TREATMENT REGIMENS FOR *HELICOBACTER PYLORI*

- Check antibiotic history as each additional course of clarithromycin, metronidazole or quinolone increases resistance risk.[11D,22A+,29B-,30A-,31A+,32A-] Stress the importance of compliance.[2A-,27C,32A-]

NO PENICILLIN ALLERGY

FIRST-LINE: 7 days, PPI twice daily[2A-,30A-,31A+]
PLUS amoxicillin 1g BD
PLUS either clarithromycin 500mg BD OR metronidazole 400mg BD

ONGOING SYMPTOMS after first-line ↓

SECOND-LINE: 7 days, PPI twice daily[2A-,30A-,31A+]
PLUS amoxicillin 1g BD
PLUS second antibiotic not used in first line, either clarithromycin 500mg BD OR metronidazole 400mg BD

ONGOING SYMPTOMS after first-line AND previous exposure to MZ and CLAR ↓

SECOND-LINE, 10 days, PPI twice daily[2A-,30A-,31A+]
PLUS amoxicillin 1g BD
PLUS second antibiotic, either tetracycline hydrochloride 500mg QDS OR levofloxacin 250mg BD[30A-,31A+,33A+,34A+]

PENICILLIN ALLERGY

FIRST-LINE: 7 days, PPI twice daily[2A-,30A+,31A+]
PLUS clarithromycin 500mg BD
PLUS metronidazole 400mg BD

If penicillin allergy AND previous exposure to clarithromycin, OR if ONGOING SYMPTOMS after first-line ↓

SECOND-LINE: 10 days, PPI twice daily[2A-,30A+,31A+,33A+]
PLUS metronidazole 400mg BD
PLUS levofloxacin 250mg BD[31A+,33A+,34A+]

ONGOING SYMPTOMS after first-line AND previous exposure to levofloxacin ↓

SECOND-LINE: 7 days, PPI twice daily[2A-,30A+,31A+]
PLUS tripotassium dicitratobismuthate 240mg QDS[35D]
OR bismuth subsalicylate 525mg QDS[34A+,35D,36A+,37A+,38A+]
PLUS tetracycline hydrochloride 500mg QDS
PLUS metronidazole 400mg BD[2D]

- PPI medication: lansoprazole 30mg BD, omeprazole 20-40mg BD, pantoprazole 40mg BD, esomeprazole 20mg BD, rabeprazole 20mg BD.
- If diarrhoea develops, consider *Clostridium difficile* and review need for treatment.
- Only offer third-line eradication on advice from a specialist.[31A+,33A+,39A-,40A+,41D]

WHEN SHOULD I RETEST FOR *HELICOBACTER PYLORI*?

- As 64% of patients with functional dyspepsia will have persistent recurrent symptoms, do not routinely offer re-testing after eradication.[2D]

- if compliance poor, or high local resistance rates[11D,29B-]
- persistent symptoms, and HP test performed within two weeks of taking PPI, or within four weeks of taking antibiotics[19A+,20B+,21B+,22C]
- patients with an associated peptic ulcer, after resection of an early gastric carcinoma or MALT lymphoma[2D,11D,26C]
- patients requiring aspirin, where PPI is not co-prescribed[2D]
- patients with severe persistent or recurrent symptoms, particularly if not typical of GORD[11D,26C]

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- UBT is most accurate[15A+,16C]
- SAT is an alternative[15A+,18A+]

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Wait at least four weeks (ideally eight weeks) after treatment.[11D,19A+] If acid suppression needed use H_2 antagonist.[35D]

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Use second-line treatment if UBT or SAT remains positive[2D]

DO NOT use serology for re-testing[2D,15A+,16C]

WHAT SHOULD I DO IN ERADICATION FAILURE?

- Reassess need for eradication.[2D] In patients with GORD or non-ulcer dyspepsia, with no family history of cancer or peptic ulcer disease, a maintenance PPI may be appropriate.[2D,26C]

WHEN SHOULD I REFER FOR ENDOSCOPY, CULTURE AND SUSCEPTIBILITY TESTING?

- Patients in whom the choice of antibiotic is reduced due to hypersensitivity, known local high resistance rates, or previous use of clarithromycin, metronidazole, and a quinolone.[2A-,11D,28D]
- Patients who have received two courses of antibiotic treatment, and remain HP positive.[2D,11D,28D]
- For any advice, speak to your local microbiologist, or the *Helicobacter* Reference Laboratory.

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bsg BRITISH SOCIETY OF GASTROENTEROLOGY
BSAC BRITISH SOCIETY FOR ANTIMICROBIAL CHEMOTHERAPY
BIA British Infection Association
RCGP Royal College of General Practitioners
Royal College of Nursing