Retrospective Cohort Study

Does the antibody production ability affect the serum anti-\textit{Helicobacter pylori} IgG titer?

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Abstract

AIM: To investigate the relationship between serum titers of anti-\textit{Helicobacter pylori} (\textit{H. pylori}) immunoglobulin G (IgG) and hepatitis B virus surface antibody (HBsAb).

METHODS: Korean adults were included whose samples had positive Giemsa staining on endoscopic biopsy and were studied in the hepatitis B virus surface antigen (HBsAg)/HBsAb serologic assay, pepsinogen (PG) assay, and \textit{H. pylori} serologic test on the same day. Subjects were excluded if they were positive for HBsAg, had a recent history of medication, or had other medical condition(s). We analyzed the effects of the following factors on serum titers of HBsAb and the anti-\textit{H. pylori} IgG: Age, density of \textit{H. pylori} infiltration in biopsy samples,
serum concentrations of PG I and PG II, PG I/II ratio, and white blood cell count.

RESULTS: Of 111 included subjects, 74 (66.7%) exhibited a positive HBsAb finding. The serum anti-\textit{H. pylori} IgG titer did not correlate with the serum HBsAb titer ($P = 0.185$); however, it correlated with the degree of \textit{H. pylori} infiltration on gastric biopsy ($P < 0.001$) and serum PG II concentration ($P = 0.042$). According to the density of \textit{H. pylori} infiltration on gastric biopsy, subjects could be subdivided into those with a marked (median: 3.95, range 0.82-4.00) ($P = 0.458$), moderate (median: 3.37, range 1.86-4.00), and mild \textit{H. pylori} infiltrations (median: 2.39, range 0.36-4.00) ($P < 0.001$). Subjects with a marked \textit{H. pylori} infiltration on gastric biopsy had the highest serological titer, whereas in subjects with moderate and mild \textit{H. pylori} infiltrations titers were correspondingly lower ($P < 0.001$). After the successful eradication, significant decreases of the degree of \textit{H. pylori} infiltration ($P < 0.001$), serum anti-\textit{H. pylori} IgG titer ($P < 0.001$), and serum concentrations of PG I ($P = 0.028$) and PG II ($P = 0.028$) were observed.

CONCLUSION: The anti-\textit{H. pylori} IgG assay can be used to estimate the burden of bacteria in immunocompetent hosts with \textit{H. pylori} infection, regardless of the HBsAb titer after HBV vaccination.

Key words: Antibody; \textit{Helicobacter pylori}; Hepatitis B; Immunoglobulin G; Pepsinogen

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Core tip: Koreans receive a routine childhood immunization program, including hepatitis B vaccinations, but serum hepatitis B virus (HBV) surface antibody responses are variable. It is unclear whether the beneficial functional immune aspects inherent in vaccine responders can be translated into a robust immune response after \textit{H. pylori} infection. In this study, the serum anti-\textit{H. pylori} immunoglobulin G (IgG) titer appears to be significantly linked to the bacterial load of the stomach, regardless of the ability of antibody production after HBV vaccination. The serum anti-\textit{H. pylori} IgG assay can be used to estimate the burden of bacteria in immunocompetent hosts with \textit{H. pylori} infection.

INTRODUCTION

\textit{Helicobacter pylori} (\textit{H. pylori}) infection triggers inflammatory and immune responses\textsuperscript{[1,2]}. The serum anti-\textit{H. pylori} immunoglobulin G (IgG) titer is affected by various factors, including bacterial colonization, persistence, virulence, and host immune responses\textsuperscript{[3,4]}. However, the persistence of \textit{H. pylori} over decades in infected individuals suggests that the anti-\textit{H. pylori} IgG does not play a role in the host immune response.

Serum antibody titers depend on the ability of individuals to produce antibodies. It is known that in Koreans, serum titers of the surface antibody against the hepatitis B virus (HBsAb) vary after hepatitis B virus (HBV) vaccinations\textsuperscript{[5]}. Approximately 10% of Koreans do not develop an adequate immune response after they have received a vaccination series, and the rate of non-responsiveness correlates with older age, smoking, male gender, and the presence of chronic diseases\textsuperscript{[6,7]}. Similarly, variable anti-\textit{H. pylori} IgG titers may reflect different immune statuses in individuals with a similar \textit{H. pylori} burden. Taken together with an established link between the HBV vaccine response and immune constitution\textsuperscript{[8,9]}, these findings suggest that the evaluation of the HBsAb response in HBV-vaccinated individuals could provide useful information regarding their immune states.

The immune response via the activation of helper T cells may stimulate production of both the \textit{H. pylori} IgG and HBsAb\textsuperscript{[2,8]}, although the theoretical background underlying this mechanism remains uncertain. Little is known about the serum anti-\textit{H. pylori} IgG titer as a parameter of the immune response to \textit{H. pylori} infection because the knowledge of the \textit{H. pylori} immunopathogenesis is limited. In addition, it is unclear whether the beneficial functional immune aspects inherent in vaccine responders can be translated into a robust immune response after \textit{H. pylori} infection.

In the present study, gastric biopsy samples were analyzed to determine whether there is a correlation between the serum titers of the anti-\textit{H. pylori} IgG and HBsAb in conditions with a similar \textit{H. pylori} burden. In addition, variables that significantly correlated with the serum titers of the anti-\textit{H. pylori} IgG and HBsAb were analyzed.

MATERIALS AND METHODS

Study population

In this cross-sectional study, Korean adults who underwent upper esophagogastroduodenoscopy (EGD) with gastric biopsies for pathology and Giemsa staining, serum pepsinogen (PG) assay, serum anti-\textit{H. pylori} IgG assay and serum HBV surface antigen (HBsAg)/HBsAb assay on the same day at our center were included (Figure 1). The subjects were excluded in following conditions: (1) negative Giemsa staining; (2) positive HBsAg finding; (3) recent medication; (4) history of \textit{H. pylori} eradication; (5) serum anti-\textit{H. pylori} IgG testing other than the Vidas assay; or (6) the presence of disease(s) including any condition related to immunosuppressed state. This study was registered at ClinicalTrials.gov ID: KCT0001302 (https://cris.nih.go.kr) after the approval.
According to the manufacturer’s instructions, negative and the serum PG findings were provided if the index value was equal to 1.0, of < 1.0 and if HBsAb was of < 7.5 mIU/mL, while positive findings were provided if it was of > 12.5 mIU/mL.

Upper gastrointestinal endoscopy and gastric biopsy
Each participant underwent EGD on the same day of blood sampling at our center using GIF-H260 (Olympus, Tokyo, Japan) endoscope. During EGD, gastric biopsy was performed for pathology, histologic assay of H. pylori density and Giemsa staining. The biopsied specimens were fixed in 95% ethanol and embedded in paraffin blocks. Thereafter, the samples were sectioned and stained with hematoxylin and eosin (HE) and Giemsa. Histologic assay of H. pylori density were graded as mild, moderate and marked infiltration. If the density differed according to the biopsied site, the highest density and location were collected for the statistical analysis. Based on the Updated Sydney System, the grades were scored as either none (0), mild (1), moderate (2), or marked (3) for activity (the intensity of acute polymorphonuclear cell infiltrates), inflammation (the intensity of chronic mononuclear cell infiltrates), atrophy, and intestinal metaplasia.

H. pylori eradication and follow-up tests
A first-line therapy was performed with amoxicillin 1 g, clarithromycin 500 mg, and a proton pump inhibitor 20 mg twice daily to the subjects who agreed on H. pylori eradication. Four weeks after the eradication, a urease breath test was carried out. If it was positive, a second-line therapy was performed with tetracycline 500 mg, bismuth 300 mg four times a day, metronidazole 500 mg and a proton pump inhibitor twice a day. Follow-up tests for EGD and serum assays were performed as the initial tests described above.

Statistical analysis
For the statistical analysis, SPSS version 19.0 (SPSS Inc., Chicago, IL, United States) were used. A P-value less than 0.05 was considered statistically significant. Continuous variables were summarized as mean ± SD using the Student’s t-test, while categorical variables were summarized as frequency (%) using the χ²-test. The differences between the groups were compared using the ANOVA test for continuous variables.

The strength of correlation between the serum anti-H. pylori IgG titer and variables were estimated by correlation analysis. For continuous variables that were found to be related to severe H. pylori infiltration on gastric biopsy, a receiver operating characteristic (ROC) curve was constructed by plotting sensitivity (true-positive rate) against 1-specificity (false-positive rate). Accuracies of the significant variables were measured based on the area under the ROC curve (AUC) analysis with a 95%CI and standard error (SE) values.

Follow-up data were analyzed to compare the changes between the subjects with successful eradication.
and those with persistent *H. pylori* infection. For the eradicated subjects, differences between pre- and post-eradication were analyzed using the Wilcoxon signed rank test. In similar, differences between initial and follow-up data were analyzed using the Wilcoxon signed-rank test in the subjects with persistent *H. pylori* infection.

## RESULTS

### Characteristics of the subjects

A total of 111 Korean adults were tested with the Vidas assay, and 74 (66.7%) subjects exhibited a positive HBsAb finding. The degrees of *H. pylori* infiltration on gastric biopsy were mild in 14 subjects, moderate in 23 subjects, and marked in 74 subjects (Table 1). The serum HBsAb findings did not differ between the groups (Table 2). Of all variables, marked degree of *H. pylori* infiltration showed the highest serum anti-*H. pylori* IgG titer (*P* < 0.001) and serum PG II concentration (*P* = 0.021).

### Variables correlated with serum HBsAb titer

There was no significant correlation between serum anti-*H. pylori* IgG titer and serum HBsAb titer (*P* = 0.557). The serum HBsAb titer was not related to any of the tested variables including the counts of platelet and white blood cell (Table 3).

### Variables correlated with serum anti-*H. pylori* IgG titer

The serum anti-*H. pylori* IgG titer was positively correlated with the density of *H. pylori* infiltration on gastric biopsy (*P* < 0.001) and the serum PG II concentrations (*P* = 0.042) using the correlation analysis. However, it was neither related to the positive HBsAb finding (*P* = 0.905) nor the serum HBsAb titer (*P* = 0.557). Distribution of serum anti-*H. pylori* IgG titer according to the *H. pylori* infiltration are shown in Figure 2.

Significant variables for *H. pylori* infiltration were analyzed using the ROC curve analysis (Figure 3). The cut-off value of serum anti-*H. pylori* IgG titer for correlating with severe density of *H. pylori* infiltration was 2.9 AU/mL with sensitivity and specificity values 81.1% and 51.4% (AUC = 0.659, 95%CI: 0.548-0.770, SE = 0.057, *P* = 0.007). However, serum PG II concentration showed no statistical significance (AUC = 0.593, 95%CI: 0.481-0.705, SE = 0.057, *P* = 0.111) on the ROC analysis.

### Subgroup analysis of the followed-up subjects

Of 111 included subjects, 41 were followed up for EGD and serum assays. Of these 41 followed-up subjects, 29 underwent *H. pylori* eradication therapy, and 4 failed on eradication. Therefore, a comparison was made between 25 subjects with successful eradication and 16 subjects with persistent infection (including 4 who failed on eradication). There was no difference on the initial test findings between the eradicated and persistent groups (Table 4).

After *H. pylori* eradication, significant decreases were noticed on the degree of *H. pylori* infiltration (*P* < 0.001), serum PG I concentration (*P* = 0.028) and serum PG II concentration (*P* = 0.028). As a consequence, the serum PG I/II ratio was significantly increased after eradication (*P* = 0.028). On the contrary, there was no significant differences between the initial and follow-up data on *H. pylori* infiltration (*P* = 0.335) and serum PG I/II ratio (*P* = 0.395) in the subjects with persistent *H. pylori* infection.

### DISCUSSION

A significant link has been found between the serum anti-*H. pylori* IgG titer and the bacterial load of the stomach, regardless of the antibody producing capability of the host. Furthermore, significant decreases of the degree of *H. pylori* infiltration, serum anti-*H. pylori* IgG titer, and serum concentrations of PG I and PG II in the subjects with successfully eradicated *H. pylori* infection were observed. At the same time, such changes were not observed in the subjects with persistent *H. pylori* infection. Based on these results, the serum anti-*H. pylori* IgG titer could be considered an indicator of the

### Table 1 Baseline characteristics of the included subjects n (%)

| Variables                          | Subjects (n = 111) |
|------------------------------------|-------------------|
| Age (years old, mean ± SD)         | 55.3 ± 9.7        |
| Gender (male:female)               | 66:45             |
| Serum anti-*H. pylori* IgG titer (AU/mL, mean ± SD) | 3.26 ± 0.97 |
| Serum PG I level (ng/mL, mean ± SD) | 72.0 ± 28.8 |
| Serum PG II level (ng/mL, mean ± SD) | 22.0 ± 9.2 |
| Serum PG ratio (mean ± SD)         | 3.5 ± 1.2         |
| Presence of corpus gastric atrophy as reflected by serum PG assay | 23 (20.7) |
| Degree of *H. pylori* infiltration on biopsy | Mild: 14 (12.6); Moderate: 23 (20.7); Marked: 74 (66.7) |
| Scores based on Updated Sydney system | Activity (mean ± SD): 1.92 ± 0.69; Chronic inflammation (mean ± SD): 2.04 ± 0.38; Atrophy (median with ranges): 0.97 (0-3); Intestinal metaplasia (median with ranges): 0.64 (0-3) |
| Biopsied site                      |                   |
| Antrum                             | 69 (62.2)         |
| Body or angle                      | 36 (32.4)         |
| Fundus or cardia                   | 6 (5.4)           |
| Serum HBsAb titer (mIU/mL, median with ranges) | 102.19 (1-1000) |
| Positive HBsAb assay              | 78 (70.3)         |
| Platelet (× 10^9/μL, mean ± SD)    | 235.3 ± 48.2      |
| White blood cell count (× 10^9/μL, mean ± SD) | 5838.8 ± 1595.9 |
| Neutrophil (%)                     | 56.0 ± 9.3        |
| Lymphocyte (%)                     | 36.4 ± 8.7        |
| Monocyte (%)                       | 4.7 ± 1.6         |
| Eosinophil (%)                     | 1.84 (0-13)       |
| Basophil (%)                       | 0.41 (0-5)        |

HBsAb: Hepatitis B surface antibody; PG: Pepsinogogen; *H. pylori*: *Helicobacter pylori*.
bacterial burden in infected subjects. This finding may lead to novel opportunities toward enhancing *H. pylori* eradication.

*H. pylori* has the ability to persist despite a vast array of host immune responses, which appear to differ between infected subjects[12]. The present findings

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### Table 2: Characteristics of the subjects according to the degree of *H. pylori* infiltration on gastric biopsy

| Variables                          | Mild *H. pylori* infiltration (n = 14) | Moderate *H. pylori* infiltration (n = 23) | Marked *H. pylori* infiltration (n = 74) | P value |
|------------------------------------|--------------------------------------|------------------------------------------|----------------------------------------|---------|
| Age (yr, mean ± SD)                | 54.7 ± 8.4                           | 57.7 ± 12.0                              | 54.7 ± 9.0                             | 0.428   |
| Gender (male)                      | 6 (42.9)                             | 16 (69.6)                                | 44 (59.5)                              | 0.276   |
| Serum anti-*H. pylori* IgG titer (AU/mL)\(^1\) | 2.39 (0.36-4.00)                      | 3.37 (1.86-4.00)                         | 3.95 (0.82-4.00)                       | < 0.001 |
| Serum PG I level (ng/mL, mean ± SD)| 58.0 ± 19.3                          | 75.5 ± 32.6                              | 73.6 ± 28.7                            | 0.146   |
| Serum PG II level (ng/mL, mean ± SD)| 15.6 ± 6.3                           | 22.9 ± 9.5                               | 22.9 ± 9.2                             | 0.021   |
| Serum PG I / II ratio (mean ± SD)  | 4.1 ± 1.7                            | 3.4 ± 1.0                                | 3.4 ± 1.1                              | 0.118   |
| Presence of corpus gastric atrophy as reflected by PG assay | 3 (21.4)                             | 5 (21.7)                                 | 15 (20.3)                              | 0.986   |
| Biopsied site (antrum:body or angle:funus or cardia) | 1:3:0                                 | 15:7:3                                   | 43:26:5                                | 0.625   |

1Values are shown as median with ranges due to asymmetrical distribution. HBsAb: Hepatitis B surface antibody; PG: Pepsinogen; *H. pylori*: *Helicobacter pylori.*

### Table 3: Correlation analysis for the serum anti-*H. pylori* IgG titer and serum HBsAb titer

| Variables                          | Correlation coefficient | P value |
|------------------------------------|-------------------------|---------|
| Serum anti-*H. pylori* IgG titer    |                         |         |
| Old age                            | -0.009                  | 0.924   |
| Increased density of *H. pylori* infiltration | 0.389                  | < 0.001 |
| Increased serum PG I level         | 0.116                   | 0.224   |
| Increased serum PG II level        | 0.194                   | 0.042   |
| Increased serum PG I / II ratio    | -0.18                   | 0.059   |
| Higher degree of activity          | 0.272                   | 0.004   |
| Higher degree of inflammation      | 0.125                   | 0.192   |
| Higher degree of atrophy           | 0.021                   | 0.826   |
| Higher degree of intestinal metaplasia | -0.047             | 0.624   |
| Presence of gastric corpus atrophy as reflected by PG assay | -0.015                  | 0.876   |
| Increased HBsAb titer             | -0.056                  | 0.557   |
| Increased platelet count           | -0.061                  | 0.522   |
| Increased white blood cell count   | -0.078                  | 0.417   |
| Serum HBsAb titer                 |                         |         |
| Old age                            | -0.088                  | 0.358   |
| Increased density of *H. pylori* infiltration | -0.07                  | 0.466   |
| Increased serum PG I level         | 0.046                   | 0.634   |
| Increased serum PG II level        | -0.054                  | 0.572   |
| Increased serum PG I / II ratio    | 0.136                   | 0.154   |
| Higher degree of activity          | 0.077                   | 0.42    |
| Higher degree of inflammation      | -0.112                  | 0.24    |
| Higher degree of atrophy           | 0.036                   | 0.706   |
| Higher degree of intestinal metaplasia | 0.054                   | 0.573   |
| Presence of gastric corpus atrophy as reflected by PG assay | -0.164                  | 0.086   |
| Increased platelet count           | 0.008                   | 0.935   |
| Increased white blood cell count   | -0.069                  | 0.473   |

HBsAb: Hepatitis B surface antibody; PG: Pepsinogen; *H. pylori*: *Helicobacter pylori.*
suggest that the serum anti-*H. pylori* IgG titer is related to the burden of *H. pylori* antigens, because lymphocytes are sensitized to the *H. pylori* antigens and IgG is produced by B cells against a variety of *H. pylori* surface (flagellar) proteins and bacterial toxins. Furthermore, the development of the positive HBV antibody response involves not only the T cell functions, but also other functional pathways, including B cell activity and antigen presentation of the peptide-based vaccine.[6,7,13] These findings suggest that the amount of IgG production via the host immune response upon *H. pylori* infection is more closely related to the burden of *H. pylori* antigens than to the ability of the host to produce antibodies, which is gauged by the serum HBsAb titer.

### Table 4 Findings of the followed-up subjects (n)

| Initial test findings | Successful *H. pylori* eradication (n = 25) | Persistent *H. pylori* infection (n = 16) | P value | Before eradication | After eradication | P value (Z') | Initial Follow-up | P value |
|-----------------------|---------------------------------------------|------------------------------------------|--------|-------------------|------------------|------------|------------------|--------|
| Age (yr, mean ± SD)   | 52.3 ± 7.9                                  | 55.3 ± 12.7                              | 0.351  |                   |                   |            |                   |        |
| Gender (male:female)  | 15:10                                       | 9:07                                     | 1      |                   |                   |            |                   |        |
| Degree of *H. pylori* infiltration on biopsy (mild:moderate:marked) | 4:05:16                                    | 2:04:10                                  | 0.907  |                   |                   |            |                   |        |
| Anti-*H. pylori* IgG titer (AU/mL, mean ± SD) | 3.00 ± 1.17                                | 3.17 ± 0.92                              | 0.632  |                   |                   |            |                   |        |
| PG I level (ng/mL, mean ± SD) | 79.3 ± 31.7                                | 64.9 ± 23.4                              | 0.126  |                   |                   |            |                   |        |
| PG II level (ng/mL, mean ± SD) | 23.4 ± 8.5                                 | 18.9 ± 9.1                               | 0.117  |                   |                   |            |                   |        |
| PG ratio (mean ± SD)  | 3.5 ± 1.1                                   | 3.9 ± 1.5                                | 0.419  |                   |                   |            |                   |        |
| Presence of corpus gastric atrophy as reflected by serum PG assay | 4 (16.0)                                   | 2 (12.5)                                 | 0.566  |                   |                   |            |                   |        |
| HBsAb titer (mIU/mL, median with ranges) | 72.2 (3.1-1000)                            | 170.3 (3.1-1000)                         | 0.632  |                   |                   |            |                   |        |
| Positive HBsAb assay | 16 (64)                                     | 12 (75)                                  | 0.513  |                   |                   |            |                   |        |
| Duration of the follow-up period (months, median with ranges) | 18.1 (2-61)                                | 20.2 (6-41)                              | 0.887  |                   |                   |            |                   |        |

Subjects with successful *H. pylori* eradication (n = 25)

Follow-up test findings

| Degree of *H. pylori* infiltration on biopsy (none:mild:moderate:marked) | 0:4/5:16 | 25:0:0:0 | < 0.001 |            |                   | (-4.520) |                   |        |
| Anti-*H. pylori* IgG assay (negative:lowest:middle: highest quartiles) | 3:2:14:6 | 20:4:1:0 | < 0.001 | (-4.171) |                   |         |                   |        |
| PG I level (ng/mL, mean ± SD) | 79.3 ± 31.7 | 54.2 ± 14.5 | 0.028 | (-2.201) |                   |         |                   |        |
| PG II level (ng/mL, mean ± SD) | 23.4 ± 8.5 | 7.0 ± 1.7 | 0.028 | (-2.201) |                   |         |                   |        |
| PG ratio (mean ± SD) | 3.5 ± 1.1 | 7.8 ± 1.6 | 0.028 | (-2.200) |                   |         |                   |        |
| HBsAb titer (mIU/mL, median with ranges) | 72.5 (3.1-1000) | 18.4 (3.1-1000) | 0.308 |         |                   |         |                   |        |

Subjects with persistent *H. pylori* infection (n = 16)

Follow-up test findings

| Degree of *H. pylori* infiltration on biopsy (none:mild:moderate:marked) | 0:2:4:10 | 1:3:2:10 | 0.335 |            |                   |            |                   |        |
| Anti-*H. pylori* IgG assay (negative:lowest:middle: highest quartiles) | 1:0:8:7 | 0:2:7:7 | 1.18 |            |                   |            |                   |        |
| PG I level (ng/mL, mean ± SD) | 64.9 ± 23.4 | 71.8 ± 25.2 | 1 |            |                   |            |                   |        |
| PG II level (ng/mL, mean ± SD) | 18.9 ± 9.1 | 21.4 ± 10.3 | 0.779 | (10.3) |                   |         |                   |        |
| HBsAb titer (mIU/mL, median with ranges) | 3.9 ± 1.5 | 3.6 ± 0.8 | 0.395 | (3.1-1000) |                   |         |                   |        |

1 Z values are shown for the significant variables using Wilcoxon signed rank test; 2 The serum anti-*H. pylori* IgG titer was compared using the quartiles because it was measured using the Vidas *H. pylori* IgG assay until 2012, and using the Chorus *H. pylori* IgG assay thereafter. SD: Standard deviation; HBsAb: Hepatitis B surface antibody; PG: Pepsinogen; *H. pylori*: Helicobacter pylori.
In the present study, it was found that the serum anti-\textit{H. pylori} IgG titer positively correlated with the degree of \textit{H. pylori} infiltration on the biopsied specimen, regardless of the biopsied site of the stomach. This finding is consistent with the results of previous studies, in which the significance of the serum anti-\textit{H. pylori} IgG titer was demonstrated, and indirectly indicates the relationship between the severity of histological changes and mucosal bacterial density\cite{14-16}. Evaluation of the serum anti-\textit{H. pylori} IgG titer can detect \textit{H. pylori} infection in patients with marked atrophic gastritis and metaplastic gastritis, even in the event of negative biopsy specimens, and provide an indicator of the efficacy of \textit{H. pylori} eradication\cite{17-20}.

Serum PG assays are widely used for the measurements of gastric inflammation\cite{21,22} and in combination with the serum anti-\textit{H. pylori} IgG assay during gastric cancer screening\cite{10,23}. The link between the immune response and \textit{H. pylori} infection-induced gastric inflammation, as measured by the serum PG assay, has been established\cite{24}. In that study, the \textit{Salmonella typhi} (\textit{S. typhi}) IgG seroconversion was more common in the subjects with the \textit{H. pylori} infection than in those without it after anti-\textit{S. typhi} vaccination. In the present study, the serum anti-\textit{H. pylori} IgG titer positively correlated with the serum PG levels and \textit{H. pylori} infiltration in biopsy samples, regardless of the HBsAb titer. This suggests that the bacterial burden directly correlates with the degree of gastric inflammation, despite the differential development and recruitment of specifically committed cells that occurred after the \textit{H. pylori} infection in the subjects.

The limitation of this study is that only 41 subjects underwent the follow-up tests. Furthermore, the serum anti-\textit{H. pylori} IgG titer was followed up using the Chorus \textit{H. pylori} IgG assay (DIESSE Diagnostica Senese, Siena, Italy) because the initially used Vidas \textit{H. pylori} IgG assay was not available after 2012. Despite these limitations, significant differences in the follow-up findings of serum assays and \textit{H. pylori} infiltration were found only in the subjects in whom \textit{H. pylori} eradication was successfully achieved. In support of these observations, a recent study described a high rate of concurrence and similar diagnostic accuracy between the Vidas \textit{H. pylori} IgG assay and the Chorus \textit{H. pylori} IgG assay\cite{25}.

In conclusion, the findings of this study show that the serum anti-\textit{H. pylori} IgG titer is significantly associated with the bacterial load of the stomach, regardless of the antibody producing capability of the host. Although the anti-\textit{H. pylori} IgG response requires preserved function of several immune pathways, it appears that the serum anti-\textit{H. pylori} IgG titer correlates with the intragastric bacterial load rather than with the HBsAb titer. The serum anti-\textit{H. pylori} IgG titer is therefore useful for estimating the bacterial burden of \textit{H. pylori} infection.

**COMMENTS**

**Background**

Serum antibody titters depend on the ability of individuals to produce antibodies. It is unclear whether the beneficial functional immune aspects inherent in hepatitis B virus vaccine responders can be translated into a robust immune response after \textit{Helicobacter pylori} (\textit{H. pylori}) infection.

**Research frontiers**

In this cross-sectional study, consecutive Korean adults were included whose samples had positive Giemsa staining on endoscopic biopsy and were studied in the hepatitis B virus surface antigen (HBsAg)/HBsAb serologic assay, pepsinogen (PG) assay, and anti-\textit{H. pylori} immunoglobulin G (IgG) assay on the same day. This approach allows the authors to demonstrate correlation between serum HBsAb titer and anti-\textit{H. pylori} IgG titer.

**Innovations and breakthrough**

In this study, the authors demonstrated that the serum anti-\textit{H. pylori} IgG titer correlates with the intragastric bacterial load rather than with the HBsAb titer.

**Applications**

The serum anti-\textit{H. pylori} IgG titer is therefore useful for estimating the bacterial...
TERMINOLOGY
Serologic testing for IgG antibodies to *H. pylori* is commonly used noninvasive method to diagnose *H. pylori* infection. The IgG antibody titer is indicative of the severity of gastritis and the presence of *H. pylori*.

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