LETTERS

Is a vaccination program against hepatitis A needed in India?

Hepatitis A virus (HAV) infection is endemic in India. A similar situation was prevalent in developed countries a few decades back, and recently in some developing Southeast Asian countries.1 Because of control of the possible transmission factors, they achieved a marked reduction in the prevalence of the virus.2 But this has led to the emergence of a large population of nonimmune susceptibles who can develop hepatitis A if infected. Assuming a similar situation in India, we undertook a study to determine the seroprevalence of IgG anti HAV antibody (AHA) status in a hospital-based population to identify any high-risk population who are likely to benefit from vaccination against hepatitis A.

Patients attending the medical outpatient department of Lok Nayak Hospital, New Delhi, from May 1995 to May 1996, who did not have any evidence of hepatobiliary disease, were included in the study. They were evaluated on the basis of a questionnaire, clinical examination, liver function tests and ELISA for AHA (Hepavase; General Biological, Taiwan).

Of 395 subjects, 240 were from the low socioeconomic (LS) group and 155 from the high socioeconomic (HS) group. The male-female ratio was 1.4:1. The overall prevalence of 36.7% (Table) of AHA-negative subjects compares well with a recent study from Mumbai3 which found a prevalence rate of 22% (35% among those aged less than 10 years), but not with a study from Pune4 where the prevalence rate was almost nil in those aged above 10 years. This increased prevalence rate may indicate an epidemiological shift of hepatitis A in India, as has occurred in the developed world and in some developing countries.5 Our results show no significant difference in prevalence rates between LS and HS groups while the difference was significant between men and women. Both these are contrary to the observations in the Mumbai study.3

Such a shift may raise the age of HAV infection and increase severity of hepatitis A infection.6 We agree with the editorial6 that since a safe, immunogenic hepatitis A vaccine is available, there is an urgent need to balance between the economic and social costs due to the disease burden and the cost of intervention. A system to generate such data needs to be devised.

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References


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Helicobacter pylori eradication: not enough grounds for recommendation

I appreciate the efforts taken to organize the “First National Workshop on Helicobacter pylori: the Indian scenario”, and the resultant Position Paper.7 But I cannot agree with the reasoning of the Consensus Committee.2

If we do not have information to challenge Western recommendations, we also do not have data to suggest that such recommendations are valid in our country. It is precisely in such a situation that a conservative approach is justified, so as to reduce the indiscriminate use of antibiotics and the risk of promoting resistance. The Maastricht Consensus Report5 strongly recommends eradication for “gastritis with severe abnormalities” and advises eradication in patients with “functional dyspepsia”, among others. Will we now “tentatively” recommend these indications for H. pylori eradication in our country?

Table: Age-specific prevalence of anti-HAV antibody-negative subjects

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Sex</th>
<th>Socioeconomic status</th>
<th>Low</th>
<th>High</th>
<th>Total</th>
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<td>Men</td>
<td>Women</td>
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<td>22/681</td>
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<td>22/681</td>
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<td>28/681</td>
<td>39/681</td>
<td>61/141</td>
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<td>&gt;40</td>
<td>33/681</td>
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</tbody>
</table>

*p<0.01 as compared to men

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Patients with chronic duodenal ulcer form a spectrum of clinical severity in terms of frequency of relapses and complications. If H. pylori eradication were not taken into account, they could broadly be classified as those requiring intermittent histamine H$_2$ receptor antagonist (H$_2$RA) therapy, long-term maintenance H$_2$RA therapy, or surgery. It follows that patients who need only intermittent H$_2$RA therapy are the ones who are likely to have the least benefit from H. pylori eradication.

 Till such time as a proven regimen is available in our country which matches western eradication figures, it may be more prudent to confine H. pylori eradication to patients who are likely to derive the maximum benefit from this intervention.

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References

Giant fibrovascular polyp of the esophagus

We read with interest the recent article reporting a pedunculated leiomyoma of the esophagus. We report a man with a giant fibrovascular polyp of the esophagus which had a similar presentation.

A 60-year-old man presented with progressive painless dysphagia of 6 months’ duration. Barium swallow revealed a diffuse intraluminal soft tissue mass in the mid third esophagus with mild dilatation of the proximal esophagus. Esophagoscopy showed a large polyoid lesion arising at 23 cm from the incisors and extending to 34 cm. The pedicle could not be clearly identified. Biopsy revealed squamous hyperplasia. Transhiatal esophagectomy was performed with gastric transposition. On gross examination, the esophagus showed a pedunculated polyp with verrucous appearance, measuring 11 cm X 7 cm X 6 cm, arising from the upper third (Fig). Microscopically, the lesion revealed normal epithelium and inflamed lamina propria and hyperplastic muscularis mucosae. The submucosa was composed of fibrous tissue rich in vessels of various caliber. This tissue showed proliferation of spindle-shaped cells with eosinophilic cytoplasm. Mitotic activity and necrosis were absent. On immunohistochemical analysis, the spindle cells stained positive with antibodies to smooth muscle actin, vimentin and focally with desmin. A diagnosis of giant fibrovascular polyp was made.

Giant fibrovascular polyps often arise directly inferior to the cricopharyngeus. This has been attributed to the narrow caliber and presence of redundant mucosa in this part. The polyp arises as a submucosal nodule or redundant fold which is subject to the propulsive forces generated during swallowing, finally resulting in a large polyoid mass. Endoscopic snare polypectomy is technically difficult and bears a risk of bleeding. Surgical removal is most commonly done by transcervical approach with vertical esophageotomy. In our patient, we had entertained a diagnosis of verrucous carcinoma; hence, we performed transhiatal esophagectomy. The patient is doing well after two years.

Fibrovascular polyps should be differentiated from leiomyoma; they are tumor-like lesions with proliferation of fibroblasts and myofibroblasts along with laying down of collagen. Histologically, they do not have a fasciculated pattern, are rich in blood vessels, and arise from the muscularis mucosae or muscularis propria. The young fibroblasts show some features of smooth muscle cells and hence are referred to as myofibroblasts. The expression of smooth muscle actin should not lead to a misdiagnosis of leiomyoma.

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References