LETTERS

Prevalence of Helicobacter pylori infection by 13C-urea breath test in conference delegates

Delegates attending the annual conference of the Indian Society of Gastroenterology at New Delhi, November 2000, were encouraged to undergo 13C-urea breath test (Izinta Trading Co., Hungary) for their H. pylori status. The subjects could participate if they had not taken anything by mouth in the previous two hours and had not received any antibiotic or proton-pump inhibitor in the last one month.

A baseline breath sample was collected by blowing air into an inflatable aluminium bag that was then sealed. The subject was given 200 mL of orange juice in which a 13C-urea tablet was dissolved. After 30 minutes another breath sample was taken and analyzed by CO2 gas chromatography (Izinta Trading Co., Hungary).

One hundred and thirty-two subjects (123 men) aged 25–65 years participated; two of the women tested were pregnant. Eight subjects did not report for the breath sample at 30 minutes. Of the 124 subjects who completed the study, 71 (57.3%) tested positive.

The prevalence of H. pylori in India ranges from 31%–84%; most centers report a figure of around 60%. However, most of these studies have been hospital-based. Age-related serology-based prevalence studies suggest that in India infection occurs at an earlier age than in the West. In a group of 50 children studied, 82% tested positive for H. pylori with 13C-urea breath test.

Our study population consisted predominantly of gastroenterologists; we do not know how many were endoscopists or had upper GI symptoms. It is possible that persons with GI symptoms were more inclined to undergo the test. Most of the subjects were from the middle or high-middle socioeconomic group. These may be why the prevalence rate was not very high in this survey.

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References

Mouth guard for endoscopy custom-made from plastic syringe

I had three patients for endoscopy who had difficulty in opening their mouths completely. Two of them had oral submucous fibrosis and one had been operated on for carcinoma of the cheek and had post-radiation fibrosis. The standard pediatric mouth guard could not be inserted in these patients. I devised a mouth guard using a plastic 20 mL syringe. After removing the piston, the required length of the distal end of the syringe was cut using a knife blade, and the cut edges were smoothened (Fig). In the second patient, even this mouth guard could not be inserted and another one using a 10 mL syringe had to be designed similarly.

Using these modified mouth guards, endoscopy could be done successfully in all three patients. The mouth guards have sufficient length to prevent the patient from biting the endoscope. The only extra precaution to be taken is that the assistant should hold the guard properly to avoid its slipping. Similar mouth guards can be used for routine endoscopies if one wishes to use disposable guards for every patient.

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Acquisition of Helicobacter pylori and reinfection after eradication

I commend the authors of the article1 on H. pylori acquisition rates and reinfection after eradication in Indian patients; this is the first prospective study of its kind in the country. I have a few comments on the study, though.

I disagree with the authors that absence of infection after eradication therapy can be confirmed by antral biopsy histology and rapid urease test. H. pylori colonization in the antrum becomes patchy following therapy; the organisms are more likely to be found in the gastric body than in the antrum.2 Hence it is necessary to obtain at least two biopsies each from the antrum and corpus (preferably from the anterior and posterior walls).
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Regarding the issue of therapy for *H. pylori* infection in patients with nonulcer dyspepsia, we had clearly stated that there are no Indian recommendations for treatment in this group. Our viewpoint is similar but, as we stated in our article, our intention was only to study the outcome vis-à-vis the presence or absence of infection and not its effect on the host. We believe Dr Dhar will agree with us that there is no evidence yet that infection acquisition rates are likely to be different in patients with or without peptic ulcer.

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Blister pack ingestion resulting in esophago-pleural fistula

Most ingested foreign bodies (FB) that perforate the gastrointestinal tract (GIT) are lodged at the site of perforation. We report a patient who inadvertently swallowed a blister pack; this was passed out later per rectum but left behind an esophago-pleural fistula.

A 50-year-old man accidentally swallowed a 2 cm x 2 cm blister pack with sharp edges, made of plastic and aluminium foil (Fig). Following this, he developed severe retrosternal pain and dysphagia which lasted for a day, and was subsequently asymptomatic. Ten days later, he presented with features of right-sided pneumothorax. X-rays of the chest and neck showed a loculated hydropneumothorax but no radio-opaque FB. Routine blood tests were normal except for leukocytosis. Pleural paracentesis revealed frank pus with protein 4.3 g/dL, glucose 8 mg/dL and amylase 800 Somogyi units; culture grew Streptococcus spp and Candida albicans. An intercostal drain was placed and he was started on broad-spectrum intravenous antibiotics and analgesics. However, the drain output was persistently high (>1 L/day); cultures repeatedly grew mixed flora, including anaerobes, *Staphylococcus aureus* and *Pseudomonas aeruginosa*, and there was no significant clinical improvement.

Gastrografin study revealed leakage of contrast from the posterior-lateral wall of the lower third of the esophagus into