Pragmatic eradication of *H. pylori*

Sir,

Hippisley-Cox and Pringle emphasize pragmatism in their pilot study of *Helicobacter pylori* elimination in a single general practice (June *Journal*).[1] We have performed a similar study, but with one major difference — that of testing by serology before treating. We believe this is preferable to blind treatment.

An urban, non-fundholding, group practice of 6450 patients in Exeter had 97 patients whose computerized repeat therapy included acid-suppressant medication by H_2 blockers or proton pump inhibitors. A records search for reflux oesophagitis or hiatus hernia revealed 55 patients, who were excluded from the study. Of the remaining 42, eight had previously been tested by serology (three positive, five negative). These figures mirror those of Hippisley-Cox and Pringle.

The 34 untested patients were sent a letter offering testing and describing the possible role of *H. Pylori* in their condition. Twenty-nine accepted testing, resulting in 16 positive tests. These were offered triple therapy with omeprazole 20 mg BD, clarithromycin 500 mg BD, and metronidazole 400 mg TDS for one week. Two patients ceased treatment because of nausea, but one tolerated amoxycillin instead of metronidazole, thus completing the therapy.

Of the 29 untested patients, 22 had collected acid-suppressant medication in the three months before the study — 13 of these testing positive, and nine negative. All nine with negative tests, but only seven of the 13 testing positive, collected medication in the three months after the study (Fisher exact test 2-tailed; $P = 0.05$).

Our concern about Hippisley-Cox and Pringle's approach is that about half the patients selected by using prescription records do not have antibodies to *H. Pylori*. Furthermore, IgG seropositivity may signify past or current infection, so it is probable that fewer than half of patients are currently infected. It is therefore questionable whether we can offer treatment, which has frequent side-effects, without testing.

The antibody test is available, cheap (£8.86 locally) and 95% sensitive.[2] The cost of testing will be more than recouped in triple therapies not given to the half whose results are negative: therapy costing £41 in Hippisley-Cox and Pringle's study and £45 in ours. Furthermore, triple therapy carries three prescription charges for non-exempt patients, a factor frequently neglected in cost analyses.

Despite our criticism of this one point, we wish to congratulate Hippisley-Cox and Pringle on their study, and echo their call for randomized controlled trials in this field. It is an important primary care problem.

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Sir,

Helicobactor pylori eradication therapy is now recommended in all infected patients with known peptic ulcer disease.[1] There is much debate, however, about the merits of eradication therapy for *H. pylori* in the absence of peptic ulcer, because there is no convincing evidence that it improves symptoms, and it is unclear whether it influences later development of gastric cancer.

Hippisley-Cox and Pringle,[2] in their pilot study (June *Journal*), selected patients on maintenance acid suppression on the basis of four criteria, including chronic dyspepsia that had not been investigated. The majority of these patients will not have peptic ulceration;[3] it is likely that only half of them will have *H. pylori*; and the authors gave antibiotic therapy without testing for *H. pylori*. Laboratory serological tests for *H. pylori* are now widely available, cheap, and have high sensitivity (90–100%) and specificity (76–96%, depending on the assay[4]). Although less sensitive and more expensive, practice-based serology tests are also available if there is no access to a laboratory assay.

We feel it is unwise to give multiple drug treatment blindly, with a considerable incidence of side-effects (50% in most studies[5]), when *H. pylori* can readily be diagnosed by GPs. Indiscriminate use of antibiotics will lead to microbial resistance and risk of allergic reaction. The cost of serological testing would easily be covered by the savings from not treating uninfected patients.

We would agree with the authors that primary care based studies are needed to investigate the benefits of *H. pylori* eradication in patients with or without known peptic ulceration. However, it cannot be assumed that all dyspeptic patients have *H. pylori*, and GPs, even in a spirit of pragmatism, should not prescribe eradication therapy without first diagnosing the infection.

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Non-valvular atrial fibrillation (NVAF)

Sir,

Rodgers *et al* (May *Journal*)[1] highlight the changes in the treatment of NVAF. They comment on the potentially large numbers of patients who will be eligible for warfarin treatment and suggest that patients would need to discuss treatment with their GP. They also comment that factors other than clinical indications will affect the decision about whom and when to treat.

A Cumbria practice research group project on atrial fibrillation in our practice suggests that the actual numbers of patients suitable for and agreeing to warfarin treatment are smaller than anticipated.

We assessed prevalence of atrial fibrillation in patients over the age of 59 by opportunistic screening and computer searches for patients with atrial fibrillation or repeat prescriptions for digoxin. Of a total list size of 4800, 971 patients were