

Institution/Department : Kaohsiung Veterans General Hospital

Principal Investigator (PI) : Prof. Ping-I Hsu

Research Project Title : Comparison of two rescue therapies for *Helicobacter pylori* infection — a multicenter randomized controlled trial

NCT Number : NCT02547012

Date of the document : 2017/10/30

ABSTRACT

Background: Although proton pump inhibitor (PPI) -amoxicillin-levofloxacin triple therapy has been recommended by the Maastricht IV/Florence Consensus Report for rescue treatment of both standard triple therapy and non-bismuth quadruple therapy, the eradication rates of the rescue treatment for standard triple therapy and non-bismuth quadruple therapy by intention-to-treat analysis are only 66.9% and 77.5%, respectively. It is therefore mandatory and urgent to develop a highly effective rescue therapy for second-line treatment of *H pylori* infection. From the profiles of antibiotic susceptibility data following eradication therapy, tetracycline, amoxicillin and levofloxacin are all good candidates of antibiotics used in the rescue treatment for both standard triple therapy and non-bismuth quadruple therapy. Our recent study also revealed that adding tetracycline to levofloxacin-based rescue treatment might achieve a very high eradication rate (95.8%) for *H pylori* infection after failure of non-bismuth quadruple therapy.

Aims: To investigate the efficacy of PPI-amoxicillin-levofloxacin-tetracycline quadruple therapy and PPI-amoxicillin-levofloxacin triple therapy in rescue treatment for first-line anti-*H pylori* therapy.

Methods: Consecutive 164 *H pylori*-infected adult patients with failure of first-line anti-*H pylori* therapy are randomly assigned to either EALT (esomeprazole 40 mg b.d., amoxicillin 500 mg q.d.s., levofloxacin 500 mg o.d., and tetracycline 500 mg q.d.s.) therapy or EAL (esomeprazole 40 mg b.d., amoxicillin 500 mg q.d.s., and levofloxacin 500 mg o.d.) for 10 days. Additionally, antibiotic susceptibility of *H pylori* and *CYP2C19* polymorphism of the hosts are examined. Repeated endoscopy with rapid urease test, histological examination and culture or urea breath test is performed at six weeks after the end of anti-*H pylori* therapy. The rates of eradication, adverse

events and compliance will be compared (1) between EAL and EALT groups in patients with failure of first-line anti-*H pylori* therapy by chi-square test. Besides, the host and bacterial factors influencing the efficacy of above two salvage regimens are assessed by multivariate analysis.

INTRODUCTION

Helicobacter pylori (*H pylori*) infect more than 50% of humans globally. It is the principal cause of chronic gastritis, gastric ulcer, duodenal ulcer, gastric adenocarcinoma and gastric mucosa-associated lymphoid tissue lymphoma (MALToma) [1,2]. *H pylori* eradication has become the standard and most widely adopted therapy to cure peptic ulcer disease [3]. This therapy is also strongly recommended in the treatment of *H pylori*-related MALToma [4]. In regions with high incidence of gastric adenocarcinoma, eradication of *H pylori* is advocated as a preventative measure [5].

Standard triple therapy has been recommended as first-line regimen for *H pylori* infection in main international guidelines [6,7]. However, several large clinical trials and meta-analyses have shown that the eradication rate of the standard therapy has generally declined to unacceptable levels (i.e., 80% or less) recently [8,9]. In some European countries, the success rates are disappointingly low with values only 25-60% [10,11]. Therefore, several novel first-line therapies including sequential therapy, concomitant therapy and hybrid therapy have emerged to treat naive *H pylori* infection [12-14].

The Maastricht IV/Florence Consensus Report [15] has recommended treatment of *H pylori* infection according to antibiotic resistance rates in local areas recently. In some countries with low clarithromycin resistance (< 15%) of *H pylori*, standard triple therapy is still the best option for first-line anti-*H pylori* therapy, but bismuth-containing quadruple therapies such as sequential therapy and concomitant therapy are the preferred option in countries with clarithromycin resistance >20%.

In clinical practice, the regimen for second-line therapy of *H pylori* infection depends on the regimen used in first-line therapy. After failure of a standard triple therapy, either a bismuth-containing quadruple therapy or PPI-amoxicillin-levofloxacin triple therapy is recommended [15]. Bismuth-containing quadruple therapy regimen fails in 5-63% of patients with an average eradication rate of 76% on the basis of a pooled analysis [16-18]. PPI-

amoxicillin-levofloxacin has been recommended as an encouraging strategy for second-line therapy [19]. A meta-analysis by Saad et al. [19] showed that a 10-day regimen of levofloxacin-based triple therapy was superior to 7-day bismuth-based quadruple therapy. However, levofloxacin-based triple therapies seem less effective in Asia. Our recent study showed that PPI-amoxicillin-levofloxacin triple therapy only achieved a 69.9% eradication rate for rescue treatment of standard triple therapy in Taiwan [20].

Currently, the best second-line therapy after failure of non-bismuth quadruple therapies (such as sequential therapy, concomitant therapy or hybrid therapy) remains unclear. Although PPI-amoxicillin-levofloxacin triple therapy also has been recommended by the Maastricht IV/Florence Consensus Report as a rescue treatment for sequential therapy [15], the mean eradication rate of the rescue regimen is suboptimal (mean, 77.5% [79/102]; range: 50% [3/6] to 100% [7/7]) [21-25].

Antibiotic resistance is the key factor determining the outcome of rescue treatment for anti-*H. pylori* therapy. According to our previous reports [20,26], the drug resistant rates to tetracycline, levofloxacin, amoxicillin, clarithromycin and metronidazole were 0%, 21%, 6%, 59% and 57% respectively following standard triple therapy [20] and 0%, 25%, 0%, 75% and 75% respectively following sequential therapy [26]. The data indicate that tetracycline, amoxicillin and levofloxacin are good candidates of antibiotics used in the rescue treatment for both standard triple therapy and non-bismuth quadruple therapy (such as sequential therapy, concomitant therapy and hybrid therapy).

Although PPI-amoxicillin-levofloxacin triple therapy has been recommended by the Maastricht IV/Florence Consensus Report for rescue treatment of both standard triple therapy and non-bismuth quadruple therapy [15], the eradication rates of the rescue treatment for standard triple therapy and sequential therapy by intention-to-treat analysis are only 66.9% [20] and 77.5% [23], respectively. Our recent study revealed that adding tetracycline to levofloxacin-based rescue treatment might achieve a very high eradication rate (95.8%) for *H. pylori* infection after failure of sequential therapy [26]. We therefore design the prospective,

multicenter, randomized controlled trial to investigate (1) the efficacy of PPI-amoxicillin-levofloxacin-tetracycline quadruple therapy and PPI-amoxicillin-levofloxacin triple therapy in rescue treatment for standard triple therapy, (2) the efficacy of PPI-amoxicillin-levofloxacin-tetracycline quadruple therapy and PPI-amoxicillin-levofloxacin triple therapy in rescue treatment for nonbismuth-containing quadruple therapy (such as sequential therapy, concomitant therapy and hybrid therapy), and (3) the bacterial and host factors determining the efficacy of PPI-amoxicillin-levofloxacin-tetracycline quadruple therapy and PPI-amoxicillin-levofloxacin triple therapy.

REFERENCES

1. Suerbaum S, Michetti P. *Helicobacter pylori* infection. *N Engl J Med* 2002;**347**: 1175–86.
2. Malfertheiner P, Chan FK, McColl KE. Peptic ulcer disease. *Lancet* 2009;**374**:1449–61.
3. Sung JJY, Chung SCS, Ling TKW, et al. Antibacterial treatment of gastric ulcer associated with *Helicobacter pylori*. *N Eng J Med* 1995;**332**:139-42.
4. [Zucca E](#), [Dreyling M](#); [ESMO Guidelines Working Group](#). Gastric marginal zone lymphoma of MALT type: ESMO clinical recommendations for diagnosis, treatment and follow-up. *Ann Oncol* 2009;**20**(Suppl 4):113-4.
5. Asaka M, Kato M, Takahashi S, et al, Guidelines for the management of *Helicobacter pylori* infection in Japan: 2009 revised edition. *Helicobacter* 2010;**15**:1–20.
6. Malfertheiner P, Megraud F, O'Morain C, et al. Current concepts in the management of *Helicobacter pylori* infection: the Maastricht III Consensus Report. *Gut* 2007;**56**:772-81.
7. Fock KM, Katelaris P, Sugano K, et al. Second Asia-Pacific Consensus Guidelines for *Helicobacter pylori* infection. *J Gastroenterol Hepatol* 2009;**24**:1587-600.
8. Graham DY, Fischbach L. *Helicobacter pylori* treatment in the era of increasing antibiotic resistance. *Gut* 2010; 59: 1143-53.
9. Gumurdulu Y, [Serin E](#), [Ozer B](#), et al. Low eradication rate of *Helicobacter pylori* with triple 7-14 days and quadruple therapy in Turkey. *World J Gastroenterol* 2004;**10**:668-71.
10. [Bigard MA](#), [Delchier JC](#), [Riachi G](#), Thibault P, Barthelemy P. One-week triple therapy using omeprazole, amoxycillin and clarithromycin for the eradication of *Helicobacter pylori* in patients with non-ulcer dyspepsia: influence of dosage of omeprazole and clarithromycin. *Aliment Pharmacol Ther* 1998;**12**:383-8.
11. Gatta L , Vakil N , Leandro G, et al. Sequential therapy or triple therapy for *Helicobacter pylori* infection: systematic review and meta-analysis of randomized controlled trials in adults and children. *Am J Gastroenterol* 2009;**104**:3069–79.
12. Chuah SK, Tsay FW, [Hsu PI](#), Wu DC. A new look at anti-*Helicobacter pylori* therapy. *World J Gastroenterol* 2011;**17**:3971-5.
13. Wu DC, Hsu PI, Wu JY et al. Sequential and concomitant therapies with 4 drugs are

- equally effective for eradication of *H pylori* Infection. *Clin Gastroenterol Hepatol* 2010;8:36-41.
14. Hsu PI, [Wu DC](#), [Wu JY](#), Graham DY. Modified sequential *Helicobacter pylori* therapy: proton pump inhibitor and amoxicillin for 14 days with clarithromycin and metronidazole added as a quadruple (hybrid) therapy for the final 7 days. *Helicobacter* 2011;16:139-45.
 15. Malfertheiner P, Megraud F, O'Morain CA, et al. Management of *Helicobacter pylori* infection — The Maastricht IV/ Florence Consensus Report. *Gut* 2012;61:646-64.
 16. [Wu DC](#), [Hsu PI](#), [Tseng HH](#), et al. *Helicobacter pylori* Infection: A randomized, controlled study comparing 2 rescue therapies after failure of standard triple therapies. *Medicine (Baltimore)* 2011 ; 90 : 180-5.
 17. Gisbert JP. "Rescue" regimens after *Helicobacter pylori* treatment failure. *World. J. Gastroenterol* 2008 ; 14 : 5385-402.
 18. Hojo M, Miwa H, Nagahara A, et al. Pooled analysis for *Helicobacter pylori* infection. *Scand J Gastroenterol* 2001 ; 36 : 690-700.
 19. Saad RJ, Schoenfeld P, Kim HM, et al. Levofloxacin-based triple therapy versus bismuth-based quadruple therapy for persistent *Helicobacter pylori* infection: a meta-analysis. *Am. J. Gastroenterol* 2006 ; 101 : 488-96.
 20. [Kuo CH](#), [Hu HM](#), [Kuo FC](#), et al. Efficacy of levofloxacin-based rescue therapy for *Helicobacter pylori* infection after standard triple therapy: a randomized controlled trial. *J. Antimicrob. Chemother* 2009 ; 63 : 1017-24.
 21. [Pontone S](#), [Standoli M](#), [Angelini R](#), et al. Efficacy of *H. pylori* eradication with a sequential regimen followed by rescue therapy in clinical practice. *Dig Liver Dis* 2010 ; 42 : 541-3.
 22. Manfredi M, Bizzarri B, De'angelis GL. *Helicobacter pylori* Infection: Sequential therapy followed by levofloxacin-containing triple therapy provides a good cumulative eradication rate. *Helicobacter* 2012;17:246–53.
 23. Perna F, Zullo A, Ricci C, et al. Levofloxacin-based triple therapy for *Helicobacter pylori*

retreatment: role of bacterial resistance. *Dig Liver Dis* 2007 ; 39 : 1001–5.

24. Zullo A, De Francesco V, Hassan C. Second-line treatment for *Helicobacter pylori* eradication after sequential therapy failure: a pilot study. *Therapy* 2006 ; 3 : 251–4.
25. Gisbert JP, Molina-Infante J, Marin AC, et al. Second-line rescue triple therapy with levofloxacin after failure of non-bismuth quadruple "sequential" or "concomitant" treatment to eradicate *H. pylori* infection. *Scand J Gastroenterol* 2013 ; in press.
26. Hsu PI, Lai KH, Tseng HH, et al. Eradication of *Helicobacter pylori* prevents ulcer development in patients with ulcer-like functional dyspepsia. *Aliment Pharmacol Ther* 2001 ; 15 : 195-201.
27. Hsu PI, Lai KH, Tseng HH, et al. Correlation of serum immunoglobulin G *Helicobacter pylori* antibody titers with histologic and endoscopic findings in patients with dyspepsia. *J Clin Gastroenterol* 1997 ; 25 : 587-91.
28. Hsu PI, Lai KH, Chien EJ, et al. Impact of bacterial eradication on the cell proliferation and p53 protein accumulation in *Helicobacter pylori*-associated gastritis. *Anticancer Res* 2000 ; 20 : 1221-8.
29. Peng NJ, Lai KH, Liu RS, et al. Endoscopic 13C-urea breath test for the diagnosis of *Helicobacter pylori* infection. *Dig Liver Dis* 2003 ; 35 : 73-7.
30. Peng NJ, Lai KH, Liu RS, et al. Clinical significance of oral urease in the diagnosis of *H. pylori* infection by 13C-urea breath test. *Dig Dis Sci* 2001 ; 46 : 1773-8.
31. Kita T, Sakaeda T, Aoyama N, et al. Optimal dose of omeprazole for CYP2C19 extensive metabolizers in anti-*Helicobacter pylori* therapy: pharmacokinetic considerations. *Biol Pharm Bull* 2002 ; 25 : 923-7.

PATIENTS AND METHODS

Patients

Consecutive 164 *H pylori*-infected adult patients (≥ 20 years old) with failure of first-line anti-*H pylori* therapy will be enrolled for this study after giving informed consent. The presence of *H pylori* after a previous eradication therapy is defined as (1) positive results of both rapid urease test and histology, (2) a positive result of ^{13}C urea breath test, or (3) a positive result of culture. Criteria for exclusion included (a) ingestion of antibiotics, bismuth, or PPI within the prior 4 weeks, (b) patients with allergic history to the medications used, (c) patients with previous gastric surgery, (d) the coexistence of serious concomitant illness (for example, decompensated liver cirrhosis, uremia), and (e) pregnant women.

Methods

Using a computer-generated number sequence, the eligible patients are randomized to either EALT (esomeprazole 40 mg b.d., amoxicillin 500 mg q.d.s., levofloxacin 500 mg o.d., and tetracycline 500 mg q.d.s.) therapy or EAL (esomeprazole 40 mg b.d., amoxicillin 500 mg q.d.s., and levofloxacin 500 mg o.d.) for 10 days. All drugs are taken one hour before meals or night sleep.

Patients are asked to return at the 2nd week to assess drug compliance and adverse events. To assess eradication efficacy, repeated endoscopy with rapid urease test, histological examination and culture or urea breath test is performed at six weeks after the end of anti-*H pylori* therapy. Eradication is defined as (1) negative results of all rapid urease test, histology and culture or (2) a negative result of urea breath test.

Demographic data

A complete medical history and demographic data are obtained from each patient, including age, sex, medical history, history of smoking, alcohol, coffee and tea consumption. Smoking was defined as consumption of cigarettes 1 pack or more per week. Coffee or tea consumption is defined as drinking 1 cup or more per day.

Adverse events are prospectively evaluated. The adverse events are assessed according to a 4-

point scale system: none; mild (discomfort annoying but not interfering with daily life); moderate (discomfort sufficient to interfere with daily life); and severe (discomfort resulting in discontinuation of eradication therapy). Compliance is checked by counting unused medication at the completion of treatment. Poor compliance is defined as taking less than 80% of the total medication.

Histological examination

Two biopsy specimens are taken from the lesser curvature sites of the antrum and the corpus, respectively. They are fixed in 10% buffered formalin, embedded in paraffin, and sectioned. The sections, 4- μ m thick, are stained with a haematoxylin and eosin stain and a modified Giemsa stain to observe the presence of curved rod shape bacteria on the mucosal surface [28]. Biopsy specimens are assessed by a histopathologist (HH Tseng), blinded to patient status and the results of other laboratory tests.

Urea breath test

The urea breath test is performed according to our previous studies [29]. The cutoff value is set at 4.8‰ of $\delta^{13}\text{CO}_2$ [30]. The staffs who are blind to the *H pylori* status perform the tests.

Culture and antimicrobial resistance

One antral gastric biopsy specimen is obtained for isolation of *H pylori*, using previously described culture methods [14]. All stock cultures are maintained at -80°C in Brucella broth (Difco, Detroit, MI) supplemented with 20% glycerol (Sigma Chem. Co. St. Louis, MO). The organisms are identified as *H pylori* by Gram staining, colony morphology, and positive oxidase, catalase, and urease reactions. As previously described in more detail [8], the antibiotic susceptibility is tested by E test (AB Biodisk, Solna, Sweden). *H pylori* strains with a MIC value $> 0.5 \mu\text{g/mL}$, $> 1 \mu\text{g/mL}$, $> 4 \mu\text{g/mL}$, $> 8 \mu\text{g/mL}$ and $> 1 \mu\text{g/mL}$ are considered to be resistant to amoxicillin, levofloxacin, tetracycline, metronidazole and clarithromycin, respectively [14,16].

Genotyping of *CYP2C19*

Blood sampling for genotyping of *CYP2C19* is carried out before endoscopy for the subjects who provide informed consent for genetic study. The *CYP2C19* genotype is determined using the polymerase chain reaction-restriction fragment length polymorphism (PCR-RFLP) [31]. A two single-tube tetra-primer PCR assays is applied to detect the *CYP2C19**2 and the *3 allele, respectively. To genotype the *CYP2C19**2 polymorphism, four primers (Table 1) are combined in one tetra-primer PCR assay. Amplification of *CYP2C19* exon 5 with primers Ex5U and Ex5L produced a 321-bp product that served as internal control for the quality of the PCR amplification and as template for the allele-specific amplification (ASA). ASA produced the 229-bp PCR product specific for the *2 allele and the 127-bp PCR product specific for the wild-type allele. The tetra-primer PCR produced amplification of the 309-bp *CYP2C19* exon 4 region (Ex4U and Ex4L), and ASA (*3mutU and *3wtL) produced the 110-bp PCR product for the *3 allele and the 228-bp PCR product for the wild-type allele. The following reaction mixture was prepared for the tetra-primer PCR assay to genotype *CYP2C19**2: 16.4 mL of water, 2.5 mL of buffer 1 (1.5 mM MgCl₂), 0.2 mL of Gold Taq (5 U/mL), 0.5 mL of dNTP mixture (10 mM), 0.4 mL of Ex5U (10 mM), 0.5 mL of Ex5L (10 mM), 0.75 mL of *2mutU (10 mM), 0.75 mL of *2wtL (10 mM), and 3.0 mL of genomic DNA (;50 ng/mL). The following cycling conditions were used: 10 min at 94 °C; 44 cycles of 94 °C for 30 s, 50 °C for 30 s, and 72 °C for 60 s; and a final extension of 7 min at 72 °C. Separation by 2% agarose gel electrophoresis and ethidium bromide staining allowed identification of the three PCR products and the interpretation of the *CYP2C19**2 genotype.

Table 1. Oligonucleotides used in this study.

Primer	5' position ^a	Sequence ^b	3' position ^a
Exon 5			
2C19Ex5U ^c	8	CAGAGCTGGCATATTGTATC	28
2C19Ex5L ^c	328	GTAAACACACAACTAGTCAATG	307
2C19*2mutU	100	ATCATTGATTATTTCCCA ^d	117
2C19*2wtL	134	AATTTGTTATGGGTTCCT	117
Exon 4			
2C19Ex4U ^e	21	TATGAAGTGTTTTATATCTAATGTTTACTCA	51
2C19Ex4L ^f	329	ACTTCAGGGCTTGGTCAATATAGA	306
2C19*3mutU	220	GTAAGCACCCCTGA	234
2C19*3wtL	248	GGCCTTACCTGGATC	234

Genotypes are classified into three groups: homEM (*CYP2C19**1/*CYP2C19**1); hetEM

(*CYP2C19**1/*CYP2C19**2 and *CYP2C19**1/*CYP2C19**3); PM (*CYP2C19**2/*CYP2C19**2, *CYP2C19**2/*CYP2C19**3, and *CYP2C19**3/*CYP2C19**3).

Statistical analysis

The primary outcome variable is eradication rate. The secondary outcome variables are the rate of adverse events and compliance. Chi-square test with or without Yates correction for continuity and Fisher's exact test are used when appropriate to compare the major outcomes between groups. A *P* value less than 0.05 is considered statistically significant.

Eradication rates are evaluated by ITT and per-protocol (PP) analyses. ITT analysis includes all randomized patients who have taken at least one dose of study medication. Patients whose infection status is unknown following treatment are considered treatment failures for the purposes of ITT analysis. The PP analysis excludes the patients with unknown *H. pylori* status following therapy and those with major protocol violations.

To determine the independent factors affecting the treatment response, Host and bacterial parameters are analyzed by univariate analysis. Those variables found to be significant by univariate analysis are subsequently assessed by a stepwise logistic regression method to identify independent factors for eradication outcome.