Kyoto global consensus report on *Helicobacter pylori* gastritis

Kentaro Sugano,¹ Jan Tack,² Ernst J Kuipers,³ David Y Graham,⁴ Emad M El-Omar,⁵ Soichiro Miura,⁶ Ken Haruma,⁷ Masahiro Asaka,⁸ Naomi Uemura,⁹ Peter Malferttheiner,¹⁰ on behalf of faculty members of Kyoto Global Consensus Conference

**ABSTRACT**

**Objective** To present results of the Kyoto Global Consensus Meeting, which was convened to develop a global consensus on (1) classification of chronic gastritis and duodenitis, (2) clinical distinction of dyspepsia caused by *Helicobacter pylori* from functional dyspepsia, (3) appropriate diagnostic assessment of gastritis and (4) when, whom and how to treat *H. pylori* gastritis.

**Design** Twenty-three clinical questions addressing the above-mentioned four domains were drafted for which expert panels were asked to formulate relevant statements. A Delphi method using an anonymous electronic system was adopted to develop the consensus, the level of which was predefined as ≥80%. Final modifications of clinical questions and consensus were achieved at the face-to-face meeting in Kyoto.

**Results** All 24 statements for 22 clinical questions after extensive modifications and omission of one clinical question were achieved with a consensus level of ≥80%. To better organise classification of gastritis and duodenitis based on aetiology, a new classification of gastritis and duodenitis is recommended for the 11th international classification. A new category of *H. pylori*-associated dyspepsia together with a diagnostic algorithm was proposed. The adoption of grading systems for gastric cancer risk stratification, and modern image-enhancing endoscopy for the diagnosis of gastritis, were recommended. Treatment to eradicate *H. pylori* infection before preneoplastic changes develop, if feasible, was recommended to minimise the risk of more serious complications of the infection.

**Conclusions** A global consensus for gastritis was developed for the first time, which will be the basis for an international classification system and for further research on the subject.

**INTRODUCTION**

For decades endoscopic ‘gastritis,’ gastric erosions and even histological findings of gastric inflammation have failed to attract much attention from clinicians as the majority of patients with these findings remain asymptomatic. Although gastritis is often used to describe dyspeptic symptoms, the presence of such symptoms correlates poorly with histological or endoscopic gastritis. Although the term ‘gastritis’ is still used as a concept to explain dyspeptic symptoms, gastritis as a term refers to gastric inflammation, often accompanying structural mucosal changes.¹ This gastric inflammation (gastritis) has long been associated with peptic ulcer, gastric cancer and pernicious anaemia, but the cause or causes of gastritis remain poorly understood. The discovery of *Helicobacter pylori* was a cause of gastritis² focused attention on the aetiology, natural history and prognosis of gastritis.

Worldwide the most common cause of chronic gastritis is infection with *H. pylori*. *H. pylori* causes progressive damage to the gastric mucosa and is now accepted as playing a causative role in a number of important diseases, including duodenal ulcer disease, gastric ulcer disease, gastric adenocarcinoma and gastric mucosa-associated lymphoid tissue (MALT) lymphoma.²⁻⁵ Indeed, *H. pylori*-induced gastritis is considered as the most important risk factor for peptic ulcer and its complications as well as for gastric cancer.⁶

The current International Statistical Classification of Diseases and Related Health Problems (ICD-10), issued in 1990 by the International Conference for the Tenth Revision of the ICD was endorsed by the WHO at the 43rd general assembly in 1990 and has been used for disease statistics since 1994 among member countries of the WHO. In the ICD-10, all the digestive diseases are classified under K code with different two-digit numbers.⁶ However, *H. pylori* was not integrated into gastritis classification in the gastritis section (K29) of ICD-10, even though *H. pylori* gastritis is the predominant type of gastritis and clinically by far the most relevant because of its predisposing role of severe gastro-duodenal complications.²⁻⁵ Moreover, the current ICD-10 classification of gastritis is not organised according to aetiology but is merely a mixture of phenotype and aetiology and also includes duodenitis (box 1). Therefore, a revision of the gastritis and duodenitis classification based on all the possible aetiologies was proposed after the working group meeting for the ICD-11 revision held in Tokyo in 2010 and submitted as the ICD11 β foundation component. However, in the ICD11 β foundation classification (box 2), the original plan was changed. In an attempt to gather broader opinions on the rationale of the new classification system originally proposed to ICD-11, we devoted one section to this important issue at this meeting.

As stated above, if *H. pylori* gastritis is categorised as an infectious disease, the inclusion of *H. pylori* gastritis-associated dyspeptic symptoms as a ‘functional disease’ entity poses a special challenge,⁷,⁸ despite it being implicated in the pathogenesis of functional dyspepsia (FD) symptoms.⁹ Despite the definition given by Rome III,⁹ a conceptual ambiguity on how to deal with *H. pylori* gastritis-associated...
dyspeptic symptoms in the context of the clinical assessment of FD still remains.\(^5\)\(^{10-12}\) Accordingly, guidelines and meta-analyses that included dyspepsia associated with \(H.\) \(p\)ylori under the umbrella of ‘functional dyspepsia’\(^5\)\(^{10-12}\) would require reconsideration in accordance with advances made in the area of \(H.\) \(p\)ylori gastritis.

Third, there has been significant technical progress in diagnostic tools for GI diseases. Advanced endoscopy with image-enhanced modalities and magnification allows diagnosis of gastritis with a high degree of accuracy, even before histological confirmation.\(^13\)\(^-\)\(^15\) Furthermore, non-invasive diagnostic tests such as the \(\text{^{13}C}\) urea breath test, faecal antigen test and serological parameters serve as surrogate markers of gastritis severity.\(^5\) Classification systems for grading gastritis such as the Operative Link for Gastritis Assessment (OLGA) and Operative Link for Gastric Intestinal Metaplasia Assessment (OLGIM) have also been proposed.\(^16\)\(^-\)\(^18\) in addition to the internationally accepted Sydney System,\(^19\)\(^20\) and their utility needs to be evaluated and agreed upon.

In 2013, the Japanese government insurance policy approved eradication therapy for \(H.\) \(p\)ylori-positive gastritis after endoscopic examination, to exclude more serious diseases such as ulcer and cancer, in line with the Japanese guidelines for \(H.\) \(p\)ylori management.\(^11\) However, no global consensus has been published on when to recommend eradication therapy for \(H.\) \(p\)ylori gastritis and how to follow up after eradication.

Since the global awareness of gastritis is still confounded by a number of controversial issues as described above, a meeting was set up in Kyoto to achieve global consensus on \(H.\) \(p\)ylori gastritis; to attempt conceptual changes in gastritis classification in general; to agree diagnosis and management strategies with special reference to FD and cancer prevention.

### Box 1 Current International Statistical Classification of Diseases and Related Health Problems (ICD-10) classification of gastritis (K29 code) http://apps.who.int/classifications/icd10/browse/2015/en#/K29

| K29  | Gastritis and duodenitis               |
|------|---------------------------------------|
| Excl.| eosinophilic gastritis or gastroenteritis (K52.8) |
|      | Zollinger–Ellison syndrome (E16.4)    |
| K29.0| Acute haemorrhagic gastritis          |
| Ind.| Acute (erosive) gastritis with haemorrhage |
| Excl.| erosion (acute) of stomach (K25.–)    |
| K29.1| Other acute gastritis                 |
| K29.2| Alcoholic gastritis                  |
| K29.3| Chronic superficial gastritis         |
| K29.4| Chronic atrophic gastritis           |
|      | Incl: Gastric atrophy                |
| K29.5| Chronic gastritis, unspecified        |
|      | Incl: Chronic gastritis              |
|      | Antral                                |
|      | Fundal                                |
| K29.6| Other gastritis                       |
|      | Incl: Giant hypertrophic gastritis    |
|      | Granulomatous gastritis              |
|      | Ménétrier disease                    |
| K29.7| Gastritis, unspecified                |
| K29.8| Duodenitis                           |
| K29.9| Gastroduodenitis, unspecified         |

Excl, exclusion criteria; Incl, inclusion criteria.

### METHOD

**Consensus development process**

Four major topics were chosen by core members of the organising committee (KS, NU and PM). Drafts of clinical questions (CQs) about each topic were prepared by the ad hoc committee of the Japanese Society of Gastroenterology (JSGE) and were further revised by core members (KS, PM and EME-O). Altogether, 23 CQs were selected for the first round of voting.

Faculty members were selected from members of the JSGE, European Helicobacter Study Group, Asian Pacific Association of Gastroenterology, Healthy Stomach Initiative and the working group members of gastroenterology for ICD-11. These members were assigned to one of the four subgroups by core members (KS, NU and PM) based on their expertise and two members from each subgroup were invited to serve as moderators. The faculty members of each group were assigned one or two CQs for which they were asked to prepare statements and supporting evidence. These statements were edited by moderators and core members and uploaded to the electronic voting system developed by JSGE.

The Delphi method was used for consensus development, and voting by each faculty member was done anonymously through the electronic system. Each faculty member was asked to indicate one of the following levels of agreement: strongly agree, agree with minor reservation, agree with major reservation, disagree with minor reservation, disagree with major reservation and strongly disagree. If the member’s vote was other than strongly agree or agree with minor reservation, they were asked to give the reasons for reservation or disagreement.

Consensus level was predefined as ≥80% of the sum of the votes of strongly agree plus agree with minor reservation. After the first round of voting, moderators in each subgroup initiated further discussion about the statements which failed to reach consensus. After this discussion, the revised statements were uploaded to the electronic voting system for a second round of voting. This process resulted in several CQs being modified for improved understanding and to better fit the statements. At the second round of voting, faculty members were asked to provide recommendation as to the grade of evidence and the levels of supporting evidence for the statements. Recommendation grade and evidence level were based on the GRADE system\(^21\)\(^22\) (see online supplementary table S1 and S2). Electronic reminders were automatically sent to all faculty members twice (3 days and 1 day before the closing dates). Voting rates of 100% were achieved in the two voting sessions.

The second round of voting was followed by a face-to-face meeting in Kyoto on 31 January to 1 February 2014. On the first day, preliminary plenary voting was conducted since faculty members had hitherto been blinded to the voting results in other sections. This process identified several statements which failed to achieve consensus of ≥80%. Each group then met to resolve disagreements and better reflect opinions from all group members. On the second day, the revised statements were presented at plenary discussions with all group members. Voting for each statement was done using a key pad system with the levels of agreements being shown on the screen in real time. Statements that failed to reach consensus were discussed, revised if considered necessary and voted on again. Finalised statements were summarised by moderators assigned to each group.

The five colleagues who could not attend the face-to-face meeting or missed the final voting were invited later to give
Please note that this classification is continuously updated and hence is subject to change. This classification is not authorised by WHO.

2A Classification of gastritis at the foundation layer of ICD11

Helicobacter pylori-induced gastritis
Drug-induced gastritis
Autoimmune gastritis
Stress-induced gastritis

Special forms of gastritis
- Allergic gastritis
- Gastritis due to biliary reflux
- Lymphocytic gastritis
- Ménetier disease
- Eosinophilic gastritis

Infectious gastritis
- Gastric phlegmone
- Bacterial gastritis
H. pylori-induced gastritis
Enterococcal gastritis
Mycobacterial gastritis
Tuberculous gastritis
Non-tuberculous mycobacterial gastritis
Mycobacterium avium-intracellulare gastritis
Gastritis due to other specified non-tuberculous mycobacteria
Secondary syphilitic gastritis
- Viral gastritis
Cytomegaloviral gastritis
Enteroviral gastritis
- Fungal gastritis
Gastritis due to mucormycosis
Gastric candidiasis
Gastric histoplasmosis
- Parasitic gastritis
Gastric anisakiasis
Cryptosporidium gastritis
Gastric strongyloides stercoralis

Gastritis due to other diseases classified elsewhere
- Gastritis due to Crohn’s disease
- Gastritis due to sarcoidosis
- Gastritis due to vasculitis

Gastritis due to external causes
- Alcoholic gastritis
- Radiation gastritis
- Chemical gastritis
- Gastritis due to other specified external causes

Gastritis of unknown aetiology with specific endoscopic or pathological features
- Superficial gastritis
  - Acute superficial gastritis
  - Chronic superficial gastritis
- Acute haemorrhagic gastritis
- Chronic atrophic gastritis

their votes for all the finalised statements without notification of the plenary voting results. The impact of their votes is discussed below.

For management of conflict of interest (COI), each member was asked to present COI status according to the JSGE guidelines. If a relevant COI had existed, that person would have been asked not to vote, in accordance with the recent consensus, but no such case was encountered. The majority of the funding was provided by JSGE with a hand-reach support from industries, which were otherwise not involved in the planning, organisation or manuscript writing and did not join in the discussions.
Guidelines

Process and results

At the first round of voting 16 CQs achieved the predefined consensus level of ≥80%. Six statements failed to reach consensus and each section met to modify their assigned statements based on the comments and opinions received. This led to some questions being split into two or being combined, resulting in 24 CQs, including 25 statements which were subjected to the second round of voting within their assigned group. The results of the second round of voting were disclosed on the first day of the face-to-face meeting in Kyoto. At this stage, all statements except one had achieved consensus. To facilitate further discussion in the break-out sessions, preliminary plenary voting was done to enable the respective section members to consider the opinions of all group members.

On the second day, the finalised CQs and accompanying statements were presented for plenary voting. If consensus levels were not reached, open discussions ensued to modify the statements, followed by voting. All the finalised CQs and statements are shown in the four consensus sections. Levels of recommendation and evidence are shown together with the voting results. For CQ1 to CQ8A, 39 members voted, while 38 voted for CQ8B to CQ14A and 37 voted for CQ14B to CQ22. During the plenary voting, one subdivided CQ (CQ19) was recombined, while another CQ (CQ21) was deleted because of redundancy, resulting in 22 CQs and 24 statements. All voting during the plenary session was done anonymously by an electronic voting system with key pads distributed to each faculty member. The five faculty members who missed the plenary voting session were asked to vote later for the finalised CQs and statements without knowledge of the plenary voting results. Their voting results were almost identical with the plenary voting results. They agreed on all the CQs with the only exception being CQ11, showing 80% (one out of five) agreement. Since there was no inconsistency between the plenary voting and voting by the absentees, combining the two sets of results did not influence the outcome. The entire consensus results are shown below.

CONSENSUS STATEMENT

Section 1. Classification of gastritis in relation to ICD-11

CQ1. Is the current ICD-10 classification for gastritis appropriate?

Statement 1

The current ICD-10 classification for gastritis is obsolete in view of the discovery of H. pylori.

Grade of recommendation: strong
Evidence level: high
Consensus level: 100%

Comment

The ICD-10 classification of gastritis was formulated in 1989 and is still in effect in most countries. At the time of formulation, the ICD-10 classification of gastritis and duodenitis (K29) was rudimentary as it was based on macroscopic and histomorphological criteria; the only aetiological factor assigned was alcohol\(^6\) (box 1). The histological classification of gastritis considered mainly aspects of atrophy and autoimmune.\(^1\)

The discovery of H. pylori had not been taken into account, possibly because even though release came after the discovery of Campylobacter pylori (H. pylori), the role of H. pylori in disease was still controversial. The recognition of H. pylori infection as the primary cause of chronic gastritis proved to be a breakthrough that reopened the chapter on gastritis and its role in disease.\(^2\) At present, no classification of gastritis would be complete without including H. pylori as the aetiological cause.

CQ2. Is the proposed ICD-11 classification for gastritis appropriate?

Statement 2

The newly proposed classification of gastritis in the ICD11 β version is an improvement because it is based on aetiological factors.

Grade of recommendation: strong
Evidence level: moderate
Consensus level: 100%

Comment

Although the ICD-10 has been updated regularly to accommodate new diseases and concepts, WHO recognised the necessity of overall systematic changes in the ICD and decided to revise the current ICD-10 to ICD-11 in 2007. As the intermediate process for this revision, the ICD11 β version was formulated with input from various scientific advisory groups. This version was open to the public so that opinions from various interest groups and a broader range of medical specialists could be reflected before compiling the ICD-11. ICD11 β foundation component consists of the core of the ICD-11 classification from which mortality and morbidity classifications will derive. However, it remains a draft and can be changed from time to time before finalisation of ICD-11 (for more details, please visit http://www.who.int/classifications/icd/revision/betaexpectations/en/).

In the ICD11 β foundation component of the gastritis section, classification of gastritis was principally based on aetiological factors with consideration of their specific pathophysiological principles (box 2). Accordingly, H. pylori gastritis is categorised as a specific nosological entity.

The assessment of gastritis based on histopathological criteria was completely changed after recognition of H. pylori as the most common cause of chronic gastritis. The Sydney System was developed as a consequence and has been integrated into clinical practice. The Sydney classification of gastritis combined histological parameters of activity, chronicity, atrophy, intestinal metaplasia, topographical distribution and aetiopathogenic information for reporting the pathology of gastritis in endoscopic biopsies.\(^19\)\(^20\)

As described above, classification of gastritis in the foundation component of ICD11 β version is principally based on causative factors, in order to cover the three most important and best defined categories of gastritis—namely, (a) H. pylori-induced, (b) drug-induced and (c) autoimmune gastritis. A specific diagnosis among these different categories of gastritis is required to direct specific management and treatment strategies. The diagnosis of H. pylori-induced gastritis has major implications for life-long healthcare. H. pylori gastritis may cause dyspeptic symptoms\(^26\)\(^27\) and result in gastroduodenal pathologies, including peptic ulcer disease (PUD) and gastric cancer. The recognised role of H. pylori as a carcinogen makes eradication of H. pylori infection the preferred strategy for the prevention of gastric cancer.\(^11\)\(^12\)\(^28\) There is more to learn about aetiologies other than H. pylori in gastritis and this is dealt with as ‘H. pylori-negative or idiopathic gastritis’.\(^29\)

The proposed aetiology-based classification for gastritis in the foundation component of ICD11 β version was further refined by this consensus meeting (box 3). Clinical validation is needed to further define and confirm the usefulness of the new classification.

Furthermore, duodenitis, which was in the gastritis section in ICD-10, is now categorised in an independent section in the
Box 3 Aetiology-based classification of gastritis (3A) and duodenitis (3B). A proposal according to the consensus at the Kyoto consensus conference

3A Proposed classification of gastritis in the Kyoto consensus conference

**Autoimmune gastritis**

- Helicobacter pylori-induced gastritis
- Bacterial gastritis other than *H. pylori*
- *Helicobacter heilmannii* gastritis
- Enterococcus gastritis
- Mycobacteria gastritis
- Secondary syphilitic gastritis

**Gastritis due to specified causes**

- Gastric phlegmone
- Viral gastritis
- Enteroxiral gastritis
- Cytomegalovirus gastritis

**Gastritis due to external causes**

- Drug-induced gastritis
- Alcoholic gastritis
- Radiation gastritis
- Chemical gastritis
- Gastritis due to duodenal reflex
- Gastritis due to other specified external cause

**Gastritis due to other diseases classified elsewhere**

- Gastritis due to Crohn’s disease
- Gastritis due to sarcoidosis
- Gastritis due to vasculitis
- Gastritis due to Henoch–Schönlein purpura
- Gastritis due to coeliac disease

Duodenitis due to external causes

- Alcoholic duodenitis
- Chemical duodenitis
- Radiation duodenitis
- Duodenitis due to other external causes
- Drug-induced duodenitis

Duodenitis due to specified causes

- Allergic duodenitis
- Eosinophilic duodenitis
- Lymphocytic duodenitis

Duodenitis due to other diseases classified elsewhere

- Duodenitis due to Crohn’s disease
- Duodenitis due to sarcoidosis
- Duodenitis due to vasculitis
- Duodenitis due to Henoch–Schönlein purpura
- Duodenitis due to coeliac disease

Statement 3

It is useful to categorise *H. pylori*-induced gastritis according to gastric subsites, because the risks of gastric cancer and peptic ulcer are affected by the patterns of gastritis.

Grade of recommendation: strong

Evidence level: high

Consensus level: 97.4%

Comment

The categorisation of *H. pylori* gastritis according to gastritis subsites is critically important for identifying those patients who remain at high risk after *H. pylori* eradication and thus are candidates for regular endoscopic and histological follow-up. Patients with severe atrophic gastritis (with or without intestinal metaplasia) in the corpus or with severe corpus predominant gastritis are those at highest risk for progression to gastric cancer of the intestinal type and for diffuse-type gastric cancer. In diffuse-type gastric cancer the prevalence of antral atrophic gastritis is almost identical to that seen in the intestinal type but is slightly less with corpus atrophic gastritis than with intestinal type gastric cancer.38

CQ4. Is it necessary to categorise gastritis according to histology (severity) and/or endoscopy?

Statement 4

It is advisable to categorise gastritis according to histology, because the risk of development of gastric cancer in *H. pylori*...
Gastritis varies according to the extent and severity of inflammation and atrophy.

Comment
The updated Sydney System has been globally implemented into clinical practice and requires proper assessment of all the relevant characteristics of *H. pylori* gastritis including atrophy and intestinal metaplasia at different gastric subsites. Categorising gastritis is clinically relevant because the ‘phenotype’ of *H. pylori* gastritis determines the risk of progression to gastroduodenal complications.

Severity and extent of atrophic gastritis and intestinal metaplasia are well established as indicators of the increased risk for developing gastric cancer. Similarly, severe *H. pylori*-induced corpus gastritis is associated with an increased risk for gastric cancer. New staging systems for the characterisation of gastritis have been introduced to assess the gastric cancer risk. They are used in clinical practice and are either based on the severity of atrophy in various gastric subsites (OLGA) or on intestinal metaplasia (OLGIM). Both systems, discussed further in section 3, are reported to have a positive impact on patient management.

CQ5. How should we classify gastric erosions in the context of chronic gastritis?

Statement 5
Gastric erosions should be reported separately from gastritis. The natural history and clinical significance of gastroduodenal erosions depend on aetiology and need further clarification.

Comment
Gastric erosions are defined as superficial mucosal breaks with a diameter of ≤3 mm or <5 mm. This small size makes it less likely to confound erosions with peptic ulcers which, by definition, penetrate the muscularis mucosae.

Gastric erosions can be detected in the context of *H. pylori* infection but are more frequently caused by intake of mucosal damaging drugs—in particular, aspirin and non-steroidal anti-inflammatory drugs (NSAIDs). Furthermore, several different morphological forms were noted after eradication of *H. pylori* as (a) flat, (b) raised, (c) haemorrhagic and (d) appearing as bleeding spots with localisation in the antrum in the absence of drugs, possibly owing to hyperacidity after eradication therapy.

From a clinical perspective, the most relevant aspect of erosions is that patients taking NSAIDs and having numerous erosions in the stomach are at increased risk of developing ulcers subsequently.

Few studies on the clinical significance or natural history of gastric or duodenal erosions have been reported. Thus, it is important to conduct a prospective research in which erosions in the stomach and duodenum are separately reported in conjunction with the category of gastritis, which is needed to better understand the natural history of gastric erosions and their potential to progress to ulceration and bleeding. Validated scores for reporting erosions for research purposes should be used.

CQ6. Is *H. pylori* gastritis an infectious disease irrespective of symptom and complications?

Statement 6
*H. pylori* gastritis should be defined as an infectious disease, even when patients have no symptoms and irrespective of complications such as peptic ulcers and gastric cancer.

Comment
*H. pylori* gastritis is an infectious disease and leads to chronic active gastritis of varying severity in virtually all infected subjects. There is a significant variability in the interindividual expressions of gastric mucosal structural damage and accordingly the associated physiological perturbations also vary. *H. pylori* gastritis may remain clinically unapparent or evolve into severe complications. The rate of progression is unpredictable. The most severe clinical expression is gastric cancer, which is often incurable by the time of diagnosis.

Cure of *H. pylori* infection leads to healing of the inflamed gastric mucosa, which may return to normal. *H. pylori* eradication may improve or resolve dyspeptic symptoms and usually cures PUD. *H. pylori* gastritis is a disease which can be cured and thus prevent severe complications. If *H. pylori* gastritis has progressed to more severe forms of gastritis, including atrophic gastritis with or without intestinal metaplasia, or severe corpus predominant gastritis, the risk of gastric cancer is increased and eradication of the infection at this stage needs to be integrated with a follow-up strategy.

Section 2 Dyspepsia associated with *H. pylori* infection

CQ7. Does *H. pylori* gastritis cause dyspepsia?

Statement 7
*H. pylori* gastritis is the cause of dyspepsia in a subset of patients.

Comment
A large number of observations support the conclusion that *H. pylori* infection may be a cause of symptoms in a proportion of patients presenting with dyspepsia. First, acute iatrogenic or self-administered infection with *H. pylori* can induce acute dyspeptic symptoms. However, while persistent colonisation virtually always leads to chronic gastritis, in the majority of individuals severe dyspeptic symptoms are transient. Second, most but not all, epidemiological studies show associations between *H. pylori* infection and (uninvestigated) dyspeptic symptoms. The most convincing evidence can be derived from *H. pylori* eradication studies in infected patients with uninvestigated or FD. In these studies, eradication is associated with a small but statistically significant benefit for symptom control over no eradication; the estimated number needed to treat is 14 and in a more recent study the number was 8. At present there are no criteria to predict whether a patient with dyspeptic symptoms will respond to eradication therapy or not. Therefore, the only way in clinical practice is to eradicate the *H. pylori* infection and see whether symptoms resolve or whether additional treatments will be required. The symptomatic gain takes at least 6 months to become significant over no eradication and this has been attributed to the time it takes for gastritis to recover.
CQ8. Should we categorise H. pylori-associated dyspepsia as a specific entity?

**Statement 8A**

In H. pylori-infected patients with dyspepsia, symptoms can be attributed to H. pylori gastritis if successful eradication therapy is followed by sustained symptom remission.

- **Grade of recommendation:** strong
- **Evidence level:** high
- **Consensus level:** 97.4%

**Statement 8B**

H. pylori-associated dyspepsia (as in statement 8A) is a distinct entity.

- **Grade of recommendation:** strong
- **Evidence level:** moderate
- **Consensus level:** 92.1%

**Comment**

Based on the Rome III consensus, FD is defined as “the presence of chronic dyspeptic symptoms (postprandial fullness, early satiation, epigastric pain or burning) without evidence of structural disease (including at upper endoscopy) that is likely to explain the symptoms” (figure 1). This group was contrasted with those in whom chronic dyspeptic symptoms have an identified organic or metabolic cause, where elimination of that cause or improvement of the disease leads to resolution or improvement of symptoms.

The Rome III consensus mentions a subset of patients with H. pylori gastritis as representative of organic dyspepsia if they respond to eradication. Patients with H. pylori gastritis in whom symptoms persist despite eradication therapy eliminating the infection were identified as having FD. As mentioned above, eradication therapy studies showed that a subset of H. pylori-infected patients with FD derive symptomatic benefit from eradication, with a delay of at least 6 months from cure of the infection.

Based on these considerations, sustained symptom control after successful eradication identifies H. pylori as the organic cause of the symptoms in these patients and provides the rationale to consider H. pylori-associated dyspepsia as a separate clinical entity. H. pylori-infected patients with chronic dyspeptic symptoms and negative endoscopy are now treated and labelled depending on their treatment response as outlined in figure 1.

CQ9. Is eradication of H. pylori infection first-line treatment for improving dyspeptic symptoms?

**Statement 9**

Eradication of H. pylori is first-line treatment for H. pylori-infected dyspeptic patients.

- **Grade of recommendation:** strong
- **Evidence level:** high
- **Consensus level:** 94.7%

**Comment**

As is apparent from statement 8, there is a group of patients with FD for whom H. pylori is considered the cause of their symptoms, and this can be established if eradication is associated with sustained symptom benefit. This scenario is the only one where patients with chronic dyspeptic symptoms and a negative endoscopy can be ‘cured’, albeit with some delay after successful eradication therapy. Moreover, very few effective alternative therapeutic approaches have been proven to have substantial and sustained benefit in FD. Finally, eradication therapy is a short treatment, with acceptable cost–benefit for controlling dyspeptic symptoms, and with other potential benefits for prevention of peptic ulcer and gastric cancer.

Based on these considerations, eradication therapy can be proposed as first-line treatment for H. pylori-infected dyspeptic patients, which is in line with a recent management algorithm by the Rome foundation.

CQ10. How effective is H. pylori eradication on dyspeptic symptoms—in the short and long term—and how does it compare with other treatments (such as proton pump inhibitors (PPIs))?

**Statement 10**

In H. pylori-infected dyspeptic patients, eradication therapy for dyspeptic symptoms is better than placebo and is the preferred option.

- **Grade of recommendation:** strong
- **Evidence level:** high
- **Consensus level:** 97.4%

**Comment**

Eradication therapy studies have confirmed that a subset of H. pylori-infected patients with FD is relieved of dyspeptic symptoms by eradication therapy. To date, only a limited number of studies have directly compared eradication therapy with other treatments that are used for FD, such as PPIs or proton pump inhibitors. Eradication is the preferred treatment. Future trials should compare eradication with treatment modalities other than placebo in H. pylori-infected patients with chronic dyspeptic symptoms and a negative endoscopy.

CQ11. Should patients who remain dyspeptic after successful H. pylori eradication be considered to have FD?

**Statement 11**

Figure 1 Diagnostic algorithm of Helicobacter pylori-associated dyspepsia. Patients with dyspeptic symptoms after negative routine laboratory and upper gastrointestinal endoscopy except for positive H. pylori tests, should undergo eradication therapy. If sustained symptomatic relief is obtained, their dyspeptic symptoms are considered as H. pylori-associated dyspepsia. On the other hand, if dyspeptic symptoms do not resolve or recur after eradication therapy, they are judged to have functional dyspepsia. EGD, oesophagogastroduodenoscopy.
Patients who remain symptomatic after successful *H. pylori* eradication should be considered to have FD.

Grade of recommendation: weak
Evidence level: moderate
Consensus level: 97.4%

Comment
As indicated in statements 8A and 8B and in agreement with the Rome III criteria,96 2 *H. pylori* infected dyspeptic patients with negative endoscopy who experience sustained symptom control are labelled as having *H. pylori*-associated dyspepsia. Conversely, when symptoms do not benefit in the long term from successful eradication, this indicates that *H. pylori* gastritis did not cause the symptoms in these patients. Consequently, they can keep the label ‘functional dyspepsia’ (figure 1).

Section 3 Diagnosis of gastritis
CQ12. Is it possible to make a diagnosis of atrophy and/or intestinal metaplasia by endoscopy?

Statement 12
Atrophic mucosa and intestinal metaplasia can be accurately detected by image-enhanced endoscopy, after appropriate training.
Grade of recommendation: strong
Evidence level: high
Consensus level: 84.2%

Comment
Conventional endoscopy is, in most hands, an inadequate tool for diagnosing atrophy and intestinal metaplasia and therefore it remains mandatory that a biopsy is carried out, allowing histomorphological assessment of the gastric mucosa according to the Sydney classification.19 20 However, image-enhanced endoscopy has improved the accuracy and reproducibility of endoscopic diagnosis of premalignant gastric lesions. This includes chromoendoscopy,65 high-resolution magnification endoscopy66 67 and image-enhanced endoscopy combined with magnification,15 68–72 (figure 2). These methods are now routinely available in Japan and will be increasingly used worldwide. Adequate evaluation of the stomach mucosa with each of these methods requires appropriate training66 and offers the advantage of targeted biopsies.

CQ13. Is the updated Sydney System appropriate for histological diagnosis of gastritis?

Statement 13
Accurate histological assessment of gastritis requires biopsy sampling of both antrum and corpus.
Grade of recommendation: strong
Evidence level: high
Consensus level: 92.1%

Comment
Premalignant lesions of the stomach may be unevenly distributed. Therefore, accurate histological assessment of gastritis requires biopsy sampling of both antrum and corpus. This may facilitate the classification and grading of preneoplastic gastric lesions.73 Various studies have shown that more extensive biopsy sampling increases the diagnostic yield for identifying patients with premalignant lesions and provides a better overview of the severity and distribution of these lesions.74–76 This also has practical limitations, which led to the updated Sydney System. This provides guidance on the methods of sampling and the histopathological grading of individual abnormalities—in particular, inflammation, gland loss and metaplasia.20 The Sydney System recommends routine

---

**Figure 2** Image enhanced endoscopy. (A) Narrow band imaging (NBI) of the gastric mucosa. Round homogeneous sized pits with regularly arranged collecting venules are shown (left). This pattern (regular arrangement of collecting venules) named ‘RAC’ pattern in the corpus mucosa highly indicates a *Helicobacter pylori* negative state.13 In the *H. pylori*-infected mucosa with inflammation, pit patterns are elongated, varied in sizes and shapes with spaces between them. Collecting venules are obscured owing to inflammation (centre).14 When intestinal metaplasia develops, the pit pattern is further elongated with light blue lines (light blue crest sign) decorating the pits margins (right).66 The images were provided by Dr Kazuyoshi Yagi. (B) Blue laser imaging (BLI) of the gastric mucosa. BLI is a new modality of image enhancement.70 The BLI-bright mode can easily obtain lower magnification images, similar to the NBI images in (A) (left). With BLI-magnification mode, further mucosal details including periglandular capillary networks (red coloured circles surrounding the pits) are seen (centre). BLI endoscopy is useful for identifying the area of intestinal metaplasia where greenish coloured elongated pit patterns predominate (right). The images were provided by Dr Hiroyuki Osawa, Jichi Medical University.
sampling of five gastric biopsy specimens: antrum greater and lesser curvature, incisura and corpus greater and lesser curvature. Specimens need to be put into separate vials and grouped for each site or lesion. The system is widely used; the most common modification being to leave out the separate incisura sample. It is of key importance that separate specimens are obtained from endoscopically visible lesions. The accuracy of image-enhanced endoscopy in trained hands further increases the yield of targeted biopsies.

CQ14. Are grading systems such as OLGA and OLGIM useful for risk stratification?

Statement 14A
Gastric cancer risk correlates with the severity and extent of atrophic gastritis.
Grade of recommendation: strong
Evidence level: high
Consensus level: 94.7%

Statement 14B
Histological staging systems such as OLGA and OLGIM are useful for risk stratification.
Grade of recommendation: strong
Evidence level: low
Consensus level: 97.3%

Comment
Most gastric cancers are triggered by longstanding gastritis, primarily due to H. pylori infection. This can occur via a multistep pathway of precancerous lesions—in particular, atrophic gastritis, intestinal metaplasia and dysplasia—intraepithelial neoplasia. Various studies confirm an increased gastric cancer risk in patients with premalignant gastric lesions. For instance, a nationwide study from the Netherlands including approximately 98,000 patients with premalignant gastric lesions reported, on average, a 2-3% gastric cancer risk over 10 years. This risk varied with the baseline stage of premalignant lesions, being 0.8%, 1.8%, 3.9% and 32.7% for patients with atrophic gastritis, intestinal metaplasia, mild-to-moderate dysplasia and severe dysplasia, respectively.

These data confirmed the association between presence of premalignant gastric lesions and development of gastric cancer, yet also showed that the risk for developing gastric cancer in an individual with premalignant lesions is nevertheless small (2-6 per 1000 people per year). This necessitates the use of risk stratification methods.

Gastric biopsy sampling can be used to provide the most important information for risk classification. This led to the OLGA staging system. This histological staging system grades patients with gastritis into stages with corresponding gastric cancer risk. Further studies showed that this staging system provides relevant clinical information. Based on the high prevalence of atrophic gastritis in at-risk populations and the limited reproducibility and high interobserver variability in histological diagnosis of atrophic gastritis, a further proposal was made for the OLGIM system based on diagnosis and distribution of intestinal metaplasia.

The interobserver reproducibility was improved for intestinal metaplasia compared with atrophic gastritis, and the correlation between the severities of gastritis remained at least as strong. Subsequent studies with both the OLGA and OLGIM systems showed a higher gastric cancer risk in patients in stage III or IV of OLGA or OLGIM. As a result, upper gastrointestinal surveillance endoscopy should be offered to patients in these subcategories.

CQ15. Are serological tests (pepsinogen I, II, I/II, H. pylori antibody) useful for risk stratification?

Statement 15
Serological tests (pepsinogen I and II and H. pylori antibody) are useful for identifying individuals at increased risk for gastric cancer.
Grade of recommendation: strong
Evidence level: high
Consensus level: 91.9%

Comment
Serological tests for the diagnosis of chronic gastritis and gastric atrophy have been in use for more than 25 years. These include H. pylori serology (crude antigen with or without additional determination of anti-CagA antibodies) for the diagnosis of gastritis, and serum pepsinogen I and II and gastrin for the diagnosis of gland loss resulting in hypoacidity. These tests are usually applied in panels of multiple tests and have been shown to be a useful non-invasive diagnostic tool in an individual patient, and as a population screening and surveillance tool. A Japanese cohort of 9293 screenees underwent serological assessment by means of H. pylori serology and pepsinogen I and II measurement. The annual progression to gastric cancer was very low in subjects with normal pepsinogens, irrespective of H. pylori status. The annual progression to gastric cancer was substantially higher (3.5-6 per 1000 per year) in individuals with low serum pepsinogen levels, compatible with presence of atrophic gastritis. In the latter group, the incidence of gastric cancer was higher among those with negative H. pylori serology than among those with positive H. pylori serology, which is indicative of progressive and widespread atrophy and metaplasia impairing further H. pylori colonisation. Similar findings were obtained in other studies.

CQ16. When is it appropriate to search and screen for H. pylori gastritis?

Statement 16
Depending on the epidemiological context, it is appropriate to search and screen for H. pylori gastritis at an age before development of atrophic gastritis and intestinal metaplasia.
Grade of recommendation: strong
Evidence level: moderate
Consensus level: 97.3%

Comment
H. pylori infection is mainly acquired in childhood, up to the age of 12 years, in developed countries mostly by intrafamilial transmission. The bacterium and associated gastritis persist lifelong, unless treated by eradication therapy, or unless end-stage widespread atrophic gastritis and intestinal metaplasia occur. The risk for gastric cancer depends on the grade of gastric atrophy and intestinal metaplasia. H. pylori eradication can reduce the risk for cancer, but this effect is largely confined to patients without atrophy and metaplasia. In patients with these lesions, H. pylori eradication reduces gastritis, but may not stop further progression to cancer. As a result, cancer can occur more than 10 years after H. pylori eradication treatment. Against this background, it is appropriate to search and screen for H. pylori gastritis at an age when new infections become less likely (>12 years) and before development of atrophic gastritis and intestinal metaplasia. This all depends on the geographical location and epidemiological context, taking into account the prevalence of infection and age-related cancer incidence.
Section 4 Management of gastritis

CQ17. Should all H. pylori-positive individuals receive eradication therapy?

Statement 17

H. pylori infected individuals should be offered eradication therapy, unless there are competing considerations.

Grade of recommendation: strong
Evidence level: high
Consensus level: 100%

Comment

H. pylori is a major human pathogen that causes chronic and progressive gastric mucosal damage and is aetiologically related to peptic ulcer, gastric cancer and gastric atrophy. It is also closely associated with gastric MALT lymphoma, dyspepsia, hyperplastic gastric polyps and idiopathic thrombocytopenic purpura.12 46 47 61 98–104 H. pylori-positive individuals are also the major reservoir for transmission of the infection.

The decision to eradicate a chronic infection in a society should be based on quantitative data regarding the outcome of untreated infections. H. pylori causes a chronic infection, similar, for example, to asymptomatic syphilis or tuberculosis, and the final outcome for any individual cannot be predicted.105 H. pylori infection differs from many other chronic infectious diseases because it is always transmissible, thus putting others at risk. Because the gastric damage is progressive, the lack of an obvious clinical manifestation at diagnosis has no predictive value for life-time risk to an individual patient, their family or to the community. Benefits of H. pylori eradication for an individual depend in part on the degree and extent of damage that has already occurred and the reversibility of that damage. Potential benefits of eradication include stopping the progression of mucosal damage, stabilisation or reduction in risk of developing gastric cancer, resolution of mucosal inflammation, stabilisation or improvement of gastric mucosal function, return of the normal mechanisms governing acid secretion, cure of H. pylori-related PUD, reduction in risk of gastrointestinal complications of NSAID therapy and prevention of future development of H. pylori-related peptic ulcer.2 5 11 28 46 47 106–115

For society, the benefits include reduction of the reservoir of infected individuals capable of transmitting the infection to others, and avoidance of the costs associated with diagnosis, management and outcomes of H. pylori-related diseases that are prevented. Thus, H. pylori-infected patients should be offered eradication therapy unless there are competing considerations such as comorbidities, re-infection rates in their communities, competing health priorities of society and financial cost. It has to be remembered, however, that there are concerns about the negative impact of eradication therapies on human health, such as increase in allergy or obesity and perturbation of microbiota.116 117

CQ18. What is the optimal timing for H. pylori eradication in asymptomatic subjects?

Statement 18

The maximum benefit of H. pylori eradication is obtained if it is done while the mucosal damage is still non-atrophic.

Grade of recommendation: strong
Evidence level: high
Consensus level: 100%

Comment

H. pylori eradication always confers a benefit by halting progression of gastric mucosal damage, reducing the reservoir of infected individuals and reducing or preventing H. pylori-associated diseases. The maximum benefit of eradication for an individual is obtained if eradication is done while the H. pylori-induced mucosal damage has not progressed beyond the non-atrophic stage. This population is found in countries where gastric cancer is still prevalent and is concentrated in the younger generation. H. pylori eradication of adolescents and young adults has an additional advantage of reducing or preventing transmission of the infection to their children.

As noted above (Section 3), the risk for development of gastric cancer correlates with the extent and severity of atrophic gastritis. It is impossible to define the risk for an individual based on age. Cancer risk in any population relates to the rate of progression of gastric mucosal damage, which is high in populations at high risk of cancer and low in H. pylori-infected populations with a low cancer risk. Thus, while it is possible to identify an average age at which the transition from non-atrophic to atrophic phenotype occurs for any population, one should expect that any age group will contain individuals with a wide range of damage, ranging from uninfected (normal) to advanced atrophy. This emphasises the need for risk stratification based on objective parameters including a validated histological staging system rather than on age, to identify whether one eradication treatment is needed or whether the patient might require surveillance.

The incidence of gastric cancer increases with age, which is a surrogate marker for the time required for progression of atrophic gastritis. When atrophic gastritis becomes extensive and severe, the risk increases exponentially. Cancer is the culmination of a multistep process of genetic instability, with cancer cells possessing mutations in coding regions, somatic gene rearrangements and epigenetic changes such as methylation. Current data are consistent with the notion that H. pylori eradication halts the progression of damage and reduces or eliminates the H. pylori-associated events that increase genetic instability in the gastric mucosa. These include infection-associated DNA double-strand breaks,118 impaired DNA mismatch repair,119 aberrant activation-induced cytidine deaminase expression, which induces nucleotide alterations involved in DNA mutations,120 aberrant methylation in a number of gene promoters in the gastric mucosa, including cell growth-related genes, DNA-repair genes, tumour-suppressor genes, the cell adhesion gene E-cadherin and CpG islands of microRNA genes121–123 and aberrant microRNA expression.124 H. pylori infection also causes an inflammatory response with mucosal infiltration of acute and chronic inflammatory cells. Cancer risk is increased in relation to the ability of the infecting strain to cause inflammation (eg, those possessing the Cag pathogenicity island). However, all strains cause inflammation, and gastric cancer is associated with infections lacking putative virulence factors. Thus all H. pylori infections should be considered pathogenic and should be eradicated.

Because of the damage and premalignant changes, H. pylori eradication cannot ‘reset the clock’ to zero (ie, no risk) but can stop the progression of risk and stabilise or decrease the subsequent risk.

CQ19. Do we need to adopt eradication regimens according to the geographical area?

Statement 19

Eradication regimens should be based on the best locally effective regimen, ideally using individual susceptibility testing or community antibiotic susceptibility, or antibiotic consumption data and clinical outcome data. The agents available differ in...
different regions and this, in part, dictates what regimens are possible.

Grade of recommendation: strong
Evidence level: high
Consensus level: 100%

Comment
The success of a proven successful H. pylori eradication regimen depends on the pattern of resistance in the population and on the common host genotypes of drug metabolising enzymes in the population. The prevalence of H. pylori resistance to commonly used antimicrobial agents greatly varies geographically and is linked to consumption of antibiotics in the region, so the preferred eradication regimen often differs between regions. Ideally, treatment regimens should be chosen based on susceptibility testing. Within any region, only regimens that reliably produce eradication rates of ≥90% in that population should be used for empirical treatment.5 126–129

CQ20. Does eradication of H. pylori prevent gastric cancer?
Statement 20
Eradication of H. pylori reduces the risk of gastric cancer. The degree of risk reduction depends on the presence, severity and extent of atrophic damage at the time of eradication.
Grade of recommendation: strong
Evidence level: high
Consensus level: 100%

Comment
H. pylori infection is the most important cause of gastric cancer as it is estimated that 89% of non-cardia gastric cancer, representing 78% of all cases of gastric cancer, can be attributed to chronic H. pylori infection.130 Prevention of H. pylori infections removes the primary cause of gastric cancer and will thus reduce the incidence of gastric cancer in that population. The effectiveness of H. pylori eradication for prevention of gastric cancer depends on the severity and extent of atrophic damage at the time of eradication and ranges from essentially complete prevention for those with non-atrophic gastritis to stabilisation or reduction of risk in those with established atrophic changes.94–95 As noted in Section 3, risk can be stratified using a variety of approaches, such as one of the validated histological stratification systems (eg, OLGA or OLGIM),16–18 and H. pylori eradication can stabilise risk and halt the progression of risk.94 Prevention of acquisition of H. pylori infections and eradication of the infection before the development of atrophic changes are forms of primary prevention. Secondary prevention involves identification and surveillance of those at risk in order to remove intraepithelial lesions and early gastric cancer(s) before they become invasive.5 71 72 77 131 There may be also a role for cancer immunotherapy to treat premalignant lesions and halt their progression to more advanced lesions.132

CQ21. Should the outcome of eradication therapy always be assessed (ie, test for cure)?
Statement 21
The outcome of eradication therapy should always be assessed, preferably non-invasively.
Grade of recommendation: strong
Evidence level: high
Consensus level: 100%

Comment
Failure of eradication is common and allows the mucosal damage to progress, and so eradication should always be confirmed, preferably using a non-invasive test such as a urea breath test or a validated monoclonal-based stool antigen test.3 For patients requiring endoscopic follow-up, such as after endoscopic removal of a gastric adenoma, histological assessment can be used. Confirmation of cure also provides an early warning system for the increasing antibiotic resistance in a population that will manifest as increasing rates of treatment failure.128 129

CQ22. Which patients need long-term follow-up after eradication?
Statement 22
H. pylori eradication may not completely eliminate the risk of gastric cancer. Patients who remain at risk, as defined by the extent and severity of atrophy, should be offered endoscopic and histological surveillance.
Grade of recommendation: strong
Evidence level: high
Consensus level: 97.3%

Comment
Long-term follow-up such as regular endoscopic surveillance should be based on estimating the risk of developing gastric cancer after H. pylori eradication (ie, risk stratification).93 133 Cancer risk correlates with the extent and severity of atrophic gastritis and risk stratification should be confirmed using a validated histological risk scoring systems such as OLGA or OLGIM.16–18 In areas with proven expertise in endoscopic scoring, a system such as that of Kimura and Takemoto can be used initially, although histological confirmation is still recommended.134 135 Patients whose H. pylori infection was diagnosed non-invasively (eg, urea breath test or stool antigen) should be considered for histological assessment. These patients should include those within the age range in which atrophic changes are common in that population and those with a history of gastric ulcer as well as those with a pretreatment serum pepsinogen I of ≤70 ng/mL and a pepsinogen I:II ratio ≤3.136–138 All those at especially high risk, including those at risk for intraepithelial neoplasia (dysplasia) or early gastric cancer, are candidates for regular endoscopic surveillance.

DISCUSSION
The global consensus meeting on H. pylori gastritis has set a new landmark for gastritis, which has continued to be an ill-conceived clinical entity placed between a histological picture and upper abdominal symptoms.

In spite of the fact that gastritis had been long recognised as an important clinical entity, generations of gastroenterologists have neglected the importance of treatment of this nosological entity. Rudolf Schindler described chronic gastritis as a serious disease and a precursor of gastric cancer and considered their relationship as being of outstanding importance in the fight against gastric cancer.139

The discovery of H. pylori has revolutionised the pre-existing concepts of gastritis by assigning a specific aetiology to this entity underlying PUD and gastric cancer. The majority of these serious conditions are manifestations developed on the background of chronic gastritis caused by a unique infectious agent, H. pylori. For PUD, guidelines unanimously recommend eradication as the primary treatment for those with positive H. pylori tests. However, there has been no consensus on how and when to manage individuals with H. pylori gastritis itself, which is crucial to the efficiency of gastric cancer prevention because most patients with chronic gastritis may remain asymptomatic until the appearance of severe complications. Furthermore, both gastritis and duodenitis were recognised as important causes of upper gastrointestinal bleeding,140 encouraging our attention to

Guidelines
Sugano K, et al. Gut 2015;64:1353–1367. doi:10.1136/gutjnl-2015-309252

1363
these conditions now that anti-thrombotic therapies are increasingly being used.

To further compromise the concept of gastritis as a significant clinical entity, the term ‘gastritis’ has historically, but wrongly, been used as a substitute for a clinical diagnosis of FD. Historical studies, however, failed to demonstrate a significant association between histological findings of gastritis and the dyspeptic symptom complex.\(^1\)\(^\text{141}^{142}\) Hence, a potential pathogenetic role for *H. pylori* in causing dyspeptic symptoms was initially considered doubtful and its eradication in FD controversial.\(^1\)\(^\text{141}^{142}\) Meta-analysis of a large number of controlled trials with longer follow-up confirmed that eradication of *H. pylori* in patients with FD conveys a small but statistically significant benefit.\(^1\)\(^2\) Consequently, dyspepsia attributable to *H. pylori* gastritis involves an underlying organic cause and should be excluded from the FD category. Additionally, ‘dyspeptic’ patients should not automatically be labelled as having ‘gastritis’ without any histological confirmation.

Diagnostic assessment of gastritis has been advanced by the recent introduction of high-resolution endoscopy with image-enhanced modalities, and magnification is now used routinely in major hospitals in Japan. This endoscopic technology allows the identification of mucosal changes (for targeted biopsies) more precisely, leading to more accurate evaluation of cancer risks such as preneoplastic changes. Wider use of this new endoscopic system outside Japan may be limited at present.

The Kyoto consensus meeting focused attention on gastritis in all its clinical expression and dealt with four main topics: classification of gastritis in relation to ongoing ICD revision, FD and *H. pylori* infection, diagnosis of gastritis and the management of gastritis. The methodology of the meeting adopted all modern means for reaching consensus and included an internet-based Delphi method with full access to published data in a completely ‘neutral’ environment.

In summary, the Kyoto meeting proposed an aetiology-based classification for gastritis and concluded that *H. pylori* gastritis is an infectious disease. As such, *H. pylori* gastritis requires treatment whether or not it is associated with symptoms because it represents a condition that may evolve towards serious complications, including peptic ulcer and gastric neoplasia.

Consensus was reached on the existence of a separate category of patients with dyspeptic symptoms that are due to *H. pylori* gastritis. In these patients, eradication therapy is the recommended first-line treatment. Because of the diagnostic problems related to ‘gastritis’, these patients should be labelled as having *H. pylori*-associated dyspepsia and are identified by sustained dyspeptic symptom relief after eradication.

For the diagnosis of gastritis, it was agreed that risk stratification systems such as OLGA and OLGIM are useful as are the serological markers. In view of recent technological advancements, image-enhanced endoscopy should be encouraged for identifying mucosal changes which carry a high risk of developing into gastric neoplasia. Finally, it was recommended that early eradication therapy, ideally before preneoplastic changes occur, should be undertaken. However, the feasibility of implementing this strategy should be regionally tailored. As eradication therapy does not guarantee elimination of the risk of gastric cancer, follow-up should be considered for patients who have preneoplastic conditions.

Although there are still many remaining areas to be discussed, we believe the outcome of the Kyoto consensus meeting presented in this report will improve patient care and will provide a cornerstone for further refinement and research in the area of gastritis.

**Author affiliations**

1. Department of Medicine, Jichi Medical University, Tochigi, Japan
2. Translational Research Center for Gastrointestinal Disorders, University of Leuven, Leuven, Belgium
3. Department of Gastroenterology and Hepatology, Erasmus MC University Medical Center, Rotterdam, Netherlands
4. Department of Medicine, Michael E DeBakey VA Medical Center, Baylor College of Medicine, Houston, USA
5. Division of Applied Medicine, Institute of Medical Sciences, Aberdeen University, Aberdeen, UK
6. National Defense Medical College, Tokorozawa, Japan
7. Department of Gastroenterology, Kawasaki Medical School, Kurashiki, Japan
8. Department of Cancer Prevention Medicine, Hokkaido University, Sapporo, Japan
9. (Kohnodai Hospital, National Center for Global Health and Medicine, Ichikawa, Japan
10. Department of Gastroenterology, University of Magdeburg, Magdeburg, Germany

**Correction notice** This article has been corrected since it was published Online First. Hidekazu Suzuki has been added to the collaborators list.

**Acknowledgements** We thank the Japanese Society of Gastroenterology (JSGE) for providing financial support, enabling this global consensus meeting. Technical support by Omura Publishing Co Ltd and Mr Osamu Ilimura of the JSGE is greatly appreciated. We also thank Japan Convention Service Co Ltd for their excellent management of the conference.

**Collaborators** List of faculty members and affiliations (alphabetical order of family names): Takeshi Azuma, Department of Gastroenterology, Kobe University; Franco Bazzoli, Department of Gastroenterology, University of Bologna; Francis Ka-Leung Chan, Department of Medicine and Therapeutics, The Chinese University of Hong Kong; Minchu Chen, Department of Gastroenterology, The first affiliated hospital, SunYang-sen University; Naoki Chiba, McMaster University; Tetsu Tomii, Department of Gastroenterology, Kyoto University; Luiz Gonzaga Vas Coelho, Department of Internal Medicine, Faculty of Medicine, Federal University of Minas Gerais; Francesco Di Mario, Department of Clinical Experimental Medicine, University of Parma; Kwong Ming Fock, Department of Gastroenterology, Changi General Hospital; Yasuhiro Fukuda, Sasakiya Medical Center, Hyogo College of Medicine; Takahisa Furuta, Center for Clinical Research, Hamamatsu University School of Medicine; Robert Maximilian Genta, Department of Pathology, Miraca Life Sciences Research Institute and University of Texas Southwestern; Khan-lee Goh, Division of Gastroenterology and Hepatology, Department of Medicine, University of Malaya; Masanori Ito, Department of Gastroenterology and Metabolism, Hiroshima University, Tomonori Kanada, Department of Internal Medicine, Kawasaki Medical School; Peter Harry Katerliris, Department of Gastroenterology, Concord Hospital, University of Sidney; Mototsugu Kato, Division of Endoscopy, Hokkaido University Hospital; Takashi Kawai, Endoscopy Center, Tokyo Medical University Hospital; NAYOUNG Kim, Department of Internal Medicine, Seoul National University Bundang Hospital; Ryuji Kushima, Department of Pathology, Shiga University of Medical Science; Varocha Mahachai, Division of Gastroenterology, Chulalongkorn University Hospital; Takeshi Matushita, Nippon Medical School Tama Nagayama Hospital; Florian A. Algraud, INSERM U835 and Department of Bacteriology, Hiroto Miwa, Department of Gastroenterology, Hyogo College of Medicine; Kazunori Munakata, Department of Gastroenterology, Oita University; Colm Antoine O’Morain, Faculty of Health Sciences, Trinity College; Massimo Rugge, Department of Pathology, Padova University; Kiich Kato, International University of Health and Welfare; Tadashi Shimoyama, Department of Gastroenterology and Hepatology, Hiroshima University; Akiko Shiotani, Department of Internal Medicine, Kawasaki Medical College; Toshio Sugiyama, Department of Internal Medicine, Toyama University; Hidekazu Suzuki, Department of Gastroenterology, Keio University; Kazuyoshi Yagi, Department of Medicine, Niigata Prefectural Yoshida Hospital; Ming-Shiang Wu, Department of Internal Medicine, National Taiwan University.

**Contributors** KS, NU, EME-O and PM planned the meeting and prepared the clinical questions. KS, JT, EiK, EME-O, DYI and PM wrote the manuscript. SM, KH and MA helped to summarise the voting results of sections 1, 3 and 4, respectively. All other faculty members contributed to formulating one or two statements for each clinical question, participated in the meeting and voted. They also read and approved the manuscript.

**Competing interests** KS has received research grants from Eisai, Daiichi Sanyo and Takeda. He has also received lecture fees from Astellas, Fuji Film and Takeda. JT has provided scientific advice to AlfaWassermann, Almirall, AstaZeneca, Danone, GI Dynamics, GlaxoSmithKline, Ironwood, Janssen, Menarini, Novartis, Rhythm, Shire, Sucampo, Takeda, Theravance, Tsumura, Will-Pharma, Yuhan and Zeria. He has also served on speaker boards for Abbott, Almirall, AstaZeneca, Danone, Janssen, Menarini, MMS, Novartis, Shire, Takeda and Zeria. JT has received research grants from Astellas, Shire and Zeria. DYI has served on speaker boards for Astella, Novartis, Shire, Zeria and Daiichi-Sankyo. DYI has also received research support. He is also a consultant for Otsuka Pharmaceuticals and for BioGaia. KH has received lecture fees from Astellas, AstaZeneca, Daiichi Sanyo, Dai nippon Sumitomo, Eisai, Otsuka, Takeda and Zeria. He has also received research

---

Sugano K, et al. Gut 2015;64:1353–1367. doi:10.1136/gutjnl-2015-309252

removed on December 30, 2023 by guest. Protected by copyright.
funds from Astellas, Daiichi Sankyo, Eisai and Takeda. MA belongs to the department funded by Eizai Co Ltd at Hokkaido University Graduate School of Medicine. NU has received lecture fees from Astellas, AstraZeneca, Eisai and Takeda. PM has received speaker’s fee from Abbvie, Apsalis, AstraZeneca and Takeda.

Provenance and peer review Not commissioned; externally peer reviewed.

Open Access This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/
82 Rugge M, de Boni M, Pennelli G, et al. Gastric cancer screening by combined assay for serum anti-Helicobacter pylori IgG antibody and serum pepsinogen levels—ABC method. Proc Jain Acad SerB Phys Biol Sci 2011;1:87–105.

83 Broutet N, Plebani M, Sakarovitch C, et al. Pepsinogen A, pepsinogen C and gastrin as markers of atrophic chronic gastritis in European dyspeptics. Br J Cancer 2003;88:1239–47.

84 Agreus L, Kuipers EJ, Kupcinskas L, et al. Rationale in diagnosis and screening of atrophic gastritis with stomach-specific plasma biomarkers. Scand J Gastroenterol 2012;47:136–47.

85 Kuipers EJ. In through the out door: serology for atrophic gastritis. Eur J Gastroenterol Hepatol 2003;15:877–9.

86 Wataha H, Mitsushima T, Yamaji Y, et al. Predicting the development of gastric cancer from combining Helicobacter pylori antibodies and serum pepsinogen status: a prospective endoscopic cohort study. Gut 2005;54:764–6.

87 Miki K. Gastric cancer screening by combined assay for serum anti-Helicobacter pylori IgA antibody and serum pepsinogen levels—ABC method. Proc Jain Acad SerB Phys Biol Sci 2011;1:87–105.

88 Broutet N, Plebani M, Sakarovitch C, et al. Pepsinogen A, pepsinogen C and gastrin as markers of atrophic chronic gastritis in European dyspeptics. Br J Cancer 2003;88:1239–47.

89 Agreus L, Kuipers EJ, Kupcinskas L, et al. Rationale in diagnosis and screening of atrophic gastritis with stomach-specific plasma biomarkers. Scand J Gastroenterol 2012;47:136–47.

90 de Vries AC, Kuipers EJ, Rauws EA. Comparison of high resolution magnifying endoscopy and standard videendoscopy for the diagnosis of Helicobacter pylori gastritis in routine clinical practice: a prospective study. Helicobacter 2009;14:12–21.

91 Okuda M, Sugiyama T, Fukunaga K, et al. A strain-specific antigen in Japanese Helicobacter pylori recognized in sera of Japanese children. Clin Diagn Lab Immunol 2005;12:394–400.

92 Megraud F, European Paediatric Task Force on Helicobacter pylori. Comparison of non-invasive tests to detect Helicobacter pylori infection in children and adolescents: results of a multicenter European study. J Pediatr 2005;146:198–203.

93 Ford AC, Forman D, Hunt RH, et al. Helicobacter pylori eradication therapy to prevent gastric cancer in healthy, asymptomatic infected individuals: systematic review and meta-analysis of randomised controlled trials. BMJ 2014;348:g3174.

94 Take S, Mizuno M, Ishiki K, et al. Baseline gastric mucosal atrophy is a risk factor associated with the development of gastric cancer after Helicobacter pylori eradication therapy in patients with peptic ulcer diseases. J Gastroenterol Hepatol 2007;42 (Suppl 7):21–7.

95 Chen HN, Wang Z, Li X, et al. Helicobacter pylori eradication cannot reduce the risk of gastric Cancer in patients with intestinal metaplasia and dysplasia: evidence from a meta-analysis. Cancer Cancer Published Online First: 22 Jan 2015. doi:10.1007/s10512-015-0467-2.

96 de Vries AC, Kuipers EJ, Rauws EA. Helicobacter pylori eradication and gastric cancer: when is the horse out of the barn? Am J Gastroenterol 2009;104: 1342–5.

97 Zhang YY, Xia HH, Zhang Zh, et al. Review article: ‘true’ re-infection of Helicobacter pylori after successful eradication—worldwide annual rates, risk factors and clinical implications. Aliment Pharmacol Ther 2009;29:145–60.

98 Franchini M, Vescovi PP, Garofano M, et al. Helicobacter pylori-associated idiopathic thrombocytopenic purpura: a narrative review. Semin in Thromb Hemost 2012;38:463–8.

99 Franchini M, Cruciani M, Mengoli C, et al. Effect of Helicobacter pylori eradication on platelet count in idiopathic thrombocytopenic purpura: a systematic review and meta-analysis. J Antiinfect Chemother 2007;62:237–46.

100 Harvey RF, Lane JA, Naar P, et al. Clinical trial: prolonged benefit of Helicobacter pylori eradication on dyspepsia consultations—the Bristol Helicobacter Project. Aliment Pharmacol Ther 2010;32:294–400.

101 Veldhuizen van Zanten SJ, Flook N, Chiba N, et al. Comparison of high resolution magnifying endoscopy and standard videendoscopy for the diagnosis of Helicobacter pylori gastritis in routine clinical practice: a prospective study. Helicobacter 2009;14:12–21.

102 Capelle LG, Haringima J, de Vries AC, et al. Narrow band imaging for the detection of gastric intestinal metaplasia and dysplasia during surveillance endoscopy. Dig Dis Sci 2010;55:3442–8.

103 Osawa H, Yamamoto H, Miura Y, et al. Blue laser imaging provides excellent endoscopic images of upper gastrointestinal lesions. Video J Endoscopy 2014;1:607–10.

104 Lim JH, Kim N, Lee HS, et al. Correlation between endoscopic and histological diagnoses of gastric intestinal metaplasia. Gut Liver 2013;7:41–50.

105 de Vries AC, Haringima J, de Vries RA, et al. Biopsy strategies for endoscopic surveillance of pre-malignant gastric lesions. Helicobacter 2010;15:259–63.

106 El-Zimaity HM, Graham DY. Evaluation of gastric mucosal biopsy site and number for identification of Helicobacter pylori or intestinal metaplasia: role of the Sydney System. Hum Pathol 1999;30:72–7.

107 Satoh K, Kimura K, Taniguchi Y, et al. Biopsy sites suitable for the diagnosis of Helicobacter pylori infection and the assessment of the extent of atrophic gastritis. Am J Gastroenterol 2008;103:1451–62.

108 Vergara M, Catalan M, Gisbert JP, et al. Pepsinogen A, pepsinogen C and gastrin as markers of atrophic chronic gastritis in European dyspeptics. Br J Cancer 2003;88:1239–47.

109 Agreus L, Kuipers EJ, Kupcinskas L, et al. Rationale in diagnosis and screening of atrophic gastritis with stomach-specific plasma biomarkers. Scand J Gastroenterol 2012;47:136–47.

110 Fugii E, In through the out door: serology for atrophic gastritis. Eur J Gastroenterol Hepatol 2003;15:877–9.
111 Graham DY, Shiotsu A, El-Zimaity HM. Chromoendoscopy points the way to understanding recovery of gastric function after Helicobacter pylori eradication. \textit{Gastrointest Endosc} 2006;64:686–9.

112 Graham DY. Helicobacter pylori and perturbations in acid secretion: the end of the beginning [editorial]. \textit{Gastroenterology} 1996;110:1647–50.

113 Hanuma K, Miara M, Okamoto E, et al. Eradication of Helicobacter pylori increases gastric acidity in patients with atrophic gastritis of the corpus-evaluation of 24-h pH monitoring. \textit{Aliment Pharmacol Ther} 1999;13:155–62.

114 Yasunaga Y, Shinomura Y, Kanyama S, et al. Improved fold width and increased acid secretion after eradication of the organism in Helicobacter pylori associated enlarged fold gastritis. \textit{Gut} 1994;35:1571–4.

115 Lee YC, Chen TH, Chiu HM, et al. The benefit of mass eradication of Helicobacter pylori infection: a community-based study of gastric cancer prevention. \textit{Gut} 2013;62:676–82.

116 Atherton JC, Blaser MJ. Co-adaptation of Helicobacter pylori and humans: ancient history, modern implications. \textit{J Clin Invest} 2009;119:2475–87.

117 Dorer MS, Talarico S, Steger M, et al. Carcinogenic bacterial pathogen Helicobacter pylori triggers DNA double-strand breaks and a DNA damage response in its host cells. \textit{Proc Natl Acad Sci} 2011;108:14944–9.

118 Toller IM, Neelsen KJ, Steger M, et al. Genomewide DNA methylation profiling in nonulcer dyspepsia. \textit{Gut} 2007;56:1376–83.

119 Kim JJ, Tao H, Carloni E, et al. Helicobacter pylori impairs DNA mismatch repair in gastric epithelial cells. \textit{Gastroenterology} 2002;123:542–53.

120 Matsumoto Y, Manasawa H, Kinoshita K, et al. Helicobacter pylori infection triggers aberrant expression of activation-induced cytidine deaminase in gastric epithelium. \textit{Nat Med} 2007;13:470–6.

121 Shin CM, Kim N, Jung Y, et al. Genome-wide DNA methylation profiles in non-cancerous gastric mucosae with regard to Helicobacter pylori infection and the presence of gastric cancer. \textit{Helicobacter} 2011;16:179–88.

122 Ushijima T, Hattori N. Molecular pathways: involvement of Helicobacter pylori-triggered inflammation in the formation of an epigenetic field defect and its usefulness as cancer risk and exposure markers. \textit{Clin Cancer Res} 2012;18:923–9.

123 Zabaleta J. MicroRNA: a bridge from \textit{H. pylori} infection to gastritis and gastric cancer development. \textit{Front Genet} 2012;3:294.

124 Nishizawa T, Suzuki H. The role of microRNA in gastric malignancy. \textit{Int J Mol Sci} 2013;14:9487–96.

125 Miegard F, Coenen S, Versporten A, et al. Helicobacter pylori resistance to antibiotics in Europe and its relationship to antibiotic consumption. \textit{Gut} 2013;62:34–42.

126 Furuta T, Graham DY. Pharmacologic aspects of eradication therapy for \textit{Helicobacter pylori} Infection. \textit{Gastroenterol Clin North Am} 2010;39:465–80.

127 Graham DY, Shiotsu A. Which therapy for Helicobacter pylori infection? \textit{Gastroenterology} 2012;143:10–12.

128 Graham DY, Lee YC, Wu MS. Rational Helicobacter pylori therapy: evidence-based medicine rather than medicine-based evidence. \textit{Clin Gastroenterol Hepatol} 2014;12:177–86.

129 Wu JY, Liou JM, Graham DY. Evidence-based recommendations for successful Helicobacter pylori treatment. \textit{Expert Rev Gastroenterol Hepatol} 2014;8:21–8.

130 International Agency for Research on Cancer. Helicobacter pylori eradication as a strategy for preventing gastric cancer. IARC Working Group Reports. Vol 8, WHO Press, World Health Organization, Geneva, Switzerland, 2014.

131 Shiotsu A, Cen P, Graham DY. Eradication of gastric cancer is now both possible and practical. \textit{Semin Cancer Biol} 2013;23:492–501.

132 Matsueda S, Graham DY. Immunotherapy in gastric cancer. \textit{World J Gastroenterol} 2014;20:1657–66.

133 Graham DY, Shiotsu A. The time to eradicate gastric cancer is now. \textit{Gut} 2005;54:735–8.

134 Kimura K, Satoh K, Ido K, et al. Gastritis in the Japanese stomach. \textit{Scand J Gastroenterol} 1996;31(Suppl 214):17–20.

135 Kimura K, Takemoto T. An endoscopic recognition of the atrophic border and its significance in chronic gastritis. \textit{Endoscopy} 1969;1:87–97.

136 Miki K. Gastric cancer screening using the serum pepsinogen test method. \textit{Gastric Cancer} 2006;9:245–53.

137 Dinis-Ribeiro M, Yamali G, Miki K, et al. Meta-analysis on the validity of pepsinogen test for gastric carcinoma, dysplasia or chronic atrophic gastritis screening. \textit{J Med Screen} 2004;11:141–7.

138 Dinis-Ribeiro M, da Costa-Pereira A, Lopes C, et al. Validity of serum pepsinogen I/I ratio for the diagnosis of gastric epithelial dysplasia and intestinal metaplasia during the follow-up of patients at risk for intestinal-type gastric adenocarcinoma. \textit{Neoplasia} 2014;6:449–56.

139 Schindler R. Chronic gastritis. \textit{Bull NY Acad Med} 1939;15:322–37.

140 Lau JY, Barkun A, Fan DM, et al. Challenges in the management of acute peptic ulcer bleeding. \textit{Lancet} 2013;381:2033–43.

141 Jonsson KA, Gotthard R, Bodemar G, et al. The clinical relevance of endoscopic and histologic inflammation of gastroduodenal mucosa in dyspepsia of unknown origin. \textit{Scand J Gastroenterol} 1989;24:385–95.

142 Talley N, Phillips SF. Non-ulcer dyspepsia: potential causes and pathophysiology. \textit{Ann Intern Med} 1988;108:865–79.

143 Lambert JR. The role of Helicobacter pylori in nonulcer dyspepsia. A debate—for. \textit{Gastroenterol Clin North Am} 1993;22:141–51.

144 Talley NJ. The role of Helicobacter pylori in nonulcer dyspepsia. A debate—against. \textit{Gastroenterol Clin North Am} 1993;22:153–67.