication of Helicobacter pylori; a one-year follow-up of a cohort of 258 patients with duodenal ulcer or nonulcer dyspepsia [abstract]. Gastroenterology 1998;114:A81.


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