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Management of *Helicobacter pylori* infection

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Humans have probably been living in symbiosis with *Helicobacter pylori* (*H. pylori*) from time immemorial. The earliest direct evidence of *H. pylori* infection dates 58 000 years back. The true infection rate at different time epochs is uncertain; although an increase during the 19th century is known. It is one of the few infections that cause a chronic inflammatory response but that do not cause disease or symptoms in a majority of those infected. In a minority the infection will cause peptic ulcer disease or, rarely, gastric cancer. Subclinical malabsorption of nutrients may appear in older individuals because of *H. pylori* associated gastric atrophy. The proportion of infected adults decreases with increased prosperity, and most people are likely infected in childhood. The decrease in prevalence in older age in developed countries is presumed to represent a birth cohort effect so that when the next generation of children grows up they will likely retain their lower prevalence throughout their lives. The infection can be detected at an upper endoscopy with biopsies, but also indirectly by serology or, preferably due to better accuracy, Urea Breath Test (UBT) or a Fecal *Helicobacter pylori*-Antigen ELISA (F-Hp) test. Eradication treatment is in most countries done by a one-week “triple therapy” with a proton pump inhibitor and two antibiotics. The length of the therapy and the combination of antibiotics is depending on the local pattern of antibiotic resistance.

