

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 H₂ 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 amoxicillin 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,

Helicobacter 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 assay⁴). 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 studies⁵), 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

identified in the age group. Of these, 33 were on digoxin for atrial fibrillation. During the one-year study period, 795 patients were screened opportunistically for irregular pulse. Of these, 26 were diagnosed as having atrial fibrillation. Therefore, a total of 59 of the 828 patients screened were identified as having atrial fibrillation a prevalence of approximately 7%.

In order to maximize the benefit to risk ratio, the study protocol required one of three other risk factors to be present in order to initiate warfarin treatment.² These were age over 75 years, heart failure, diabetes, and hypertension. Patients not in this higher risk group were offered aspirin treatment. Some patients were excluded at this stage because of other medical conditions, such as dementia (which precluded informed consent and effective monitoring), or social conditions, such as remote location with no transport available.

Of the 59 patients with atrial fibrillation, 18 were invited to be assessed for warfarin treatment. Of these, only three agreed and actually started treatment; six others elected to take aspirin instead, and six patients were already taking aspirin. The number of patients eventually treated with warfarin was surprisingly small and may reflect transport difficulties in this rural practice.

While the study is not yet complete, our data suggest that the numbers of additional patients both requiring and agreeing to treatment and regular monitoring may not be as great as anticipated by Rodgers *et al.*

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Sore throat

Sir,
We read with interest the paper by Howe (May Journal) regarding the resolution of sore throat symptoms following antibiotic prescription.¹ Penicillin was not found to

be superior to placebo, which supports the evidence of marginal benefit of penicillin in sore throat.² The well-described deficiencies of throat swabs might lead one to anticipate the failure of a positive result to predict response to antibiotic treatment rather than the explanation being the efficacy of cephalosporins in patients with a negative swab.³

The study raises important questions about the possible benefit of cefixime. However, we would urge caution on three counts. First, what is the clinical value of a reduction in score of 3, in a composite score, on the third day of treatment? Furthermore, significance figures are not given for the differences between the groups on days 2, 4, 5, 6, and 7. It is possible that a significant difference between the groups may have arisen on one day out of six by chance. Secondly, studies on penicillin have raised the possibility of a greater risk of symptom relapse following antibiotic treatment.⁴ This study did not address this question, but the possibility of greater long-term morbidity following antibiotic treatment remains. Thirdly, given the expense of cefixime, potential side-effects, and the danger of resistance with a broad spectrum of antibiotics, is it sensible to use such drugs to effect a small reduction in symptoms in what is essentially a self-limiting illness?

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Audit

Sir,
I am increasingly concerned by the description of original papers as 'audit' when, in fact, they are nothing of the sort. An example of this misrepresentation was the paper by Vernon *et al* (May Journal) on 'How general practitioners manage children with urinary tract infection: an audit in the former Northern Region'.¹ It is perhaps pertinent that the previous paper in this issue by Lough and Murray, 'Training for audit: lessons still to be learned',² clearly demonstrated that trainers are failing to recognize basic audit methodology. Perhaps this also applies to referees and editors? If, as the Government white papers of the last year suggest, clinical audit should be further integrated into the development of quality assurance in primary care, then there are urgent questions to ask regarding the training of all general practitioners and other members of the primary health care team in basic audit methodology. I would suggest that Medical Audit Advisory Groups and Primary Care Audit Groups must take some lead responsibility in addressing these problems.

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Sir,
The paper by Lough and Murray¹ (May Journal) has made conclusions that are unjustified. In their discussion they mention that approximately 10% of projects were judged to be below the minimum competence level, and thus it must follow that nearly 90% of projects were satisfactory, which would seem to indicate that trainers spent a great deal of time and effort on individual registrars' summative assessment audit. Trainers have had an