Host gastric Lewis expression determines the bacterial density of *Helicobacter pylori* in *babA2* geno-positive infection

B-S Sheu, S-M Sheu, H-B Yang, A-H Huang, J-J Wu

**Background and aims:** We tested if host gastric Lewis antigens and the *babA2* genotype of *Helicobacter pylori* correlated with clinicohistological outcome.

**Methods:** We enrolled 188 dyspeptic patients (45 with duodenal ulcer, 45 with gastric ulcer, and 98 with chronic gastritis) with *H pylori* infection, proved by culture and gastric histology, reviewed by the updated Sydney system. Gastric expression of Lewis (Le) antigens Le\(a\), Le\(b\), Le\(y\), and Le\(x\) was determined immunochemically to determine intensity (range 0–3). The corresponding 188 *H pylori* isolates were screened for *babA2* genotype by polymerase chain reaction.

**Results:** All *H pylori* isolates had a positive *babA2* genotype. We identified Le\(a\) in 33.5%, Le\(b\) in 72.9%, Le\(y\) in 86.2%, and Le\(x\) in 97.4% of biopsies from these 188 patients. Patients who expressed Le\(a\) had a higher *H pylori* density than those who did not express Le\(a\) (p<0.001). Among 139 patients who expressed Le\(a\), *H pylori* density increased with a higher Le\(a\) intensity (p<0.05). Gastric atrophy decreased with Le\(a\) intensity and thus resulted in lower *H pylori* density in the antrum (p<0.05). For the 49 patients without gastric Le\(a\) expression, *H pylori* density was positively related with Le\(b\) and Le\(y\) expression (p<0.05).

**Conclusions:** Taiwanese *H pylori* isolates are 100% *babA2* geno-positive. Gastric Le\(a\) as well as Le\(b\) intensity may be major determinants of *H pylori* density. While lacking gastric Le\(a\) expression, Le\(b\) and Le\(y\) were closely related to *H pylori* colonisation.

**STOMACH**

*Helicobacter pylori* is a well recognised gastric pathogen in humans.\(^1\) The ability of *H pylori* to achieve persistent colonisation in the human stomach has become the focus of intense research.\(^2\) Several studies have proposed that the molecular mimicry of *H pylori* lipopolysaccharide antigens to human Lewis (Le) antigens may help *H pylori* to evade the immune response and enhance bacterial adherence to gastric epithelium.\(^3\)–\(^5\) As Le antigens are also found on the gastric epithelium in humans,\(^6\) Le antigen expression may mediate the attachment of *H pylori* to the gastric mucosa.\(^7\) Strong evidence was provided by Ilver *et al* who purified the blood group antigen binding adhesin (BabA) of *H pylori* and found that BabA selectively adheres to the Le\(a\) antigen of the host.\(^8\) Their findings suggest that gastric Le\(a\) antigens selectively interact with the products of the *babA2* (blood group associated binding gene) allele of *H pylori* and thus may possibly facilitate a more dense colonisation in the stomach. However, contradictory data focused on the role of the *babA2* genotype in terms of clinicohistological outcome without analysing the host status for Le\(a\) expression in the stomach.\(^9\)–\(^11\) Therefore, we conducted this study to elucidate if the interaction of the *babA2* genotype of *H pylori* and gastric Le\(a\) antigen expression of the host are correlated with different clinical outcomes.

As gastric Le\(a\) antigens cannot be found in all humans, some other pathways must exist to facilitate adherence of *H pylori*. In contrast with the rare expression of Le\(a\), Le\(b\) and Le\(y\) antigens are commonly expressed.\(^12\) As the adhesion peptidal formation contained Le\(a\) on both *H pylori* and gastric epithelium, these Lewis antigens may be required to establish or maintain infection.\(^13\) Thus we tested if these Lewis antigens have a role in bacterial adherence, when the host has weak or no gastric Le\(a\) expression, interacting with the BabA of *H pylori*.

**MATERIALS AND METHODS**

**Patients and study design**

A total of 188 dyspeptic patients (112 men and 76 women; mean age 44.8 years) gave informed consent and were consecutively enrolled after they were proved to have *H pylori* infection, defined as a positive culture. None had a previous history of anti-*H pylori* therapy. Each patient had undergone panendoscopy to obtain a gastric biopsy for culture and histology of *H pylori* infection. The endoscopic diagnosis of these 188 study patients included uncomplicated chronic active gastritis (n=98), duodenal ulcer (n=45), and gastric ulcer (n=45).

At gastric biopsy, five samples, including two from the antrum, two from the corpus, and one from the cardia, were obtained during endoscopy. Three gastric specimens, each one from antrum, corpus, and cardia, were stained with haematoxylin and cosin as well as with modified Giemsa stains. Apart from analysis of *H pylori* related gastric histology, these three gastric specimens were stained immunochemically for expression of Lewis antigens Le\(a\), Le\(b\), Le\(y\), and Le\(x\). The remaining two gastric specimens were used for *H pylori* culture.\(^14\) Genomic DNA of these *H pylori* isolates were then extracted by polymerase chain reaction (PCR) to detect the *babA2* genotype. Extraction of DNA was performed using the same method as reported in our previous publication.\(^15\)

**PCR and primers for *babA2* genotypes**

Extracted DNA from each strain was subjected to PCR for amplification of the *babA2* genes, applying one pair of primers (babo-F: CTT AAA TAT CTC CCT ATC CC, corresponding to bp 1 to 20 of AF033654; babo-R: CGA TTT GAT AGC CTA CGC TTA

**Abbreviations:** Le, Lewis; Lewis-N, total Lewis number; BabA, blood group antigen binding adhesin; *babA2*, blood group associated binding gene; PCR, polymerase chain reaction; TLI, total gastric Lewis antigen expression intensity; HPD, Helicobacter pylori density; IM, intestinal metaplasia; CIS, chronic inflammatory score; PBS, phosphate buffered saline.
TG, corresponding to bp 369 to 391 of AF033654) designed by Ilver and colleagues
or another self designed primer (bab7-F: CCA AAC GAA ACA AAA AGC GT, corresponding to bp 105 to 124 of AF033654; bab7-R: GCT TGT GTA AAA GCC GTC GT, corresponding to bp 357 to 375 of AF033654).

The PCR mixtures were performed in a volume of 50 µl containing 0.2 µM of each primer, 0.2 mM each of deoxynucleoside triphosphates, reaction buffer with MgCl₂, and 1 unit of DyNAzyme II DNA polymerase (Finnzymes OY, Espoo, Finland). Amplification was carried out over 30 cycles consisting of 94°C for one minute, 45°C for one minute, and 72°C for one minute in a thermal cycler (Perkins-Elmer Cooperation, Norwalk, Connecticut, USA). The two primers achieved a 391 bp product (by primers designed by Ilver et al) and a 271 bp product (using the self designed primers in this study), respectively. The sequences of these two PCR products were

![Figure 1](A, B) Gastric immunohistochemical stains of Lewis antigen Le⁺ expression. (A) Positive staining over the surface epithelium only. (B) Diffuse staining over the intercryptal epithelium. (C, D) Gastric immunohistochemical stains of Le⁻ expression. (C) Positive staining over the surface epithelium only. (D) Diffuse staining over the deep glands.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Topographic distribution of the intensity of gastric Lewis antigen expression in 188 patients with Helicobacter pylori infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lewis antigen</td>
<td>Antrum</td>
</tr>
<tr>
<td>Intensity (range 0–3)</td>
<td></td>
</tr>
<tr>
<td>Le⁺</td>
<td>0.56 (0.77)</td>
</tr>
<tr>
<td>Le⁻</td>
<td>1.37 (1.24)</td>
</tr>
<tr>
<td>Le⁺</td>
<td>1.19 (0.72)</td>
</tr>
<tr>
<td>Le⁻</td>
<td>1.61 (0.95)</td>
</tr>
</tbody>
</table>

Values are mean (SD).
*Significant difference by paired t test with two tailed analysis (p<0.05).
A, antrum; B, body; C, cardia.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Lewis antigen expression and clinicohistological features of Helicobacter pylori infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parameter (mean)</td>
<td>Le⁺ (+) (n=63)</td>
</tr>
<tr>
<td>AIS (0–9)§</td>
<td>2.31</td>
</tr>
<tr>
<td>CIS (0–9)†</td>
<td>6.89</td>
</tr>
<tr>
<td>AT [%]</td>
<td>57.1</td>
</tr>
<tr>
<td>IM [%]‡§</td>
<td>28.6</td>
</tr>
<tr>
<td>Ulcer rate (%)</td>
<td>49</td>
</tr>
<tr>
<td>HPD (1–15)†</td>
<td>9.03</td>
</tr>
<tr>
<td>Antrum (1–5)†</td>
<td>2.89</td>
</tr>
<tr>
<td>Body (1–5)**</td>
<td>3.46</td>
</tr>
<tr>
<td>Cardia (1–5)†‡</td>
<td>2.57</td>
</tr>
</tbody>
</table>

AIS, acute inflammatory score; CIS, chronic inflammatory score; AT, antral atrophy; IM, intestinal metaplasia; HPD, total density of H pylori.
*Significant difference (p<0.05): *between Le⁺ (+) and Le⁺ (−) patients; †between Le⁺ (+) and Le⁻ (+) patients; ‡between Le⁺ (+) and Le⁻ (−) patients; §between Le⁺ (+) and Le⁻ (−) patients.
determined using an ABI PRISM 377 DNA Sequencer (Applied Biosystems, Foster, California, USA).

In addition, we randomly selected 30 \textit{babA2} genopositive strains (proven by the presence of the 271 bp PCR product) to test their BabA producing phenotype by western blotting using BabA specific antiserum. BabA specific antiserum was obtained from Drs Thomas Boren and Stefan Odenbreit.

Each selected \textit{H pylori} extract was analysed on a sodium dodecyl sulphate-10% polyacrylamide gel. The blot was then subjected to a 1:500 dilution of the anti-BabA antibody and detected with goat antirabbit antibody conjugated to horse-radish peroxidase (Chemicon International Inc., Temecula, California, USA).

Analysis of \textit{H pylori} related histology

The same pathologist, unaware of the endoscopic and culture results, analysed the gastric histology. \textit{H pylori} density for each specimen was scored according to Yang and colleagues:

- score 0, no bacteria;
- score 1, one or two small clusters with less than 10 bacteria;
- score 2, less than half the superficial crypt area with less than 10 bacteria in each crypt;
- score 3, less than half the area but with more than 10 bacteria, or more than half the area with less than 10 bacteria in each crypt;
- score 4, >10 bacteria in forvelae with some free area;
- score 5, >10 bacteria without a free area.

Total \textit{H pylori} density (HPD) was defined as the sum of the densities from the three biopsy samples, obtained from the antrum, corpus, and cardia. Thus the HPD score ranged from 1 to 15. The acute inflammatory score (range 0–3), chronic inflammation score (range 0–3), atrophic change (absent, 0; present, 1), and intestinal metaplasia (IM) (absent, 0; presence, 1) were graded using the updated Sydney system.

Immunochemical staining for gastric Lewis expression

Immunostaining of biopsy specimens for Lewis antigens was performed using the standard avidin-biotin-peroxidase technique. Formalin fixed paraffin embedded tissue sections, including topographical specimens from the antrum, corpus, and cardia from each patient, were deparaffinised through xylene and hydrated with ethanol. Slides were washed with...
distilled water and then placed in 1× phosphate buffered saline (PBS) for five minutes. Incubation with 3% hydrogen peroxide for three minutes blocked the endogenous peroxidase activities of these sections. After incubation with 2% bovine serum albumin for two hours and washing with PBS, the primary monoclonal antibodies for detection of gastric Lewis antigens were used (anti-Lex, Ley, Leb, and Ley; Signet Laboratories, Inc., Dedham, Massachusetts, USA). The reaction time for the primary monoclonal antibodies (anti-Lex, Ley, Leb, and Ley) was three hours at 25°C. These slides were again washed with PBS and incubated with the secondary antibody to achieve a 1:2000 dilution of antimouse IgG and IgM conjugated to horseradish peroxidase (Chemicon International Inc., Temecula, California, USA) for two hours at 25°C. All slides were then washed with PBS and with the AEC kit (Sigma, St Louis, USA) used as substrate to illustrate the stain. All slides were evaluated blindly by the same pathologist. For each gastric site, the intensity of Lea, Leb, Ley, and Ley was scored from 0 to 3 (0, no staining; 1, staining of either surface mucous cells or deep gastric glands; 2, staining of surface cells, intercryptal epithelium, and deep glands; 3, diffuse staining of either surface mucous cells or deep gastric glands; 2, staining of surface cells, intercryptal epithelium, and deep glands; 3, diffuse staining of either surface mucous cells or deep gastric glands). Examples of intensity 1 and intensity 2 gastric Le expression are shown in fig 1A and 1B, respectively. Total gastric Lewis antigen intensity (TLI) for Ley, Ley, Leb, and Lea was the sum of three biopsy samples from the antrum, corpus, and cardia (range 0–9).

Statistics
The Student’s t test and paired t test were used as appropriate for parametric differences. One way ANOVA with Bonferroni’s method was used for multiple testing of data. Pearson’s χ² test was used for non-parametric proportions. All significance tests were two tailed and a p value <0.05 was taken as significant.

RESULTS
Prevalence of babA2 genotypes of H pylori infection in Taiwan
Fifty per cent (94/188) of H pylori isolates had a positive babA2 genotype by PCR, applying the primers used by Iver et al to obtain a band of 371 bp. However, the nucleotide sequence of this 391 bp PCR product from the Taiwanese isolates was confirmed as not being babA2 in origin but had >90% homology with the published sequence of adenine specific DNA methyltransferase in H pylori 26695. To detect the babA2 genotype for the domestic strains, we self designed a pair of primers and achieved a 271 bp PCR product whose nucleotide sequence was confirmed with >95% homology to the babA2 gene of CCUG 17878 (fig 2). Based on PCR using these primers to obtain a 271 bp band, the prevalence rate of the babA2 genotype was 100% in all 188 Taiwanese H pylori isolates. Western blotting also confirmed that the 30 randomly selected 271 bp genopositive strains had a uniformly positive phenotype.

Topographic gastric Lewis antigen expression in H pylori infected Taiwanese
Based on the presence of staining of any one of the three gastric specimens, we identified Lea in 33.5%, Ley in 72.9%, Leb in 86.2%, and Ley in 97.4% of gastric biopsies in these 188 patients. As shown in table 1, the topographic intensity of gastric Lea expression was higher in the corpus than in the antrum or cardia (1.76 v 1.61 and 1.68; paired t test, p<0.05). The intensity of Ley expression was also higher in the corpus and cardia than in the antrum (1.74 v 1.37 and 1.59 v 1.37; paired t test, p<0.05). In contrast, the topographic intensity of Leb or Ley was higher in the antrum than in the corpus and cardia (Leb: 0.56 v 0.41 and 0.45, p<0.05; Ley: 1.19 v 0.88 and 0.75, p<0.05).

Lewis antigen expression and clinicohistological features of H pylori infection
There was no difference in ulcer rate between patients with or without Lewis antigen expression in the stomach (table 2). Patients with gastric Lea expression had significantly higher HPD and CIS than those without Lea expression (HPD: 9.29 v 6.35, p<0.001; CIS: 7.59 v 6.15, p<0.05). We also found that mean HPD of 12 Ley⁺⁺⁺ patients was significantly lower than that of either 88 Ley⁺⁺ patients or 51 Ley⁺⁺⁺ patients (7.42 v 9.22 and 9.41; p<0.05 by one way ANOVA). In fig 3A, TLI of Leb was found to be positively correlated with HPD (one way ANOVA, p<0.05). In table 2, although the statistical significance was limited, HPD was evidently higher in those patients who expressed Ley, Ley, and Leb in the stomach. Furthermore, patients who expressed Leb and Ley had a higher bacterial density in biopsies (p<0.05). HPD was even elevated when the total number of gastric Lewis expression (Lewis-N) of each study patient increased (fig 3B). Multivariate logistic regression disclosed that the intensity of Ley and Leb expression, rather than Lewis-N, was an independent factor correlated with HPD in H pylori infected patients (table 3).

As also shown in table 2, patients with no expression of Leb or Ley had higher rates of IM in the stomach (p<0.01). Among those patients who expressed Ley, TLI of Ley was significantly lower in the presence of IM (2.68 v 3.83; p<0.01) but higher in the presence of antral atrophy (4.05 v 3.01; p<0.01). There was no decrease in TLI of Leb, Lea, or Leb, despite the presence of IM or antral atrophy.

Factors correlating with HPD in non-Lea patients
Of the 49 H pylori infected patients without Lea expression, HPD was higher in patients who expressed gastric Leb and Lea.

Figure 3 (A) Total Helicobacter pylori density (HPD) was positively correlated with an increase in Leb intensity (×p<0.05, significant difference analysed using one way ANOVA). (B) Total Lewis number (Lewis-N) of each patient was also positively correlated with higher HPD in the stomach (one way ANOVA, p<0.05).
(Le⁺: 7.41 ± 6.05, p < 0.05; Le⁻: 6.81 ± 4.25, p < 0.005). In Table 3, multivariate logistic regression confirmed that Le⁺ and Le⁻ antigens were both independently correlated with HPD in the 49 patients without Le⁺ expression. In contrast, for the 139 patients who expressed Le⁺, only Le⁻ but not Le⁺ antigens were independently correlated with HPD (Table 3).

**Compensatory effect of Le⁺ to maintain HPD for weak Le⁻ intensity in antral atrophy**

Among the 139 Le⁺ positive patients, the topographic distribution of *H. pylori* density and the intensity of Le⁺, Le⁻, and Le⁺ were compared between patients with and without antral atrophy (Table 4). There was no decrease in either Le⁺ or Le⁻ intensity over the antrum despite the presence of atrophy. In contrast, patients with antral atrophy had a lower Le⁺ intensity over the antrum (p < 0.05) and thus had a significantly lower bacterial density (p < 0.05).

Although both bacterial density and the intensity of Le⁺ over the antrum were lower, HPD was not decreased by the presence of antral atrophy (Table 4). The paradoxical increase in bacterial density on the body and cardia were found to maintain HPD under the presence of antral atrophy (p < 0.05). However, there was no significant increase in Le⁻ intensity elsewhere in the body or cardia (Table 4). In contrast, a significant increase in the intensity of Le⁺ over the gastric body and cardia was found in those patients with antral atrophy compared with those without antral atrophy (p < 0.05).

**DISCUSSION**

Identification of specific receptors for *H. pylori* on the gastric mucosa may explain why the organism can only adhere to those cells in humans. Liver et al disclosed that the *babA2* gene of *H. pylori* is a putative determinant allowing it to adhere to Le⁺ of the gastric epithelium and thus could promote bacterial invasion of the human stomach.² Our prospective study enrolled 188 *H. pylori* infected patients and is the first to analyse both bacterial *babA2* genotype and gastric antigen expression (including Le⁺), thus further elucidating the impact of any interactions between BabA and Le⁺ on the clinicohistological outcome after *H. pylori* infection.

In the present study, after applying the primer of Liver et al to obtain a 391 bp PCR product, we discovered it was non-*babA2* in origin. By applying our self designed primers, a 271 bp PCR product was found and was confirmed to have >95% homology to the published sequence of *babA2*. The nucleotide sequence data confirmed that our self designed pair of primers were suitable for *babA2* genotyping in Taiwan and all 188 isolates in this study were uniformly proven to have a *babA2* positive genotype. The prevalence was higher than in previous reports (38–85%),¹⁰–¹² ¹⁷ Moreover, such an extremely high prevalence of *babA2* in Taiwan suggests this could be an ideal country in which to study whether *babA2* is a good target for preventive vaccination if BabA interacts strongly with Le⁺ to impact on *H. pylori* colonisation of patients.

**Table 3** Multivariate logistic regression for independent factors relevant to total *Helicobacter pylori* density of the stomach

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Coefficient</th>
<th>Standard error</th>
<th>p Value</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 188 patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Le⁺ intensity</td>
<td>0.491</td>
<td>0.052</td>
<td>0.000*</td>
<td>(0.389–0.593)</td>
</tr>
<tr>
<td>Le⁺-N</td>
<td>-0.327</td>
<td>0.294</td>
<td>0.267</td>
<td>(-0.906–0.253)</td>
</tr>
<tr>
<td>Total Le⁻ intensity</td>
<td>0.230</td>
<td>0.075</td>
<td>0.002*</td>
<td>(0.083–0.378)</td>
</tr>
<tr>
<td>Total Le⁺ intensity</td>
<td>0.092</td>
<td>0.056</td>
<td>0.116</td>
<td>(-0.022–0.199)</td>
</tr>
<tr>
<td>Total Le⁻ intensity</td>
<td>0.123</td>
<td>0.076</td>
<td>0.221</td>
<td>(-0.057–0.244)</td>
</tr>
<tr>
<td>In 139 patients with Le⁺</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Le⁺ intensity</td>
<td>0.518</td>
<td>0.066</td>
<td>0.000*</td>
<td>(0.386–0.649)</td>
</tr>
<tr>
<td>Total Le⁻ intensity</td>
<td>0.183</td>
<td>0.074</td>
<td>0.015*</td>
<td>(0.037–0.329)</td>
</tr>
<tr>
<td>Total Le⁺ intensity</td>
<td>0.061</td>
<td>0.055</td>
<td>0.269</td>
<td>(-0.048–0.169)</td>
</tr>
<tr>
<td>Total Le⁻ intensity</td>
<td>-0.044</td>
<td>0.073</td>
<td>0.546</td>
<td>(-0.187–0.099)</td>
</tr>
<tr>
<td>In 49 patients without Le⁺</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Le⁺ intensity</td>
<td>0.594</td>
<td>0.136</td>
<td>0.000*</td>
<td>(0.318–0.868)</td>
</tr>
<tr>
<td>Total Le⁻ intensity</td>
<td>0.242</td>
<td>0.105</td>
<td>0.025*</td>
<td>(0.031–0.456)</td>
</tr>
<tr>
<td>Total Le⁺ intensity</td>
<td>0.111</td>
<td>0.093</td>
<td>0.241</td>
<td>(-0.077–0.298)</td>
</tr>
</tbody>
</table>

*Significant difference.

**Table 4** Topographic distribution of *Helicobacter pylori* density and gastric Lewis antigen intensity in 139 Le⁺ positive patients with and without antral atrophy

<table>
<thead>
<tr>
<th>Parameter (mean)</th>
<th>Antrum</th>
<th>Body</th>
<th>Cardia</th>
<th>Body+cardia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Le⁺ density</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AT (n=80)</td>
<td>0.54</td>
<td>0.39</td>
<td>0.54</td>
<td>0.93</td>
<td>1.36</td>
</tr>
<tr>
<td>Non-AT (n=59)</td>
<td>0.59</td>
<td>0.51</td>
<td>0.49</td>
<td>1.03</td>
<td>1.64</td>
</tr>
<tr>
<td>Le⁻ density</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AT (n=80)</td>
<td>1.63*</td>
<td>2.43</td>
<td>2.23</td>
<td>4.66</td>
<td>6.05</td>
</tr>
<tr>
<td>Non-AT (n=59)</td>
<td>2.15</td>
<td>2.26</td>
<td>2.25</td>
<td>4.51</td>
<td>6.44</td>
</tr>
<tr>
<td>Le⁺ intensity</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>AT (n=80)</td>
<td>1.21</td>
<td>1.31*</td>
<td>0.94*</td>
<td>2.24*</td>
<td>2.49</td>
</tr>
<tr>
<td>Non-AT (n=59)</td>
<td>1.28</td>
<td>0.88</td>
<td>0.77</td>
<td>1.66</td>
<td>2.24</td>
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<tr>
<td>H pylori density</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AT (n=80)</td>
<td>2.52*</td>
<td>3.65*</td>
<td>3.05*</td>
<td>6.71*</td>
<td>9.23</td>
</tr>
<tr>
<td>Non-AT (n=59)</td>
<td>3.35</td>
<td>3.25</td>
<td>2.67</td>
<td>5.98</td>
<td>9.38</td>
</tr>
</tbody>
</table>

*Significant difference between patients with (AT) and without (non-AT) antral atrophy, analysed by the two tailed Student’s t test (p<0.05).
The prevalence rates of the different Lewis antigens in our study were compatible with Kobayashi et al, who reported that Le⁻ had the lowest incidence and that gastric Le⁺ or Le⁻ may disappear when *H pylori* infection is induced by IM. Such a finding was indirectly supported by our data (table 1) which showed that patients without expression of Le⁺ or Le⁻ had higher rates of IM than those with Le⁺ and Le⁻ (p<0.05).

Patients with gastric Le⁺ expression had a higher bacterial density of *H pylori* than those without Le⁺ expression (p<0.05) (table 2). TLI of Le⁺ expression was also positively correlated with HPD (fig 3A). Moreover, HPD was higher in Le⁺ weak and Le⁻ strong secretors than in Le⁺ non-secretors (p<0.05). Accordingly, the intensity of Le⁺ was proved to be an independent factor in enhancing bacterial adherence in the 49 patients with Le⁺ expression (table 3). Such a finding was indirectly supported by our data (table 1) which showed that patients without expression of Le⁺ or Le⁻ had higher rates of IM than those with Le⁺ and Le⁻ (p<0.05).

There were 49 patients with *H pylori* infection but no expression of Le⁺ in the stomach. Bacterial densities of the body remained higher in patients with positive expression of Le⁺ and Le⁻ (p<0.05) (table 2). An increasing trend for HPD was found in patients whose Lewis-N ranked high (p<0.05, by one way ANOVA) (fig 3B). These data imply that there may be some additive effect of expression of other Lewis antigens, apart from Le⁺, serving as adherent receptors for *H pylori*. This is compatible with the finding of Clyne and Drumm who confirmed that blocking with a monoclonal antibody for the Le⁺ antigen on the gastric epithelium could not totally abolish adherence of *H pylori*. Therefore, we tested whether other gastric Lewis types also enhanced bacterial adherence in the 49 patients without Le⁺ expression. Our study found that patients who expressed Le⁺ and Le⁻ had higher HPD than those who did not express Le⁺ and Le⁻ (Le⁺: 7.41 v 6.05, p<0.05; Le⁻: 6.81 v 4.25, p<0.005). By multiple logistic regression, Le⁺ and Le⁻ were further confirmed to be independent factors in enhancing colonial density here (table 3). These clinical data thus support the laboratory findings of Taylor et al which found adhesion pedestal formations stabilised with Le⁺ on both *H pylori* and gastric epithelium. Accordingly, our study confirmed that Lewis antigens other than Le⁺ can be used to establish or maintain *H pylori* infection in the stomach.  

Expression of Le⁺ was stronger in the body, in contrast with the antral dominant distribution of Le⁺ and Le⁻ (table 1). Therefore, we tested whether Le⁺ and Le⁻ had additive effects when present with Le⁺ for enhancement of *H pylori* colonisation in the 139 patients with Le⁺ expression. Patients with antral atrophy had different topographic distributions of bacterial density but the total density of *H pylori* did not differ (table 4). The presence of antral atrophy decreased the intensity of Le⁺, which was expected, as Le⁺ usually stained the superficial glands. 13 When the intensity of Le⁻ was lower, bacterial density here decreased. However, overall HPD was maintained by the paradoxical increased density over the body and corpus. As the intensity of Le⁺ over the body and cardia were higher in the presence of antral atrophy, increased bacterial densities here could be mediated by Le⁺ expression. These clinical data supported the finding that gastric Le⁺ antigen can enhance bacterial adherence. Moreover, Le⁻ may have compensatory or additive effects with Le⁺ to maintain bacterial loads during ongoing atrophy changes.  

Among those patients who expressed Le⁺, TLI of Le⁺ in the presence of IM was 2.68 versus 3.83 (p<0.01) but was higher in the presence of antral atrophy (4.05 v 3.01; p<0.01). These data confirm that IM and antral atrophy may change Le⁺ expression and thus alter the *H pylori* colonisation pattern.  

In summary, Taiwanese *H pylori* isolates are 100% babA2 positive. Gastric Le⁺ intensity as well as Le⁻ intensity appear to be major determinants of bacterial density of *H pylori*. When lacking gastric Le⁺ expression, Le⁺ and Le⁻ are closely related to *H pylori* colonisation. To overcome *H pylori* adherence, genomic targets such as babA2 (or other interacting with gastric Lewis antigens) may be promising.

**ACKNOWLEDGEMENTS**

The study was supported by grants NHRI-EX91-9041SC from the National Health Research Institute, and NSC90-2320-B-006-048 and NSC90-2320-B-006-091 from the National Science Council, Taiwan. The authors also appreciate the assistance of Ms Hunt-Wei Wu and Stefan Odenbreit.

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**REFERENCES**


We are grateful to the two commentators for extending our interpretations and naturally agree that bile duct loss, rather than liver fibrosis, governs the severity of cholestatics and that there may be dissociation between these features in PBC. For the purposes of this study, we chose to examine patients with stage I–II disease to remove the possibility of hepatic encephalopathy or cirrhosis as a cause for the MTR findings. We believe that both this patient selection and the demonstration of normal cerebral magnetic resonance spectroscopy (MRS) in these patients, compared with healthy volunteers, does indeed achieve this. We found reduced GP MTRs in patients with stage I–II disease, which were associated with hypermanganesaemia and measured fatigue, but we also studied four patients with stage III–IV disease and, as a group, there were no significant differences in GP MTR indices compared with stage I–II patients. Although this may be due to the small number of individuals studied, the lack of clear distinction between stage I–II and stage III–IV disease may also reflect a process that adversely affects the brain long before the development of cirrhosis, owing to early bile duct loss. The commentators point out that the value of liver biopsy staging of PBC is limited owing to sampling error and that there may not have been a true distinction between the stage I–II and III–IV groups. We accept the possibility of sampling error but, in our view, liver biopsy still remains the gold standard for diagnosing cirrhosis. We disagree with the suggestion that cerebral MRS would have been useful in supporting the histological diagnoses as cerebral MRS abnormalities are only seen in a minority of patients with Child–Pugh A cirrhosis. *6* We did not assume that MRS would be abnormal in stage III–IV patients; in fact, there were no significant differences between these patients and stage I–II patients.

Fatigue in PBC merits further research. We hope that we will be able to take further “steps in the right direction”.

References


Acute ulcerative colitis during successful interferon/ribavirin treatment for chronic hepatitis

A 54 year old man was treated with pegylated interferon alpha 2a 180 µg weekly and ribavirin 1000 mg daily for chronic hepatitis C genotype 3a (>5×10^7 IU/mL). There was no history of gastrointestinal disease or morbidity.

At week 12, hepatitis C virus-polymerase chain reaction (HCV-PCR) was negative and alanine aminotransferase (ALT) and aspartate aminotransferase (AST) levels remained elevated at 2–3 times above the upper limit. The antiviral treatment was stopped and a virological relapse was confirmed. PCR revealed a virological relapse and AST reached 2× upper limit.

Three months later (receiving 5-ASA 2 g daily) the complete clinical and endoscopic remission was maintained at a dose of 3 g daily for eight weeks followed by 2 g daily.

Three months later (receiving 5-ASA 2 g daily) there was complete clinical and endoscopic remission. Histology showed a mild residual increase in mononuclear inflammatory cells. PCR revealed a virological relapse of HCV (high viraemia >6×10^7 IU/mL) and an unchanged twofold elevation in ALT and AST.

We suspect that the ulcerative colitis-like severe pancolitis in this patient with no

**LETTERS**

**Fatigue in primary biliary cirrhosis**

We would like to take the opportunity to clarify some of the points in response to the recent leading article (Gut 2004;53:475–7) which accompanied our report of reduced globus pallidus (GP) magnetisation ratios (MTRs) in patients with fatigue and primary biliary cirrhosis (PBC).

As we stated in the paper, fatigue in PBC is a subjective multidimensional symptom with many potential determinants, including sleep disturbance, depression, and personality, in addition to a potential central neurological cause. We therefore wholeheartedly concur with Drs Milkiewicz and Heathcote when they state that brain manganese (Mn) deposition is certainly not the cause of fatigue in all patients with PBC. We certainly do not believe that we drew this conclusion. However, we do believe that our findings of reduced GP MTRs in patients with stage I–II disease, which were associated with hypermanganesaemia and measured fatigue, do open up a novel avenue of research into a poorly understood symptom in patients with PBC.

In order to control for inter-examination systemic variability, it is necessary to normalise the raw MTRs against an internal region of interest (ROI). Although it might initially appear easier to analyse the raw MTR data, normalisation to an internal standard allows external sources of variation, unrelated to the patient, to be removed. We followed previously published protocols to calculate GP indices, normalised to the putamen and to the frontal white matter, and these were used to test associations with fatigue and blood Mn levels. The raw MTR data were used for the primary comparison between PBC patients and healthy volunteers. We chose two rather than one internal control ROI because, contrary to the assertion in the editorial, there is evidence for Mn accumulation in brain structures, other than the GP, in patients with cirrhosis. Rose et al reported significantly elevated Mn concentrations in the frontal and occipital cortex, pallidum, putamen, and caudate while Maeda et al showed elevated Mn concentrations in the GP, putamen, and frontal white matter. In both series, the highest Mn concentration was in the GP. Our choice of two standard ROIs was made to maximise the interpretation of the raw data although we accept that the a priori assumption that pathology is absent from these regions in this and all relevant magnetic resonance studies to date, which have used internal controls, may be false. This may explain the unexpected trend towards a positive association between blood Mn and the putaminal index normalised to white matter. Drs Milkiewicz and Heathcote have expressed concern about an apparent auto-correlation in our data that did not equal 1. Table 2 in our paper shows the correlation coefficients between individual MTR indices and blood Mn level. We did not compare the normalised putamen index against the normalised putamen index.

We would like to take the opportunity to clarify some of the points in response to the recent leading article (Gut 2004;53:475–7) which accompanied our report of reduced globus pallidus (GP) magnetisation ratios (MTRs) in patients with fatigue and primary biliary cirrhosis (PBC).
history of IBD was probably an adverse effect of the antiviral treatment with interferon-ribavirin rather than a concomitant disease. Similar observations have been made by others. To our knowledge, the present case is the fourth reported in the literature. Interferon has immune stimulating properties and may trigger autoimmune diseases and transplant rejections.

Hence, in light of this, the report on interferon treatment in active ulcerative colitis (Gut 2003;52:1728–33) seems interesting and warrants further research.

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Conflict of interest: None declared.

References

Author’s reply
As interferon alpha (IFN alpha) suppresses the proinflammatory cytokines and induces various anti-inflammatory cytokines, it may show efficacy in chronic active ulcerative colitis. In Crohn’s disease, lamina propria cells manifest increased secretion of IFN-gamma. It has been shown that IFN-beta treated patients compared with 14% in the placebo group. We recently presented data on the first placebo controlled use of IFN alpha in the treatment of active UC in patients with or without corticosteroid and/or immunosuppressive treatment. We observed no significant advantage of any IFN group over placebo but did not observe worsening of disease in any IFN treated patient. The mechanisms of action of IFN alpha are probably multiple but the possible interactions of IFN alpha with the cytokine cascade and immune system are usually not considered. Favoring Th1 response and suppressing Th2 type immune responses could imply that type 1 IFNs may be therapeutic in diseases such as ulcerative colitis or allergic disorders. We agree with the authors that IFN alpha might have the potential to enhance inflammatory cytokines and alter reactivity in certain situations but are also convinced that it has strong immunomodulatory and anti-inflammatory properties. Larger controlled trials with IFN alpha in ulcerative colitis are eagerly awaited.

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Conflict of interest: None declared.

References

The toll-like receptor 4 (TLR4) Asp299Gly polymorphism is associated with colonic localisation of Crohn’s disease without a major role for the Saccharomyces cerevisiae mannann-LBP-CD14-TLR4 pathway

It is with great interest that we read the paper by Frachimont and colleagues (Gut 2004;53:987–92) in which they described a novel association of the toll-like receptor 4 (TLR4) +896 A>G polymorphism with both Crohn’s disease (CD) and ulcerative colitis (UC), supporting the genetic influence of pattern recognition receptors (PRRs) in triggering inflammatory bowel disease (IBD). PRRs are sensors of pattern associated molecular patterns of microorganisms in the intestinal flora. Independently, we performed a similar study. However, special attention to the presence of anti-Saccharomyces cerevisiae antibody (ASCA) was taken, as Tada and colleagues have recently reported that the S cerevisiae mannann-LBP complex is recognised by CD14 on monocytes signalling through TLR4 leads to the production of proinflammatory cytokines in a manner similar to that induced by lipopolysaccharide (LPS).

Patients and controls were recruited from the Outpatient Department of Gastroenterology, VU University Medical Centre, Amsterdam, the Netherlands. The group consisted of 112 CD patients and 170 unrelated Dutch Caucasian controls. Diagnosis of disease was based on clinical, histopathological, and endoscopic findings. CD patients were categorised using the Vienna classification (general patient characteristics are described elsewhere). ASCA IgA and IgG ELISAs were performed as described previously.1 Genotyping for the CD14-260 C>T and TLR4+896 A>G single nucleotide polymorphisms (SNPs) was performed as described previously by our group.2 The CD14-260 and TLR4+896 genotypes, allele, and carrier frequencies were compared between the different clinical patient groups and controls. In addition, synergism between CD14 and TLR4 genotypes and alleles (carrier trait analyses) was studied. Vienna classification and ASCA status were included in the statistical modelling.

The results are shown in table 1. The frequency of the G allele was significantly increased in CD patients compared with controls (19% v 10%; p = 0.049; odds ratio (OR) 2.1 (95% confidence interval (CI) 1.0–4.1)). Disease phenotype was assessed in patients using the Vienna classification. Carriage of TLR4+896 G significantly increased the risk of colonic localisation of CD compared with non-colonic localisation (43% v 12%; p = 0.0017; OR 5.5 (95% CI 1.9–15.4)). There was a clear trend (test for trend: p = 0.0001) when we compared the increasing frequency of the G allele of TLR4+896 in controls (10%) to CD patients (19%) and to CD patients with colonic localisation (43%). We also assessed if ASCA status was correlated with carriage of the TLR4 G allele. However, there was no difference between
reperative chemoradiotherapy for oesophageal cancer: a systematic review and meta-analysis

Just as the weakest link in a chain determines how much weight the chain will hold, the weakest link in the data used by Fiorica et al. will determine how much weight we as readers should give to their findings and conclusions regarding neoadjuvant chemoradiotherapy for oesophageal adenocarcinoma (Gut 2004;53:925–30). Clearly, the weakest link in their data is the material by Walsh et al., and prior to placing any confidence in the conclusions by Fiorica et al., a careful assessment of the reliability of the Walsh data is imperative. Well known criticisms of the Walsh trial include the lack of routine staging with computed tomography scanning that led to five patients undergoing surgery alone for stage 4 disease, the exclusion of a number of patients in the neoadjuvant arm for “protocol violations” when in fact several had evidence of progressive disease and should have been considered treatment failures, and the lack of a uniform surgical technique that led to five different types of operations. The results of Walsh et al. and what are arguably the worst surgical outcomes occur at essentially every data point for both the neoadjuvant arm and what are arguably the worst surgical outcomes for oesophageal adenocarcinoma reported in the literature. However, these criticisms are overshadowed by an even greater problem in the Walsh trial related to internal inconsistencies in the survival data. Careful review of the Walsh manuscript reveals that the survival data in the text of the report does not match the data in the Kaplan-Meier survival curves, but interestingly the discrepancy is only for the neoadjuvant arm. In all cases the survival data for the surgery alone arm matches up precisely. For example, in the text of the manuscript, survival rates at surgery alone for stage 4 disease in the neoadjuvant arm is reported as 32%, yet on the Kaplan-Meier graph survival by intention to treat in the neoadjuvant arm is approximately 48%. Similar discrepancies occur at essentially every data point for both the intention to treat and the treatment actually received graphs, but only for the neoadjuvant arm, with survival on the Kaplan-Meier graph improving over time in the data in the text. Importantly, the statistics for survival are calculated from the Kaplan-Meier curves, raising concern that the difference in survival between groups is significant. However, the discrepancy is only for the neoadjuvant arm. In all cases the survival data for the surgery alone arm matches up precisely.

The association between TLR4 and CD understanding the role of impaired innate immunity in CD. TLR4 signalling is based on both endogenous (for example, LPS) and exogenous (for example, human HSPs) agonists, and as heterogeneous carriehers of the TLR4 +896 A>G does not seem to impair LPS signalling. Further agonist identification to elucidate the microorganisms involved in CD and especially in colonic localisation is essential to obtain insight into both the pathophysiological and immunogenetic aspects of CD. This insight may be helpful in developing strategies for the prevention and treatment of CD.

Table 1  CD14 – 260 and TLR4 +896 genotype distribution in Crohn’s disease (CD) patients and healthy controls (HC)

<table>
<thead>
<tr>
<th>CD14 – 260 C–T</th>
<th>TLR4 +896 A–G</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 (CC)</td>
<td>2.2 (TT)</td>
</tr>
<tr>
<td>1.1 (AA)</td>
<td>2.2 (GG)</td>
</tr>
<tr>
<td>Group</td>
<td>n (%)</td>
</tr>
<tr>
<td>HC</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>170</td>
</tr>
<tr>
<td>2.2</td>
<td>112</td>
</tr>
<tr>
<td>A1</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td></td>
</tr>
<tr>
<td>B1</td>
<td></td>
</tr>
<tr>
<td>B2</td>
<td></td>
</tr>
<tr>
<td>L1</td>
<td></td>
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<tr>
<td>L2</td>
<td></td>
</tr>
<tr>
<td>L3</td>
<td></td>
</tr>
<tr>
<td>L4</td>
<td></td>
</tr>
<tr>
<td>GL</td>
<td></td>
</tr>
</tbody>
</table>

*TLR4 G allele was more frequent in CD patients compared with HC (19% vs 11%; p = 0.0489; odds ratio (OR) 2.076 (95% confidence interval (CI) 1.041–4.142). **TLR4 G allele was significantly associated with colonic localisation compared with non-colonic localisation (43% vs 12%; p = 0.0017; OR 5.455 (95% CI 1.931–15.410)).

Conflict of interest: None declared.

References

4. van der Paardt M, Sprangers MB, van der Boechorststraat 7, 1081 BT Amsterdam, the Netherlands; sa.morre@vumc.nl

Conflict of interest: None declared.
Systemic lidocaine and mexiletine for the treatment of a patient with total ulcerative colitis

In basic research, neural modulation in ulcerative colitis has been shown. In clinical settings, local anaesthetics such as lidocaine and ropivacaine were used, administered per rectum, for the treatment of distal ulcerative colitis with a response rate of 83% after long treatment periods (6–34 weeks) for proctitis two hours after application of the gel. In experimental models, plasma concentrations of 1.2–2.1 mg/l of lidocaine has been shown to be effective for neuropathic pain. Therefore, it is possible that in ulcerative colitis, lidocaine administered per rectum could exert its pharmacological effects after being absorbed into blood and has an effect on central and/or peripheral nerves. Another possibility is direct anti-inflammatory effects of these drugs on immune cells. However, it is not known whether systemic administration of lidocaine can achieve adequate concentrations in colonic tissue to have a direct anti-inflammatory effect on immune cells. A prominent feature of this case was the close association between pain and other symptoms such as bloody diarrhoea. Systemic lidocaine caused prompt symptomatic relief followed by amelioration of ulcerative colitis which was assessed by sigmoidoscopy and blood inflammatory parameters (data not shown), suggesting that pain or pain inducing substances could be a cause of exacerbation of ulcerative colitis as well as a result of the disease. Lidocaine and mexiletine therapy could be useful for the treatment of the subgroup of patients with ulcerative colitis that are refractory to conventional medical treatments. While we do not know how to select responders to this treatment, pain could be one of the indicators.

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Conflict of interest: None declared.

References

New treatment for bile salt malabsorption

Currently available binding resins used for symptomatic bile salt malabsorption are generally poorly tolerated because of unpalatability and associated gastrointestinal side effects. We suggest that there is now a viable alternative, colesvelam hydrochloride (WelChol, Sankyo Pharmaceuticals Inc., Japan).

A 30 year old man presented with steatorrhoea, progressive weight loss, marked abdominal bloating, and lethargy. He was right hemicolectomy following a road traffic accident in 1966. Physical examination, relevant blood tests, barium follow through, colonoscopy, and microscopic examination of colonic biopsies were normal. A trial of cholestyramine in preference to a SeCHAT scan caused cessation of diarrhoea on one sachet per day. However, his abdominal bloating continued unabated and he found the treatment unpalatable. Cholestyramine was therefore changed to colesvelam 2.5 g/3.75 g on alternate days. This was well tolerated, with complete cessation of his steatorrhoea and lethargy, and no side effects. In addition, he rapidly gained weight.

A further four patients with markedly symptomatic bile salt malabsorption resistant to anti diarrhoeal agents and intolerant of cholestyramine were subsequently commenced on colesvelam (table 1). In all of these cases colesvelam was well tolerated with no side effects.

Colesvelam is a non-absorbed water insoluble polymer which sequesters bile. It has been approved for usage by the US FDA, and has been received as a valuable alternative for lowering cholesterol. Colesvelam has high affinity for dihydroxy and trihydroxy bile acids in the intestine which causes increased faecal bile acid secretion, reducing the enterohepatic circulation of bile acids. This allows 7-hydroxylase, the rate limiting enzyme in bile acid synthesis, to increase the conversion of hepatic cholesterol to bile acids. It has not yet been approved for use in the UK. One abstract suggests that colesvelam may be beneficial for patients with diarrhoea who have undergone small bowel resection for Crohn’s disease. There are unpublished data to support its role in bile salt induced diarrhoea. Colesvelam is reported to be 4–6 times as potent as traditional bile salt sequestrants, possibly due to its greater binding affinity for glycocholic acid. It is administered in tablet form, and in one study the rate of compliance with colesvelam was 93%.

The unique hydrogel polymeric...
structure enables greater tolerability with less potential drug interactions than with resins.7
Reported adverse events from the largest clinical trial to date include flatulence, dyspepsia, and diarrhoea although the incidence of adverse events does differ significantly from that observed with placebo, and is lower than with cholestyramine. It is rarely associated with constipation, unlike cholestyramine.7 Colesevelam is non-absorbed and is excreted entirely via the gastrointestinal tract, preventing systemic side effects. Furthermore, there is little evidence for clinically significant interactions involving colesevelam.8 Pharmacokinetic studies with colesevelam have not shown clinically significant effects of absorption of six other coadministered drugs.9
There is a theoretical risk of fat soluble vitamin deficiency following such efficient bile acid sequestration. None of our patients developed any significant change in fasting triglycerides or fat soluble vitamin levels to date.
Each film coated tablet contains colesevelam 625 mg (active ingredient).7 The recommended starting dose for monotherapy for hypercholesteraemia is 3.75 g once a day or 1.875 g twice per day, although the optimal dose is 4.375 g in adults.7 The optimal dose for bile salt malabsorption is not clear but an effective dose has varied between two and six tablets/day in our series. Colesevelam was obtained from IDIS Ltd.
This colesevelam is a novel bile acid binding resin in tablet form that maintains the benefits of cholestyramine, yet is palatable, associated with decreased adverse effects, and has greater potency. It provides a very attractive alternative therapy for patients with bile salt malabsorption and further study is warranted.

Table 1 Characteristics of four patients with markedly symptomatic bile salt malabsorption resistant to antidiarrhoeal agents and intolerant of cholestyramine given colesevelam

<table>
<thead>
<tr>
<th>Age (y)</th>
<th>Sex</th>
<th>Reason for bile salt malabsorption</th>
<th>Outcome with colesevelam</th>
<th>Duration of colesevelam treatment (months)</th>
<th>Current dose of colesevelam</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>M</td>
<td>Idiopathic</td>
<td>Diarrhoea resolved, no side effects</td>
<td>7</td>
<td>3.75 g/day</td>
</tr>
<tr>
<td>59</td>
<td>F</td>
<td>Right hemicolectomy</td>
<td>Diarrhoea resolved, no side effects</td>
<td>3</td>
<td>3.75 g/day</td>
</tr>
<tr>
<td>68</td>
<td>F</td>
<td>Radiation enteritis and right hemicolectomy</td>
<td>Diarrhoea resolved, no side effects</td>
<td>2</td>
<td>2.5 g/day</td>
</tr>
<tr>
<td>40</td>
<td>F</td>
<td>Radiation enteritis</td>
<td>Diarrhoea resolved, no side effects</td>
<td>2</td>
<td>1.25 g/day</td>
</tr>
</tbody>
</table>


NOTICES

The national register of hepatitis C infections with a known date of acquisition

A new call for study proposals.

In 1998, a national register of hepatitis C virus (HCV) infections with a known date of acquisition was established. The register was set up to help inform the natural history of HCV related disease in the UK and now contains anonymous data for one of the largest cohorts of individuals with known date HCV infections, with over 1120 registered patients. The majority of infections in the register are those that were acquired following transfusion of HCV infected blood that was issued before the introduction of routine screening of the blood supply for HCV, but other routes of acquisition are represented.

In order to get maximum benefit from this national resource, the register steering group would like to invite clinical and epidemiological researchers to submit proposals to access data held in the register. It is envisaged that a variety of studies might benefit from linkage with or access to the register, and proposals from all specialties and institutions are welcomed. Such studies are urgently needed to help determine the current and future burden of HCV related disease on healthcare services, and to assess the impact of currently available treatments as well as those that may become available in the future.

Any researchers interested in applying for access to information held within the national register should contact Dr Helen Harris (Register Co-ordinator) or Ms Shirley Cole (Research Assistant), Immunisation Department, CDSC, Centre for Infections, Health Protection Agency, 61 Colindale Avenue, London. NW9 6EQ, UK (tel: +44 (0)20 8200 6868 ext. 7676 (Wednesday to Friday) or ext. 7906 (Monday to Friday); fax: +44 (0)20 8200 7868; email: helen.harris@hpa.org.uk or shirley.cole@hpa.org.uk).

No data will be released that could identify individual patients directly or via linkage to other data. Any study proposals should then be submitted to the register co-ordinator for consideration by the steering group by Thursday 31 March 2005 (deadline).

6th International Symposium on Functional Gastrointestinal Disorders

This symposium is co-sponsored by the Office of Continuing Medical Education, University of Wisconsin Medical School, and the International Foundation for Functional Gastrointestinal Disorders (IFFGD). It will take place on 7–10 April 2005 in Milwaukee, Wisconsin, USA, at The Pfister Hotel, 424 E. Wisconsin Avenue, Milwaukee, Wisconsin, USA, at The Pfister Hotel, 424 E. Wisconsin Avenue, Milwaukee, Wisconsin, USA, at The Pfister Hotel, 424 E. Wisconsin Avenue, Milwaukee, Wisconsin, USA, at The Pfister Hotel, 424 E. Wisconsin Avenue, Milwaukee, Wisconsin, USA, at The Pfister Hotel, 424 E. Wisconsin Avenue, Milwaukee, Wisconsin, USA.

In reference 38 of the paper by C Gasche and P Grundtner, published in the January issue (Genotypes and phenotypes in Crohn’s disease: do they help in clinical management? Gut 2005;54:162–7), the page span is incorrect, it should read 1658–64.

In the paper by Sheu et al in the July 2003 issue of Gut (B-S Sheu, S-M Sheu, H-B Yang, A-H Huang, and J-J Wu. Host gastric Lewis agglutinin (Le) in Helicobacter pylori infection. Gut 2003;52:927–32), the B and C slides of figure 1 have been transposed and the arrow on D should be labelled Le6 not Le6.

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