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Helicobacter pylori treatment guideline: An Indian perspective

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Abstract

Treatment guidelines in many countries for *Helicobacter pylori* may differ. Owing to the various characteristics of bacteria, clinical manifestations, resistance to antibiotics, and recurrence rate, treatment regimens may change. In this letter, we would like to give an Indian perspective on *Helicobacter pylori* treatment guidelines.

TO THE EDITOR

We read with interest the review article by Jun-Hyung Cho *et al*^[1] where they have shown *Helicobacter pylori* treatment guidelines in different countries. We would like to add views from India and guidelines followed in India^[2]. We hope this letter would insight into a better understanding of treatment regimens since the prevalence is very high (nearly 80%) in the indigent populations of many developing countries^[3].

Currently, the first line (low clarithromycin resistance) is the combination of proton pump inhibitors, amoxicillin, and clarithromycin for 2 wks and in clarithromycin resistance areas, bismuth-based quadruple therapy is the first line. Imidazole-based therapy is not recommended for eradication. It is better to avoid less than 14 d. Fluoroquinolone-based concomitant therapy may be tried only after failure of second-line management^[4]. The American College of Gastroenterology (ACG) also has similar recommendations^[5]. Considering salvage therapies which include standard triple therapy that has not been previously used, bismuth-based quadruple therapy,

levofloxacin-based therapy, or rifabutin-based triple therapy^[2]. In India, antibiotic susceptibility testing-based therapy is considered an option as third-line rescue therapy though not compulsory. Furthermore, periodic² monitoring of antimicrobial susceptibility patterns can provide general guidelines with the aim to eradicate *Helicobacter pylori*^[6].

Unusually³ low prevalence of gastric cancer has been seen despite having a high prevalence of *Helicobacter pylori* in India owing to diet and genetic variations as seen in Indian patients^[7]. This is the probable reason why routine *H. pylori* eradication to prevent GC in the Indian population is not recommended^[2].

Resistance is the common cause of treatment failure and it depends upon the local variations of resistance. In India as well, in some places, a high level of antimicrobial resistance and a high recurrence rate has been observed. That is why concomitant therapy is advisable more than sequential therapy in places with high antimicrobial resistance in India. Moreover, in India, multiple strains of *H. pylori* have been seen to infect a single host at the same time and reinfection chances are also high which differs from western countries.

It is important to collaborate research at the genetic level to find out the epidemiological cause of antimicrobial resistance, which mutation is causing such resistance and treatment failure. In developing and developed countries differences in epidemiological factors may contribute to the prevalence of resistant cases.

This review has nicely addressed the fact that there are differences in guidelines but it also needs to include many perspectives on guidelines from the developing and developed worlds, so that more comprehensive precision medicine we may develop in future.

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PRIMARY SOURCES

1 Shivaram Prasad Singh, Vineet Ahuja, Uday C. Ghoshal, Govind Makharia et al. "Management of Helicobacter pylori infection: The Bhubaneswar Consensus Report of the Indian Society of Gastroenterology", Indian Journal of Gastroenterology, 2021 23 words — **4%**

[Crossref](#)

2 Adalucy Álvarez, José Ignacio Moncayo, Jorge Javier Santacruz, Mario Santacoloma et al. "Antimicrobial Susceptibility and Mutations Involved in Clarithromycin Resistance in Isolates from Patients in the Western Central Region of Colombia ", Antimicrobial Agents and Chemotherapy, 2009 14 words — **3%**

[Crossref](#)

3 Misra, Vatsala. "Helicobacter pylori and gastric cancer: Indian enigma", World Journal of Gastroenterology, 2014. 14 words — **3%**

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