ROLE OF H. PYLORI IN PATIENTS OF GASTRIC CANCER IN SOUTHERN ODISHA
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ABSTRACT: Since the discovery of Helicobacter pylori in 1983 by Robin Warren and Barry Marshall, the diagnosis and treatment of upper gastrointestinal disease have changed greatly. As infection with H. pylori is the strongest known risk factor for gastric cancer, that is why our study was undertaken in our surgery department to establish the role of H. pylori in patients of gastric cancer in Southern Odisha. Total 70 patients of gastric cancer as cases and 32 controls were studied. H. pylori infection status in all cases and controls was assessed by serological test, rapid urea broth test and histopathological examination of the gastric mucosal biopsy specimens. H. pylori infection was positive in 64 cases of cancer stomach (91.43%) and 24 patients were positive in the control group (75%). The odds ratio was estimated to be 3.56 and p. value was found to be < 0.02.

KEY WORDS: H. pylori, gastric cancer, rapid urea broth test

INTRODUCTION: Cancer stomach is the fourth most common cancer and the second leading cause of cancer-related death world-wide. It is especially prevalent in East Asia and South America and has been increasing in developing countries¹.

Gastric cancer is a multi-factorial disease. The major risk factors for gastric cancer include environmental and genetic factors. H. pylori is the strongest known risk factor for gastritis and gastric cancer and now it is considered as the most common aetiologic agent of infection-related cancers. In 1994, the International Agency for Research on Cancer labeled H. pylori a definite carcinogen (class-I carcinogen). A number of prospective studies have demonstrated an association with the development of gastric cancer ¹.

H. pylori, a spiral-shaped gram-negative rod, has evolved the ability to colonize the highly acidic harsh environment found within the stomach by converting urea to ammonia through the production of urease enzyme, which generates a neutral environment around it². H. pylori infection is very common and has coexisted with humans for many thousand years. Most of the infections are acquired in childhood via the fecal-oral or oral-oral mode of transmission³,⁴. The variable outcomes of H. pylori infection likely depend on various factors such as strain-specific bacterial constituents, inflammatory responses governed by host genetic diversity, or environmental influences, which ultimately influence the interactions between pathogen and host⁵. The primary mechanism is thought to be the presence of chronic gastric inflammation. Long-term infection with the bacteria H. pylori leads to chronic atrophic gastritis which then progresses to intestinal metaplasia, dysplasia and ultimately intestinal-type adenocarcinoma. A wide range of molecular alterations in intestinal metaplasia have been described and may affect the transformation into gastric cancer ¹.
With this background the present case control study has been undertaken to find out the prevalence of H. pylori infection and to determine the degree of association of H. pylori infection in patients of gastric cancer in Southern Odisha.

**MATERIALS AND METHODS:** This case control study was conducted in the Department of General Surgery, M.K.C.G. Medical College, Berhampur, taking into account both indoor and outdoor patients with the symptoms of gastric cancer as the study group during the period between September 2011 and September 2013.

The patients were selected on the basis of their clinical signs and symptoms supplemented by routine and special investigations to arrive at the diagnosis of gastric cancer. Then relevant tests like serology, rapid urea broth test and histopathological examination of gastric mucosal biopsy specimens were performed for detection of H. pylori. Mucosal biopsy specimens were obtained either by upper GI endoscopy or from resected stomach.

Endoscopy was carried out by a flexible upper GI video endoscope by an expert endoscopist. Four biopsy specimens were taken; two from the greater curvature of the antrum and two from the upper body of the stomach (when lesions suspected to be cancerous were noted, additional biopsies were performed). Of these four specimens, two were fixed in formalin and assessed for presence of H. pylori (by Giemsa staining) and the degree of neutrophil infiltration and intestinal metaplasia (by staining with Hematoxylin and Eosin). The remaining two were used for a rapid urea broth test.

The degree of neutrophil infiltration was classified into four grades (0 - no infiltration, 1- mild, 2- moderate, and 3- marked) and expressed as a score by two pathologists according to the updated Sydney System [6]. Consensus was reached through joint review of all the slides.

Active gastritis was classified into four categories: (no gastritis, antrum-predominant gastritis, pan-gastritis, and corpus-predominant gastritis). Intestinal metaplasia was classified in two grades (absent or present).

Gastric mucosal atrophy was evaluated according to the endoscopic-atrophic-border scale described by Kimura and Takemoto which correlates with the results of histological evaluation [7]. There were three classifications (1- mild atrophy or none, 2- moderate, and 3- severe). The pathologists were not aware of the clinical or endoscopic data. The results were scored blindly with the use of patient codes.

The gastric mucosal biopsy specimens for the detection of H. pylori by rapid urea broth test were immediately suspended into normal saline in aseptic condition and then put into the urea broth which was then monitored for 24 hours for detection of color change from yellow to pink.

Blood sample was collected immediately before endoscopy, serum was immediately separated and cryopreserved at -20°C until it was assayed for antibodies against H. pylori by ELISA test. A positive serologic test for H. pylori was defined as one with a titer of 1.8 or more.

H. pylori infection was identified by histological examination, the rapid urea broth test, and serologic evaluation. Patients in whom any of these assays were positive were classified as H. pylori-positive. Those in whom all three tests were negative were considered H. pylori-negative.

**OBSERVATION:** A total of 70 cases of cancer stomach and 32 non-cancer patients as controls were studied to determine the association of H. pylori with gastric cancer in patients of Southern Odisha and following observations were noted. All the gastric cancer patients were taken as cases after
confirmation of diagnosis on the basis of presenting symptoms, signs and investigations. The observations were recorded in tabular forms and depicted in various diagrams and simultaneously the facts and figures were compared with those of other workers.

Table – 1: AGE AND SEX DISTRIBUTION AMONG GASTRIC CANCER CASES

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Age group in years</th>
<th>No. of males</th>
<th>No. of females</th>
<th>Total no. of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11 – 20</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1.43</td>
</tr>
<tr>
<td>2</td>
<td>21 – 30</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>31 – 40</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>11.43</td>
</tr>
<tr>
<td>4</td>
<td>41 – 50</td>
<td>12</td>
<td>7</td>
<td>19</td>
<td>27.14</td>
</tr>
<tr>
<td>5</td>
<td>51 – 60</td>
<td>13</td>
<td>8</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>6</td>
<td>61 – 70</td>
<td>16</td>
<td>1</td>
<td>17</td>
<td>24.29</td>
</tr>
<tr>
<td>7</td>
<td>71 – 80</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>5.71</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>46(65.71%)</td>
<td>24(34.29%)</td>
<td>70(100%)</td>
<td>100</td>
</tr>
</tbody>
</table>

In our study, majority of the cases occurred after 40 years of age. The youngest patient in this series was 18 year old female and oldest patient was 80 year male. The average age was 55 year. The highest incidence was found in age group 51-60 years (30%). More than half of the total cases included in this study were found in between 40-60 years of age (57.14%). In this study 46 cases (65.71%) were male and 24 cases (34.29%) were female. The ratio between male and female was 1.9:1. Maximum no. of male patients was in age group 61-70 years and maximum no. of female patients was in age group 51-60 years.

Table – 2: AGE AND SEX DISTRIBUTION AMONG CONTROL GROUP

<table>
<thead>
<tr>
<th>Sl. no.</th>
<th>Age group in years</th>
<th>No. of males</th>
<th>No. of females</th>
<th>No. of controls</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21 – 30</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>2</td>
<td>31 – 40</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>3</td>
<td>41 – 50</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>4</td>
<td>51 – 60</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>18.75</td>
</tr>
<tr>
<td>5</td>
<td>61 – 70</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>21.87</td>
</tr>
<tr>
<td>6</td>
<td>71 – 80</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3.13</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>24(75%)</td>
<td>8(25%)</td>
<td>32</td>
<td>100</td>
</tr>
</tbody>
</table>

In this study, 32 patients were taken as control group among which 24 patients were male and 8 patients were female. The youngest control was 21 year old male and oldest control was 75 year old male. Maximum number of the controls was in the age group 61-70 year (n=7, 21.87%). In our study, 52 cases (74.28%) were from rural areas and 18 cases (25.72%) from urban areas. In the control group, 23 patients were from rural and 9 patients were from urban areas.

Out of 70 cases of gastric cancer, 40 cases (57.14%) were from low, 18 cases (25.71%) were from middle and 12 cases (17.15%) were from high socio-economic status group. Among 32 controls, 18 patients (56.25%) were from low, 8 patients (25%) were from middle and 6 patients (18.75%) were from high socioeconomic group. Hence cases and controls were comparable with respect to socioeconomic status.
On endoscopy, out of 70 cases, maximum no. of cases was found to contain ulceroproliferative growth (n=30; 42.85%). Rest of the cases were found to contain ulcerative lesion (n=26; 37.14%), fungating growth (n=11; 15.71%) and linitisplastica (n=3; 4.28%). Total no. of gastric cancers found in pre-pyloric region was 33 (47.14%), in body of stomach was 15 (21.43%), in pyloric antrum was 13 (18.57%) and in cardiac end of stomach was 6 (8.57%). Endoscopic findings in control group included that 10 patients had normal finding (non-ulcer dyspepsia), 8 patients had acute gastritis, 7 patients had chronic duodenal ulcers and rest 7 patients had benign-looking gastric ulcers.

On histopathological examination, adenocarcinoma was found in all cases. Out of 70 cases, intestinal type of adenocarcinoma was found in 44 cases (62.86%) and diffuse type was found in 26 cases (37.14%). Intestinal type was more common in males and diffuse type was more common in females.

In our study, it was found that sensitivity of the three tests used for detection of H. pylori are 78.13%, 95.31% and 75% for serology, rapid urea broth test and histopathology of direct smear respectively. The ELISA test used for detection of anti-H.pylori antibody detected only IgG antibody.
In our study, the total no. of H. pylori positive cases was 64 (91.43% of cases), total no. of H. pylori negative cases was 6, total no. of H. pylori positive controls was 24 (75% of controls) and total no. of H. pylori negative controls was 8. Thus, H. pylori was found in 91.43% of gastric cancer patients and in 75% of controls. In this study of 102 patients, total no. of H. pylori positive patients was 88 (86.27%) and total no. of H. pylori negative patients was 14 (13.73%).

The odds ratio (OR) is a measure of the odds of disease in the exposed compared to the odds of disease in the unexposed (controls) and is calculated as:

\[
\text{Odds Ratio (OR)} = \frac{ad}{bc} \Rightarrow \text{OR} = 3.56
\]

\[
\text{Relative Risk (RR)} = \frac{a(c+d)}{c(a+b)} \Rightarrow \text{RR} = 1.69
\]

Thus Odds Ratio was found to be 3.56 which estimated that H. pylori positive patients were 3.56 times more likely to develop gastric cancer in comparison to H. pylori negative patients. P-value calculated by Chi-square test was found to be <0.02.

**DISCUSSION:** The case-control study to establish the bacterial infective cause of gastric cancer carried out in the Department of General Surgery, M.K.C.G. Medical College, Berhampur correlates well with the results published earlier and made us think that a real association is indeed not deniable.

It was found that the prevalence of infection with H. pylori in male patients with gastric cancer was higher than in the female patients which correlated with the findings by Anderson et al (1994) 9. The infection occurs early in childhood and prevalence of H. pylori infection increases with age. This same trend was seen in our study. The maximum no. of H. pylori infected patients were in the age group 51-70 years. There was a bimodal distribution of prevalence of H. pylori infection with first peak between 55-60 years and second peak between 65–70 years.

H. pylori infection is more prevalent in developing countries than developed countries. In our study of total 102 patients, the maximum no. of patients were from rural areas (n=75, 73.53%) and 58 patients (56.86%) were of low socioeconomic status. H. pylori infection rate was highest among low socioeconomic status patients. In our study of 70 cases of gastric cancer, 40 cases occurred in persons of low socio-economic status constituting 57.14% of total cases. In our study, the prevalence of H. pylori infection among 70 cases of gastric cancer patients was 91.43% (n=64 cases) and prevalence of H. pylori infection among 32 controls was 75%.

In a study conducted by M. Kato et al., and the members of The Multi-centre Study Group 10, in the Division of Endoscopy of Hokkaido University Hospital and in the Department of Gastroenterology, Hokkaido University Graduate School of Medicine, Sapporo, Japan; it was found that the overall prevalence of H. pylori infection was 50.2% in control subjects but was 82.8% in those with gastric cancer. In our study, the high prevalence of H. pylori infection among cases and controls might be due to the fact that maximum number of patients was from low socioeconomic status group and from rural areas.

The prevalence of H. pylori antibody (IgG) among gastric cancer patients was 82.85%. In our series, ELISA technique was used to detect antibody. The sensitivity of the three tests used for detection of H. pylori was 78.13%, 95.31% and 75% for serology, rapid urea broth test and histopathology of direct smear respectively. The increased absorbance level which is related to increased density of colonization of H. pylori was seen in 76.51% of 64 positive cases tested positive for IgG H. pylori specific antibodies. A similar finding has been reported by Lamers CBHW et al in
who concluded that the serological absorbance index of IgG antibodies against H. pylori is related to the severity of antral gastritis and density of bacterial colonization.

All our gastric cancer cases showed both serologically as well as by histological study of gastric mucosal biopsy, of increased colonization of antrum with H. pylori that proves the high prevalence of infection in this population and definite association of H. pylori with gastric cancer as the major causative factor in its pathogenesis. IgM antibody has been found to have little diagnostic utility for H. pylori infections and is elevated only after infection, whereas H. pylori infections are generally chronic. IgM has extremely low sensitivity, confirming its lack of clinical utility in either children or adults.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Chen CJ et al</th>
<th>Taiwan study</th>
<th>Delpiano</th>
<th>Our study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastric cancer</td>
<td>76.2%</td>
<td>72.3%</td>
<td>87.9%</td>
<td>82.85%</td>
</tr>
</tbody>
</table>

Table 5: Comparison of various studies using sero-positivity for H. pylori (IgG antibodies) detection

In our case-control study, Odds Ratio was found to be 3.56 which estimated that H. pylori positive patients were 3.56 times more likely to develop gastric cancer in comparison to H. pylori negative patients. This is in accordance with existing literature that the risk of gastric cancer in patients with chronic H. pylori infection is increased about three fold. Our study showed a statistically significant association of H. pylori infection with gastric cancer in patients of Southern Odisha (P <0.02).

Asaka et al. reported a significantly higher prevalence of H. pylori infection in gastric cancer patients than in asymptomatic control subjects. This association was strongest for early gastric cancer. Kikuchi et al. compared cancer subjects who were younger than 40 years with well-matched controls and found an OR of 13.3. In comparison to above study, the odds ratio of our study was very low due to maximum no. of patients were in advanced stage and prevalence of H. pylori infection decreases with advanced stage of disease.

CONCLUSION: The gastric cancer is a highly lethal and very common disease of gastro-intestinal tract. Gastric cancer is highly prevalent in this part of Odisha. The prevalence of H. pylori infection among gastric cancer cases of our study was 91.43%. This sort of high prevalence of infection among gastric cancer patients, the increase in absorbance level as the density of the bacterial colonization increases shown in serological study correlating well with the histological study and the odds ratio of 3.56 and p-value of < 0.02 support the significant causal association between gastric cancer and H. pylori infection. However further detailed study is required to firmly establish the role of H. pylori as a causative agent of gastric cancer.

REFERENCES:
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