Prevalence of *Helicobacter pylori* amongst expatriates from the Indian subcontinent in Southeast Asia

*Helicobacter pylori* infection is common worldwide, particularly in the underdeveloped and developing nations.¹ It is strongly associated with peptic ulcer disease and with development of gastric carcinoma and mucosa-associated lymphoid tissue lymphoma.²,³ In our center, approximately 10% of patients attending for endoscopy are expatriate workers, mainly from the Indian subcontinent and Southeast Asia. We assessed the prevalence of *H. pylori* infection among expatriates from the Indian subcontinent.

Medical records of all patients referred for endoscopy between 2001 and 2004 were reviewed retrospectively. During this period, 381 expatriates (Indian subcontinent 267, Europe 39, Southeast Asia 75) had undergone endoscopy and *H. pylori* testing using the rapid urease test (*CLOtest*, Delta West, Bentley, West Australia). Those from the Indian subcontinent included 162 Nepalese, 59 Indian, 39 Pakistani and 7 Bangladeshi expatriates. *H. pylori* prevalence in the three main expatriate groups and different groups from the Indian subcontinent were...
compared using chi-squared test (SPSS Version 10, Chicago, IL, USA) at significance level of 0.05.

The commonest indication for endoscopy was dyspepsia (Nepalese [86.2%] significantly more than Indian [60%, p<0.05] and Pakistani [66.7%, p<0.05] but not compared to Bangladeshi [85.7%, p=ns]). There was no significant difference in the other indications. The commonest finding was gastritis/duodenitis (42.9% to 62.3%, trend p=ns). There was no difference in the frequency of peptic ulcer disease (4.7% to 14.3%, trend p=ns).

_H. pylori_ prevalence rate in expatriates from the Indian subcontinent (109 of 267; 40.8%) was higher than that among expatriates from Europe (5 of 39; 12.8%; p=0.001) and Southeast Asia (17 of 75; 22.7%; p=0.005); the rates were similar among expatriates from different countries in the Indian subcontinent (India 37.3%, Nepal 44.4%, Bangladesh 42.9%, Pakistan 30.8%). Prevalence rates were similar among men (40.4%) and women (42.5%).

Nepalese expatriates live in army barracks; infection rate is known to be high in such communal living conditions. Indian and Pakistani patients come from different socioeconomic backgrounds; a proportion are white-collared workers such as doctors, pharmacists and teachers working with government agencies, while the others are mainly laborers working with the private sector.

The _H. pylori_ infection prevalence rate amongst expatriates from the Indian subcontinent in our study is lower when compared to reports from this region based on antibody detection, which only indicates exposure to _H. pylori_. Our study showed the prevalence of active infection in symptomatic patients.

Our study has several limitations. We used the rapid urease test alone to diagnose _H. pylori_ infection; the reported sensitivity and specificity of the CLO test ranges from 57% to 100% and 53% to 100%, respectively.7

Secondly, acid suppression affects the results of the rapid urease test. Although we could not confirm this, we believe that a majority, if not all, of our patients were not using acid suppression medications, in particular proton pump inhibitor, because all the patients were referred from government peripheral clinics where such prescriptions are restricted due to their cost.

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Severity and extent of ulcerative colitis: role of C-reactive protein

Traditionally, severity of idiopathic ulcerative colitis (IUC) is assessed by the clinical criteria of Truelove and Witts,1 but these lack precision especially in the definition of severe cases. C-reactive protein (CRP) has been known to be of value in monitoring response to treatment and also correlates with disease activity and helps in management of patients with ulcerative colitis.2,3

All consecutive patients with IUC seen during the period July 2003 to May 2004 were included in the study. The diagnosis was made after clinical, sigmoidoscopic and histologic evaluation. Extent of the disease was determined by colonoscopy and/or double-contrast barium enema (12 patients) and was classified as proctosigmoiditis, left-sided colitis (involvement up to splenic flexure) and pancolitis. Severity of the disease was assessed by the original criteria of Truelove and Witts.1 CRP estimation was done by standard semiquantitative latex agglutination method (Biosystems SA, Barcelona, Spain) technique at admission. It was also estimated in 30 age- and sex- matched healthy volunteers.

Of the 35 patients seen (median age 33.8 years, range 19.4 to 61.8), 17, 6 and 12 patients had se-