***Helicobacter pylori* Infection in Uraemic Patients**

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Dear Sir,

We were interested to read the recent letter by Conz et al. [1] on the prevalence of *Helicobacter pylori* in uraemic patients.

It is current practice in our Hospital for any patient in whom renal transplantation is considered to perform endoscopy routinely, and to evaluate their *H. pylori* status, as gastropathy is a commonly occurring problem perioperatively in renal grafting.

Colloidal bismuth subcitrate (CBS; De-Nol^R) is now a recognised treatment for gastritis associated with *H. pylori* [2] although the eradication of *H. pylori* at 1 month after treatment using De-Nol alone is only of the order of 20% [3].

The letter from Conz et al. [1] is more remarkable for the information omitted than that included. The clearance rate (re-evaluation at the end of treatment) is always higher than the eradication rate (re-evaluation at 1 month after treatment), and the authors fail to state which of these was looked at.

No mention is made of the number of uraemic patients treated or the mode of *H. pylori* status re-evaluation.

No mention is made of the success rate; only that «CBS was effective in gastric sterilization».

The main concern in using heavy-metal compounds is their ability to cause encephalopathy.

Early bismuth preparations were no exception [4].

Conz et al. used a dosage of De-Nol tablets that is more than twice the standard dose and make no mention of serum bismuth concentrations.

Bismuth's main mode of elimination is via the kidneys [5], which are also thought to be the main site for bismuth sequestration on treatment [5]. Indeed, renal failure is a relative contraindication to the use of bismuth salts. The pharmacokinetics of bismuth salts in dialysed patients have not been studied.

In Ipswich, of 33 uraemic patients (mean age 54 years) evaluated by antibodies to *H. pylori* or the culture of

antral biopsy specimens, 15 were positive for *H. pylori*. Of these patients, 3 with *H. pylori* gastritis have been treated with a combination of De-Nol tablets (240 mg twice a day for a month) plus an antibiotic for the first 2 weeks of treatment. Bismuth levels were checked at the end of treatment with De-Nol, and in 1 of these 3, levels were found to be in the «alarm range» at 86 ng/ml, although subsequently falling to within safe limits at 1 month after treatment. The patient remained asymptomatic.

In conclusion, we wish to correct the false impression given in the letter from Conz et al. that *H. pylori* can be safely and effectively eradicated in uraemic patients using high dose De-Nol monotherapy. No ideal therapy for *H. pylori* gastritis exists at present, nor is the safety of bismuth salts established in patients with renal failure.

References

- Conz P, Feriani M, Milan M, Bernardini D, Crepaldi C, La Greca G: *Campylobacter pylori* infection in uremic dialyzed patients. Eradication of the infection by colloidal bismuth sub-citrate. *Nephron* 1990;55:442–443.
- Marshall BJ, Goodwin CS, Warren JR, et al: Prospective double-blind trial of duodenal ulcer relapse after eradication of *Campylobacter pylori*. *Lancet* 1988 ;ii: 1437–1442.
- Weil J, Bell GD, Jones PH, Gant P, Trowell JE, Harrison G: «Eradication» of *Campylobacter pylori*: Are we being misled? *Lancet* 1988 ;ii: 1245.
- Bader JP: The safety profile of De-Nol. *Digestion* 1987; 37: (suppl2):53–59.
- Slikkerveer A
- DeWolff FA: Pharmacokinetics and toxicity of bismuth compounds. *Med Toxicol Adverse Drug Exp* 1989; 4:303-323.