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Summary

Eradication schemes and treatment resistance: Is resistance a problem – or who cares about it?

Christian Schulz

Postgraduate Teaching Programme Barcelona 2026 | Presentation

October 17, 2026

The speaker reviewed antimicrobial resistance challenges in H. pylori eradication and recommended bismuth-based quadruple therapy as empiric first-line treatment when susceptibility testing is unavailable.

KEY POINTS

- The speaker reported that European surveillance showed clarithromycin resistance increased from 10% in 1998 to 21.6% in 2018, and levofloxacin resistance was 14% in 2008 and 16.3% ten years later, with current rates exceeding 10-15% in most countries.
- Antimicrobial susceptibility testing should be performed if clarithromycin or levofloxacin are planned in triple therapy, using real-time PCR, culture-based antibiogram, or next-generation sequencing, though reimbursement is restricted to few countries.
- Bismuth-based quadruple therapy is recommended as empiric first-line treatment in high or unknown clarithromycin resistance settings, overcoming metronidazole resistance with only about 5% decrease in success and 3.5% disruption rate.
- Potassium competitive acid blockers combined with amoxicillin may eliminate need for clarithromycin testing, but these agents are not available in Europe, Australia, or Canada despite supporting data.
- Metronidazole resistance has limited clinical impact on treatment efficacy, particularly with bismuth quadruple therapy, and in vitro testing lacks reproducibility due to lack of redox potential control.
- The speaker stated that real-time PCR for clarithromycin resistance is simple and quick, available post-COVID in all laboratories, requiring gastric biopsy and costing approximately €2 per test for reagents.

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