Failure of Helicobacter pylori eradication: is poor compliance the main cause?

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SUMMARY

Objective — The aim of the study was to evaluate whether poor compliance can be considered as the main cause of the low Helicobacter pylori (H. pylori) eradication rate observed in an ambulatory population.

Methods — Seventy-eight patients with non-ulcer dyspepsia or gastroduodenal ulcer in whom H. pylori infection was confirmed by urease Clo-test and histology or bacterial culture, received a 1-week triple therapy comprising lansoprazole 30 mg b.d., amoxicillin 1000 mg b.d. and clarithromycin 500 mg b.d. Compliance was assessed using MEMS® containers (Medication Event Monitoring System) which recorded time of medicines consumption.

Results — The overall H. pylori eradication rate was 65.4% [95% CI: 54.8-76.0%] (intention to treat). Sixty-nine subjects (88.5%) consumed greater than 85% of doses and were considered as “good compliers”. The major reason listed by the nine remaining patients for stopping treatment prematurely was side effects. In the population categorised as “good compliers”, H. pylori eradication rate was 69.6% [95% CI: 58.7-80.5%] (per protocol) indicating that compliance could not be considered as the sole reason for treatment failure. Bacterial culture in a subset of 30 patients further showed a H. pylori eradication rate of 73.9% [95% CI: 55.7-92.1%] in “good compliers” with a clarithromycin-sensitive H. pylori strain. On multivariate analysis, H. pylori eradication was inversely associated with poor compliance (P = 0.029). Presence of a gastroduodenal ulcer, age, gender and smoking habit did not differ significantly between the eradicated and noneradicated groups.

Conclusion — Although poor compliance and bacterial resistance were important factors in determining treatment success in our population, they could only explain 40% of failures suggesting that other factors must be involved.
More than 90% of the patients included in the study were receiving an eradication treatment of *H. pylori* for the first time and less than 10% had taken a proton pump inhibitor during the week before the therapy. The study was approved by the local ethics committee for clinical research in private practice and all patients gave written informed consent. Endoscopy was performed with Olympus (GIFXQ10), Pentax (EG-2901) and Fujinon (EG-200) gastrosopes. Endoscopes and biopsy equipment were disinfected between the procedures with 2% glutaraldehyde, according to standard procedures.

**Treatment**

All patients received a 1-week triple therapy comprising lansoprazole 30 mg, amoxycillin 1000 mg and clarithromycin 500 mg, all twice daily with food [1, 3]. Patients with gastroduodenal ulcer additionally received a 3-week treatment of lansoprazole 30 mg per day, following completion of the eradication regimen.

**Assessment of eradication and side effects**

Assessment of *H. pylori* eradication was performed by 13C-urea breath test four to eight weeks after completion of the treatment (positive = excess of 13C > 0.5%, specificity and sensitivity 95% to 100%) [22, 23].

All patients were seen or contacted by phone, 1 to 7 days after the end of the therapy and interviewed about possible side effects.

**Assessment of patient compliance**

Each patient received 3 MEMS boxes, containing a 7-day supply of each medication. Written information provided with the MEMS boxes instructed the patient to (i) take each medicine twice daily, allowing approximately 12 hours between each dose, (ii) retain the medication within its container until immediately prior to consuming the dose, (iii) return the empty container on completion of the course.

Compliance was defined as the percentage of doses taken (as assessed by the number of container openings) during the 8 days (192 h) following the first dose. Arbitrarily, patients were considered to be “good compliers” if they had taken at least 12 out of 14 doses of each medicine (compliance > 85%) during the assessed time period, as reported in some large clinical studies [4].

**Assessment of *H. pylori* sensitivity**

Culture was performed in the last 30 patients because a planned interim analysis showed a lower eradication rate than expected in the patients considered as “good compliers”.

One to two antral biopsies were taken for bacterial culture and transported at room temperature in a specific medium (Portage Merlin® BiaMerieux SA, Marcy-l'Étoile, France). The same day the samples were inoculated on Columbia agar plates containing 10% horse plasma (Gelose pylori®, BiaMerieux) and incubated for 3-9 days at 35-37°C in a microaerophilic atmosphere (5% O2, 10% CO2, 85% N2) and 100% relative humidity. *H. pylori* was identified by colony morphology and positive biochemical reaction for catalase, urease and oxidase. The minimum inhibitory concentrations (MICs) of amoxycillin and clarithromycin were determined using the E-test method (AB Biodisk, Solna, Sweden) according to the manufacturers instructions, on Muller-Hinton agar containing 5% sheep blood. The breakpoint MICs used to define antibiotic resistance were chosen according to the available data published in the literature: 2mg/L for amoxycillin [24] and 1 mg/L for clarithromycin [25].

**Statistical method**

Both an intention-to-treat (ITT) and a per-protocol (PP) analysis were performed. Patients were included in the ITT analysis if they were positive for *H. pylori* infection in the rapid urease test and if they had agreed to be involved in the study. Patients who had taken less than 85% of the prescribed eradication treatment were not included in the PP analysis.

A multivariate analysis was performed to assess potential association between success of the treatment and compliance, gender, age, gastric ulcer or nonulcer dyspepsia, or smoking habit. The potential association between compliance and gender, age, gastroduodenal disease, side effects, or number of medicines taken, was assessed by the chi-square or the Fisher’s exact probability test. The null hypothesis of no difference was rejected at a P level of < 0.05. The binomial distribution was used to determine the exact value of the 95% confidence interval.

**Results**

Seventy-eight patients (38 women, 40 men) were included in the study between July 1997 and May 1999. The mean age was 44 years with a range of 20-77 years. Fifty-eight patients had nonulcer dyspepsia, 14 duodenal ulcer and 6 gastric ulcer. Fourteen subjects were smokers (≥ 10 cigarettes per day). Twenty-four patients (31%) took 1-5 medicines for chronic disease management in addition to the eradication treatment. No patient was lost during the follow up period.

Overall (ITT analysis), *H. pylori* eradication treatment was successful in 51 of 78 patients (65.4%, 95% CI: 54.8-76.0%). Sixty-nine patients (88.5%) were “good compliers” and less than 10% of them had taken 1-2 doses at an interval greater than 15 hours or smaller than 9 hours. Nine patients (11.5%) demonstrated compliance lower than 85% (figure 1). Six stopped their treatment prematurely because of side effects (nausea, vomiting, stomatitis and epigastric pain) and three missed doses of their medicines. *H. pylori* eradication rate was 69.6% (95% CI: 58.7-80.5%) (48 of 69 patients) in the population categorised as “good compliers” (PP analysis) and only 33.3% (3 of 9) in subjects having taken less than 85% of the prescribed medicines. On multivariate analysis, *H. pylori* eradication was inversely associated with poor compliance (P = 0.029). Presence of a gastroduodenal ulcer, age, gender and smoking habit did not significantly affect eradication rate.

Adverse events were reported by 67% of the patients, but were usually mild (table I). All tested strains at culture were sensitive to amoxycillin, 4 (1.3%) were resistant to clarithromycin (MICs > 1mg/L). Further analysis in this subset of patients showed an overall *H. pylori* eradication rate of 66.7% (95% CI: 49.9-83.7%) (20 of 30 patients), which was comparable to overall eradication rate. “Good compliers” with a clarithromycin-sensitive *H. pylori* strain demonstrated an eradication rate of 73.9% (95% CI: 55.7-92.1%) (17 of 23 patients). The presence of clarithromycin resistant strains was associated with a low
Table I. – Side effects associated with H. pylori eradication treatment.

<table>
<thead>
<tr>
<th>Severity of side effects</th>
<th>Incidence of side effects according to patient judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade a</td>
<td>50 % (39 patients)</td>
</tr>
<tr>
<td>(loose stools, metallic taste, stomatitis, nausea, fatigue)</td>
<td></td>
</tr>
<tr>
<td>Grade b</td>
<td>9 % (7 patients)</td>
</tr>
<tr>
<td>(diarrhoea, stomatitis, fatigue)</td>
<td></td>
</tr>
<tr>
<td>Grade c</td>
<td>8 % (6 patients)</td>
</tr>
<tr>
<td>(epigastric pain, stomatitis, nausea, vomiting, fatigue)</td>
<td></td>
</tr>
<tr>
<td>No side effects</td>
<td>33 % (26 patients)</td>
</tr>
</tbody>
</table>

* Severity of side effects:
  — Grade a: Slight discomfort, not interfering with daily activities
  — Grade b: Moderate side effects, interfering partially with daily activities
  — Grade c: Side effects severe enough to lead the patient to stop his therapy

Discussion

Compliance was inversely associated with severe (grade c) side effects (P < 0.001). Gender, age, gastroduodenal disease and the number of additional medicines for chronic disease management did not differ significantly between “good compliers” and patients having taken less than 85% of the prescribed medicines.

In large clinical studies [1-5] using the proton pump inhibitor triple therapy, the rate of side effects is disparate, ranging from 10 to 60% according to the trial. In our study, side effects were reported by 67% of the patients. This high rate can be explained to some extent by the method of interview: usual adverse events of H. pylori eradication treatment comprising a proton pump inhibitor and 2 antibiotics.

In our study, poor compliance was clearly associated with low eradication rate (P = 0.029). However, this factor cannot be considered as the sole reason for treatment failure, as even within the population classified as “good compliers”, our eradication rate of approximately 70% was lower than those reported in large clinical trials [1-5]. Bacterial resistance also cannot explain most treatment failures because the sub-group (n=30) of clarithromycin-sensitive patients had a similarly low eradication rate of 73.9%.

In conclusion, although poor compliance and bacterial resistance were important factors, they could only explain 40% of treatment failures in our ambulatory population, suggesting that other factors were involved. Additional studies are required to further investigate the reasons for treatment failure associated with 1-week H. pylori eradication treatment comprising a proton pump inhibitor and 2 antibiotics.

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REFERENCES


