

H Pylori and the odd patient

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Patient 1: Mrs EZ

- 74 year old female
- Dyspepsia post laparoscopic liver resection for cerular adenocarcinoma
- Gastroscopy: Active gastritis – H Pylori positive
- Problem: **Penicillin allergy**

Patient 2: Mr AS

- 48 year old male with epigastric pain
- Heavy drinker
- Gastrosocopy revealed antral gastritis - H Pylori positive
- Standard eradication given
- Represented with upper GIT bleed 4 weeks later
- Gastrosocopy revealed heamorrhagic gastritis – H Pylori positive
- Problem: **Failed eradication**

Patient 3: Mrs IM

- 52 year old female
- Presented with constant epigastric pain
- Gastrosocopy revealed severe antral gastritis with superficial ulceration – H Pylori positive
- Problem: **Patient has Porphyria**

Evidence based treatment of H Pylori

- Gold Standard: >94% Eradication Rate (Dependant on local sensitivity patterns) 7 – 10 days
 - Clarithromycin 500 mg twice daily
 - Amoxicillin 1 g twice daily
 - Lansoprazole 30 mg twice daily
- Other drugs used in 2, 3, and 4 drug regimes of varying duration:
 - Tetracycline
 - Metronidazole
 - Bismuth
 - Sucralfate
 - Other PPIs
 - H2 Blockers
 - Rifabutin
 - Levofloxacin
 - Moxifloxacin

Penicillin Allergy

- As per standard regime but replace Amoxil with:
 - Metronidazole 75 – 90%
 - Tetracycline 75 – 85%
- 4 drug Bismuth regimes can be used
- Moxi or Levofloxacin 2nd line regimes can be used.

Failed primary therapy

- Three or four drug bismuth regime 75 – 85%
 - Complex dosing
 - Bismuth not readily available
- PPI + Amoxil + Metronidazole 75 – 80%
 - Increasing metronidazole resistance
- Moxi or levofloxacin + PPI + Amoxil 75 – 90%
- Marked difference in results if susceptibility testing is used to guide therapy

Porphyria

- No formal guidelines
- The following should be avoided:
 - Clarythromycin
 - PPIs (Certain may be used with caution)
 - Tetracycline
 - Metronidazole
- The following drugs can be used:
 - H2 blockers
 - Amoxil
 - Bismuth
 - Levofloxacin