Challenges in Diagnosis of H. Pylori Infection in Children

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Abstract:
H. pylori infection is usually acquired in early childhood. Its role in gastrointestinal and extra intestinal complaints and serious consequences in adulthood make it as challenging issues. Despite different clinical presentations, in most children, the presence of H. pylori infection does not lead to clinically apparent disease, even when it causes chronic active gastritis. Some of most important recommendations for managing H. pylori infection in children based on Guidelines from ESPGHAN and NASPGHAN consisted as:
1. Diagnostic testing for H pylori infection is not recommended in children with functional abdominal pain.
2. In children with first-degree relatives with gastric cancer, testing for H pylori may be considered.
3. In children with refractory iron-deficiency anemia, in which other causes have been ruled out, testing for H pylori infection may be considered.
4. There is insufficient evidence that H pylori infection is causally related to otitis media, upper respiratory tract infections, periodontal disease, food allergy, sudden infant death syndrome (SIDS), idiopathic thrombocytopenic purpura, and short stature.
5. It is recommended that the initial diagnosis of H pylori infection be based on a positive histopathology plus a positive rapid urease test or a positive culture.
6. The 13C-urea breath test (UBT) is a reliable noninvasive test to determine whether H pylori has been eradicated.
7. ELISA-test for detection of H pylori antigen in stool is a reliable noninvasive test to determine whether H pylori has been eradicated.
8. Tests based on the detection of antibodies (IgG, IgA) against H pylori in serum, whole blood, urine, and saliva are not reliable for use in the clinical setting.
9. It is recommended that clinicians wait at least 2 weeks after stopping proton pump inhibitor (PPI) therapy and 4 weeks after stopping antibiotics to perform biopsy-based and noninvasive tests (UBT, stool test) for H pylori.

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