patients (but we did observe lesions on the necks of some patients).

Our data coincided with those of the French study and reinforce the specificity of this dermatologic sign. However, this was not the only coincidence; cases also occurred among the investigators after contact with the infected material in each of the outbreaks. Perhaps both signs may characterize this dermatitis: the comet sign and “the sign of the infected investigators” of the outbreaks.

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sence of infection is predicted to result in at least 60% fewer cases of gastric cancer worldwide (10).

Our study has several limitations. First, because of the study’s retrospective nature, pathologists reviewed archived hematoxylin and eosin–stained sections of biopsy specimens. The inability to use additional techniques (e.g., special staining, immunohistochemistry) commonly used to visualize H. pylori might have resulted in underdetection of the true rate of infection in the study population. Second, in 99% of cases, only 1 biopsy specimen was obtained from the antrum instead of the 5 antrum and corpus biopsy specimens recommended for appropriate diagnosis by the Updated Sydney Classification System (7). Third, the relatively small sample size precluded exploration of additional relationships between demographic characteristics and histologic grades.

Our results indicate a high prevalence of H. pylori in patients with gastritis, peptic ulcer, and gastric cancer and suggest that H. pylori infection represents a serious public health problem in ROG. Studies are needed to explore demographic, socioeconomic, and behavioral risk factors that contribute to the high prevalence of H. pylori infection in symptomatic and asymptomatic persons living in ROG so that preventive measures can be identified.

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