

GIT

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GIT infections

- *Helicobacter pylori (H.Pylori)*
- *Campylobacter*

Helicobacter pylori (H. Pylori)

Organism classified first as *Campylobacter pylori*

Now *Helicobacter pylori*

Marshall and Warren cultured organism from human gastric mucosa and showed the association with gastric inflammation

Important Human Pathogens:

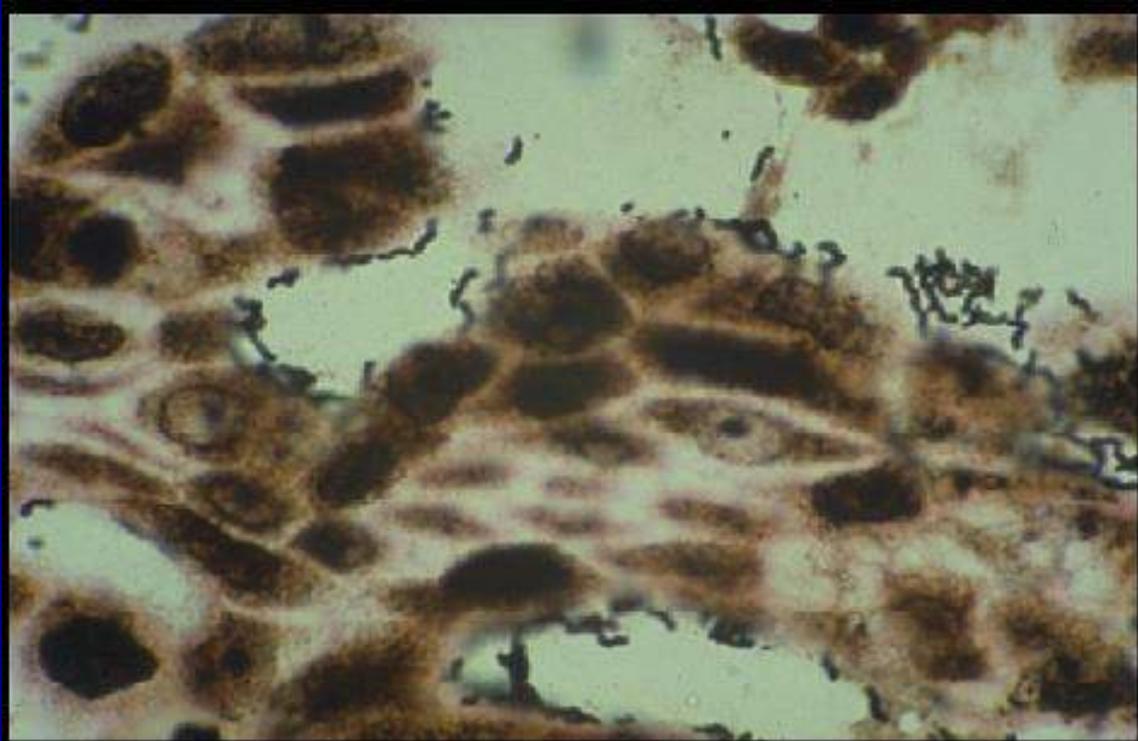
Helicobacter pylori (human; no animal reservoir)

H. cinaedi (male homosexuals; rodents)

H. fenneliae (male homosexuals; rodents)

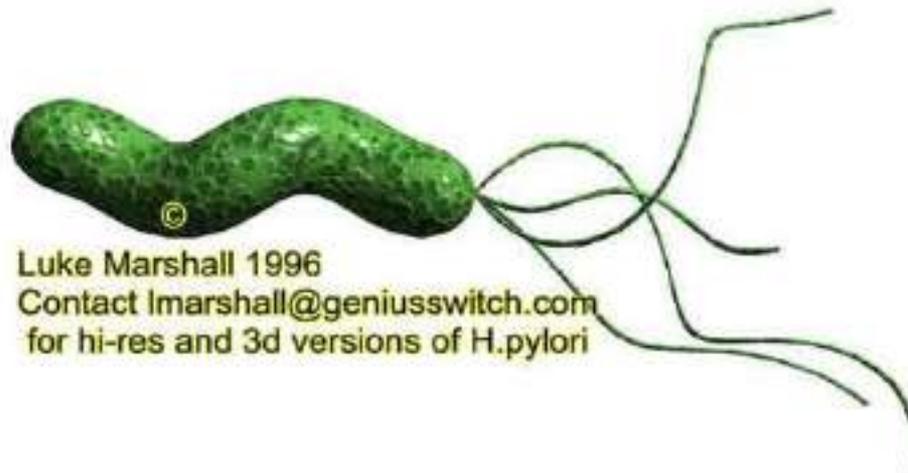
H. pylori

H. pylori on gastric mucus-secreting epithelial cells From Dr. Marshall's stomach biopsy taken 8 days after he drank a culture of *H. pylori* (1985) > stomach lining is infected



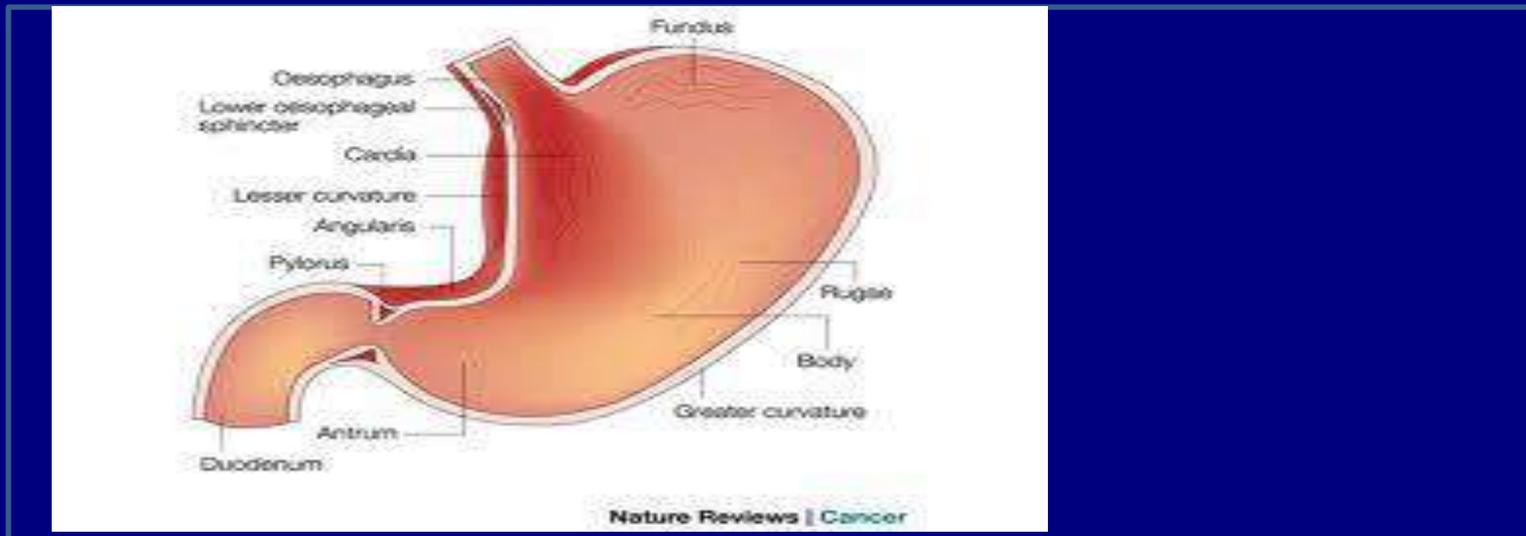
H. Pylori / Properties

- **Gram negative, spiral, flagellated (motile) bacilli** (0.5-0.9 μm wide by 2-4 μm long)
 - Cells become rod-like and coccoid on prolonged culture
 - *H. pylori* have 4-6 sheathed flagella attached at one pole
 - Single polar flagellum on *H. fennellae* & *H. cinaedi*



H. Pylori / Properties

- **Slow growing, requires complex media, microaerophilic (requires carbon dioxide, some Oxygen and Nitrogen)**
- **Oxidase, catalase and urease positive**
- **Proliferates in mucus overlying gastric antral mucosa > non invasive**



H. pylori

- **Culture:**

- On special medium containing vancomycin, polymyxin and trimethoprim (Skirrow's)
- At 37 °C for 3-7 days in microaerophilic conditions.

- **Epidemiology:**

- **human** (Not zoonotic) appears to be the sole reservoir and source of *H. pylori*.
- How infection is **transmitted** is unknown, but it is presumed to be by the oral-oral or, possibly, faecal-oral route.
- Infection rates are strongly related to poor **living conditions** and **overcrowding** during childhood.

H. Pylori / *epidemiology* cont'd

- Nosocomial infection from inadequately disinfected endoscopes has also occurred
- There is a steady rise in seropositivity with increasing age
- Remarkably, *H. pylori*, colonizes roughly half of the world's Population
 - ~ 20% below the age of 40 years are infected
 - 50% above the age of 60 years are infected
 - In developing countries, About 10% acquisition rate per year for children between 2 and 8 years of age (0.1% in developed)

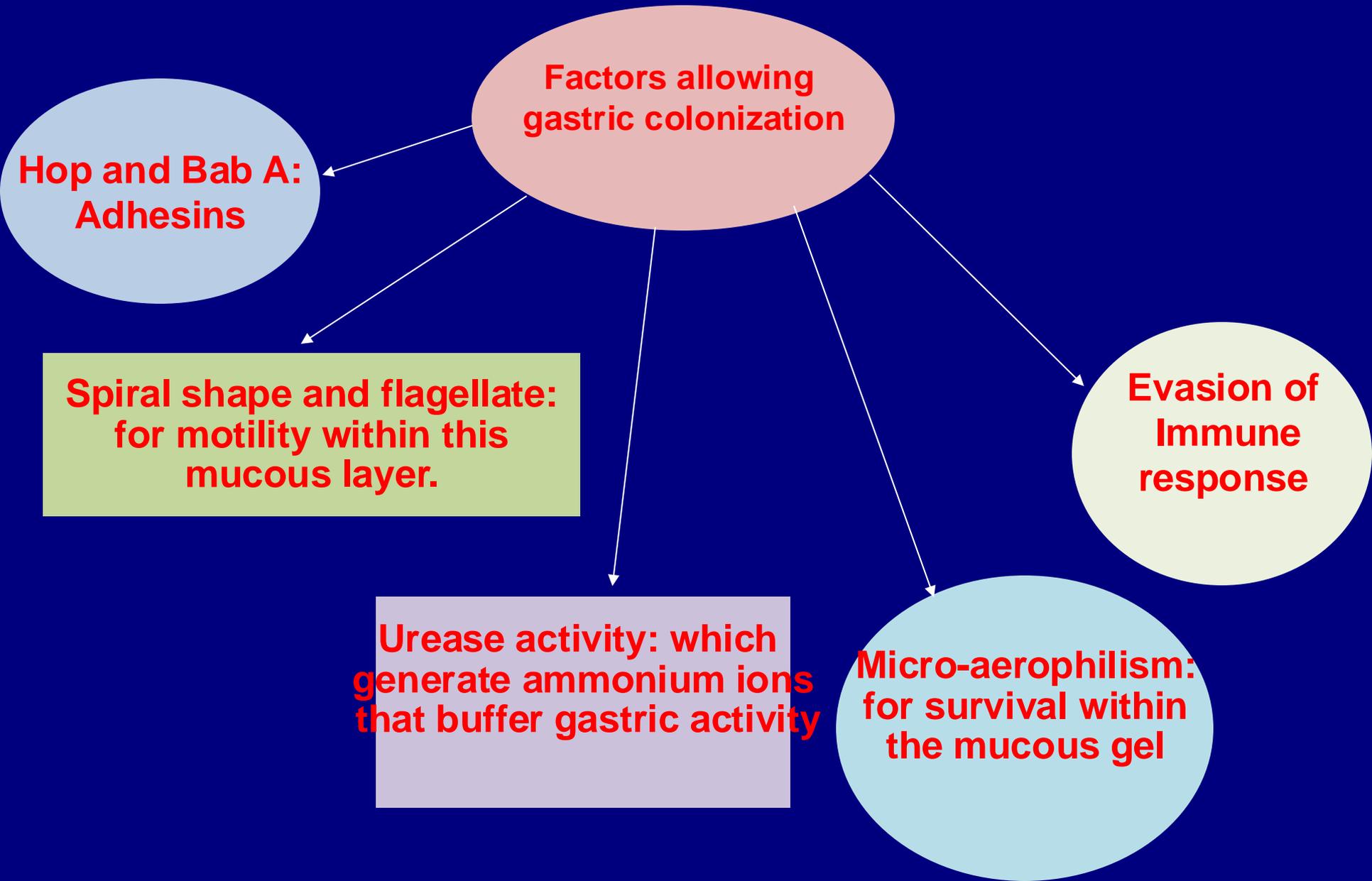
H. Pylori / Pathogenesis

- sheathed flagella 'lophotrichous' > motile
 - enables penetration into viscous environment (mucus)
- Adhesins: Hemagglutinins; Sialic acid binding adhesin
- Mucinase: Degrades gastric mucus; Localized tissue damage
- Urease converts urea (abundant in saliva and gastric juices) into bicarbonate (to CO_2) and ammonia
 - Neutralize the local acid environment
 - Localized tissue damage

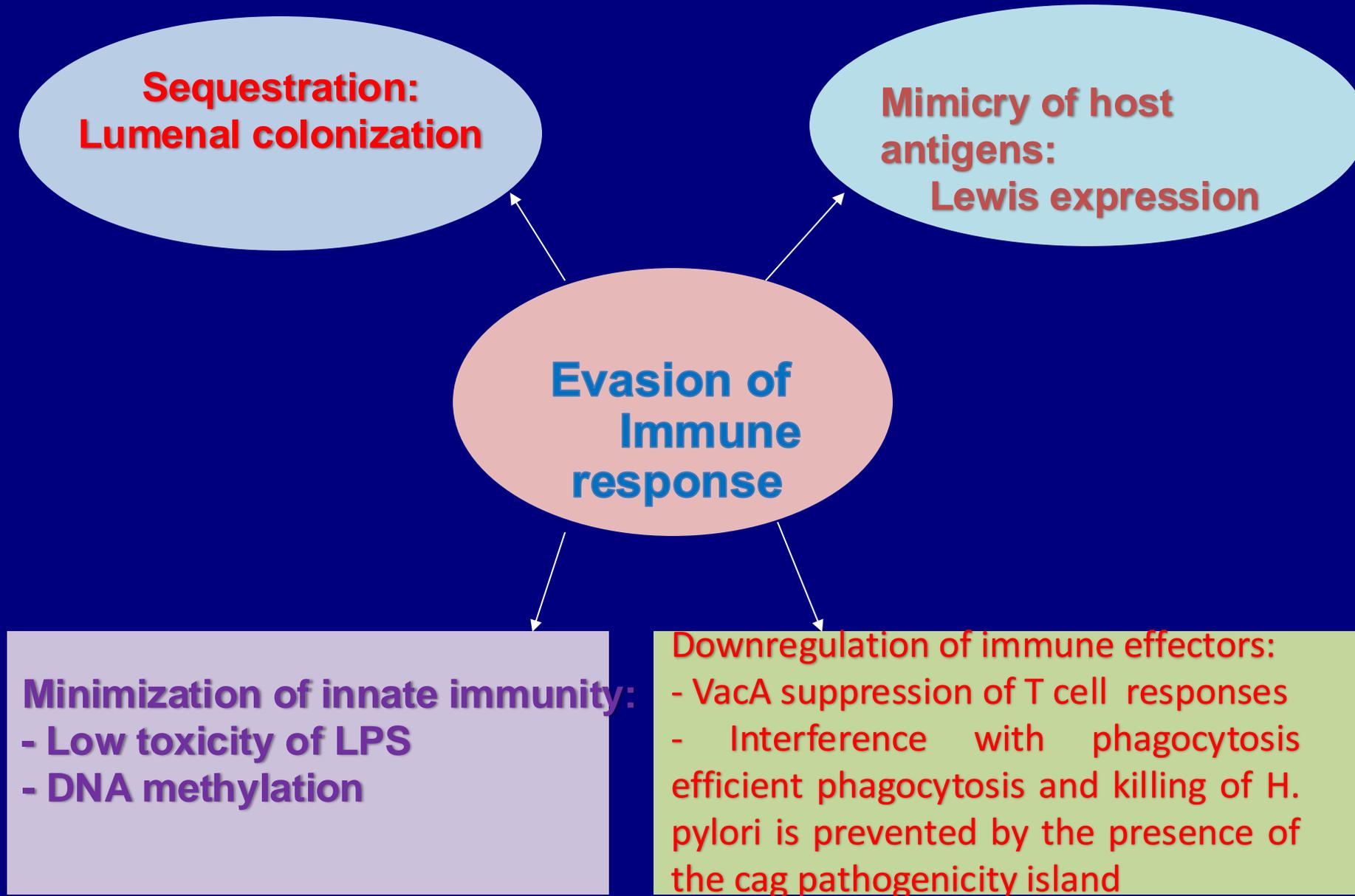
H. Pylori / Pathogenesis

- vacuolating toxin (VacA) and cytotoxin (CagA) > Epithelial cell damage
- The vacuolating toxin has been associated with pore formation in host cell membranes, the loosening of the tight junctions between epithelial cells (thus affecting mucosal barrier permeability causing vacualation)
- Protection from phagocytosis & intracellular killing:
 - Superoxide dismutase
 - Catalase

Pathology and Pathogenesis



Pathology and Pathogenesis



Pathology and Pathogenesis

Most *H. pylori* colonized persons do not develop clinical sequelae due to differences in:

1. Variability of virulent genes among different strains
2. Host susceptibility to disease
 - ✓ Polymorphisms in cytokines encoding genes
 - ✓ For example, colonized people with polymorphisms in the interleukin (IL) 1 gene that cause the production of large quantities of this cytokine in response to *H. pylori* infection are at increased risk of gastric adenocarcinoma.
3. Environmental factors.
 - Smoking increases the risks of ulcers and cancer in *H. pylori*-positive individuals.
 - Diets high in salt and preserved foods increase cancer Risk
 - Whereas diets high in antioxidants and vitamin C are protective.

H. pylori/ Clinically

- most infections are symptomless
- Acute infection:
 - Abdominal pain, vomiting and fever may exist but no disseminated stage
- Last for 1-2 weeks on average.

H. pylori/ Clinically

- chronic active gastritis; Type B.
- Gastric (70%) and duodenal ulcers (more than 90%).
 - less than 20% of infected people will have peptic ulcers
 - GIT Haemorrhage, perforation, pyloric stenosis as complications
 - Other causes of ulcers: NSAIDS, Stress ulcers, chemotherapy...
- non-ulcer dyspepsia
- gastric malignancies.

Pathology and Pathogenesis

Variability of virulent genes among different strains

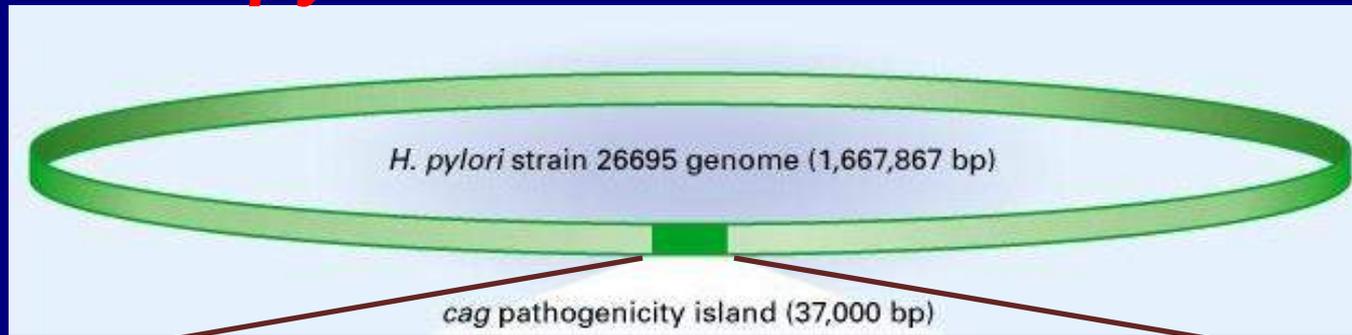
1. *cagA* and *cag* Pathogenicity Island (*cag* PAI):

- The *cag* island is a group of genes that encodes a bacterial secretion system through which a specific protein, CagA, is translocated into epithelial cells.
- CagA affects host cell signal transduction, inducing proliferative, cytoskeletal, and inflammatory changes

2. *vacA* gene mosaics

Pathology and Pathogenesis

Genome of *H. pylori*



The proteins encoded by these genes assemble to form a complex type IV secretion apparatus capable of delivering CagA from the bacterium into host cells

Translocation of CagA into gastric epithelial cells

Phosphorylation of CagA by host-cell kinases c-Src and Lyn

Binding to and activation of cellular phosphatase SHP-2

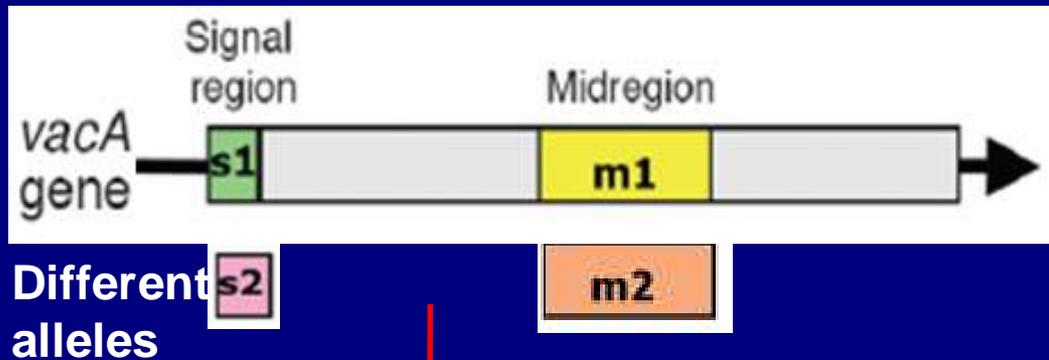
Growth factor-like response in host cell, cytoskeletal rearrangements

Pathology and Pathogenesis

Fewer than 15% develop associated illnesses such as peptic ulceration, gastric adenocarcinoma, or gastric lymphoma

(Why)

1. Because not all *H. pylori* strains are positive for cagA gene.
2. Because of different alleles of vacA gene.



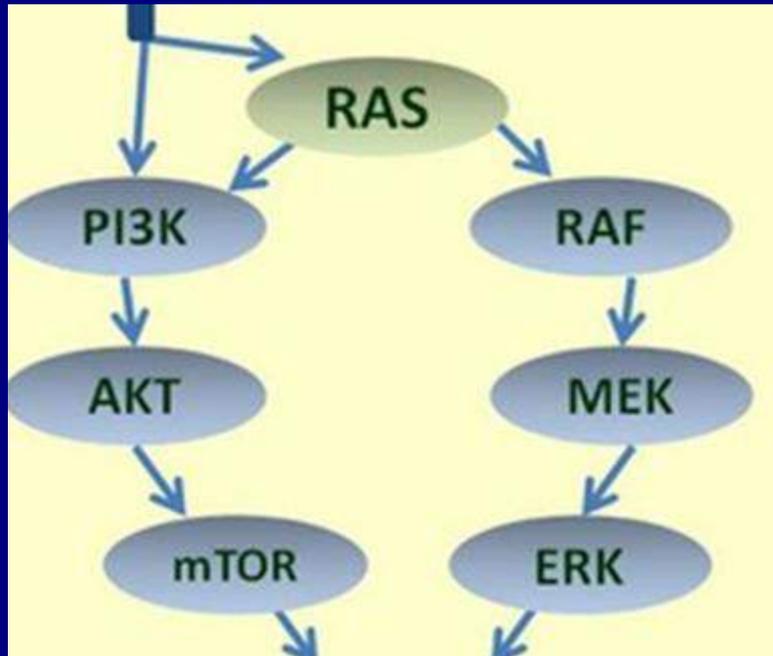
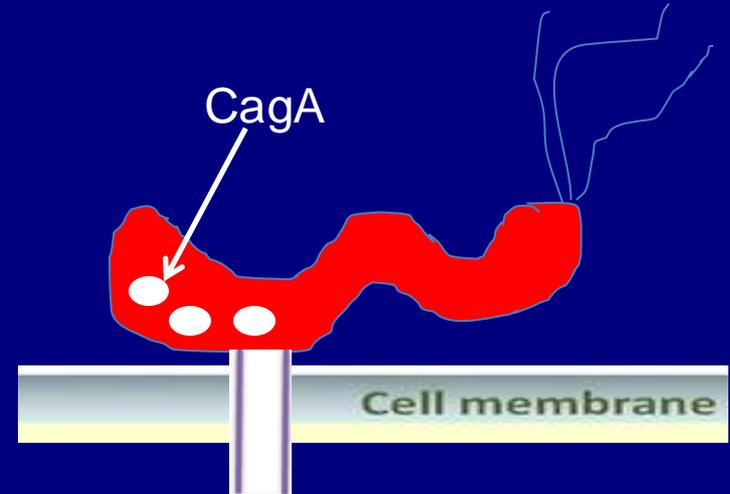
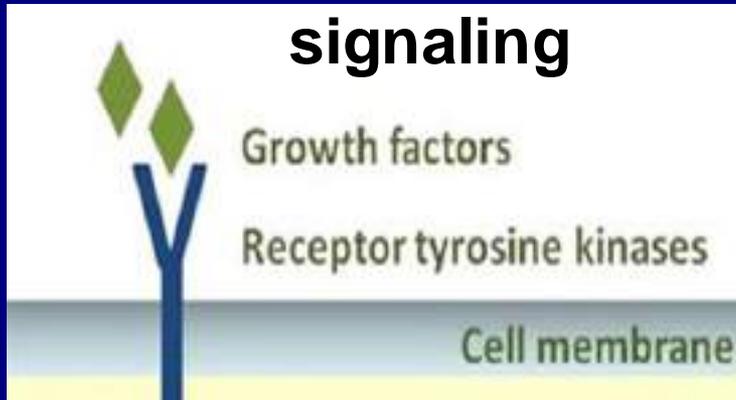
Possible genotypes:

- s1m1: exhibits the highest toxicity (vaculation)
- s1m2: moderate level of toxicity.
- s2m1: nontoxic
- s2m2: nontoxic

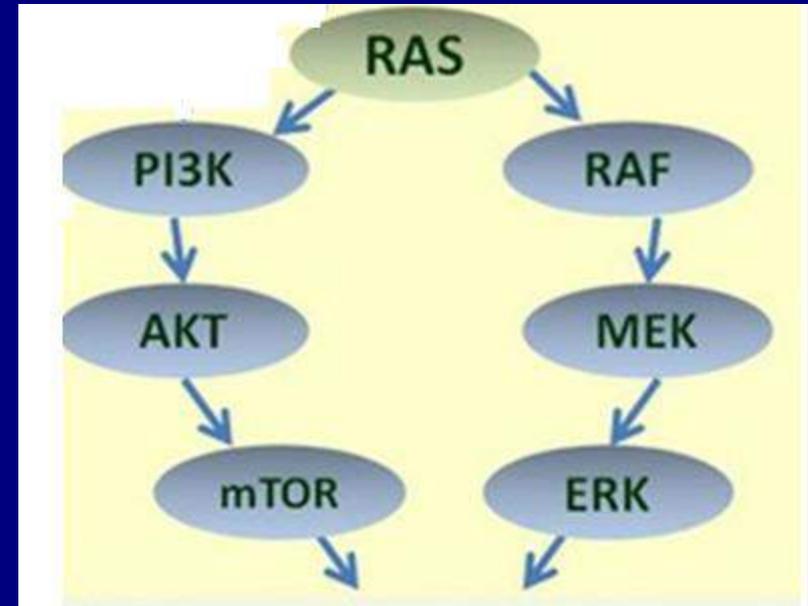
The illnesses caused by *H. pylori* infection are associated with the presence or absence of cagA gene and the presence with different vacA alleles

Pathology and Pathogenesis

Normal vs. CagA induced signaling



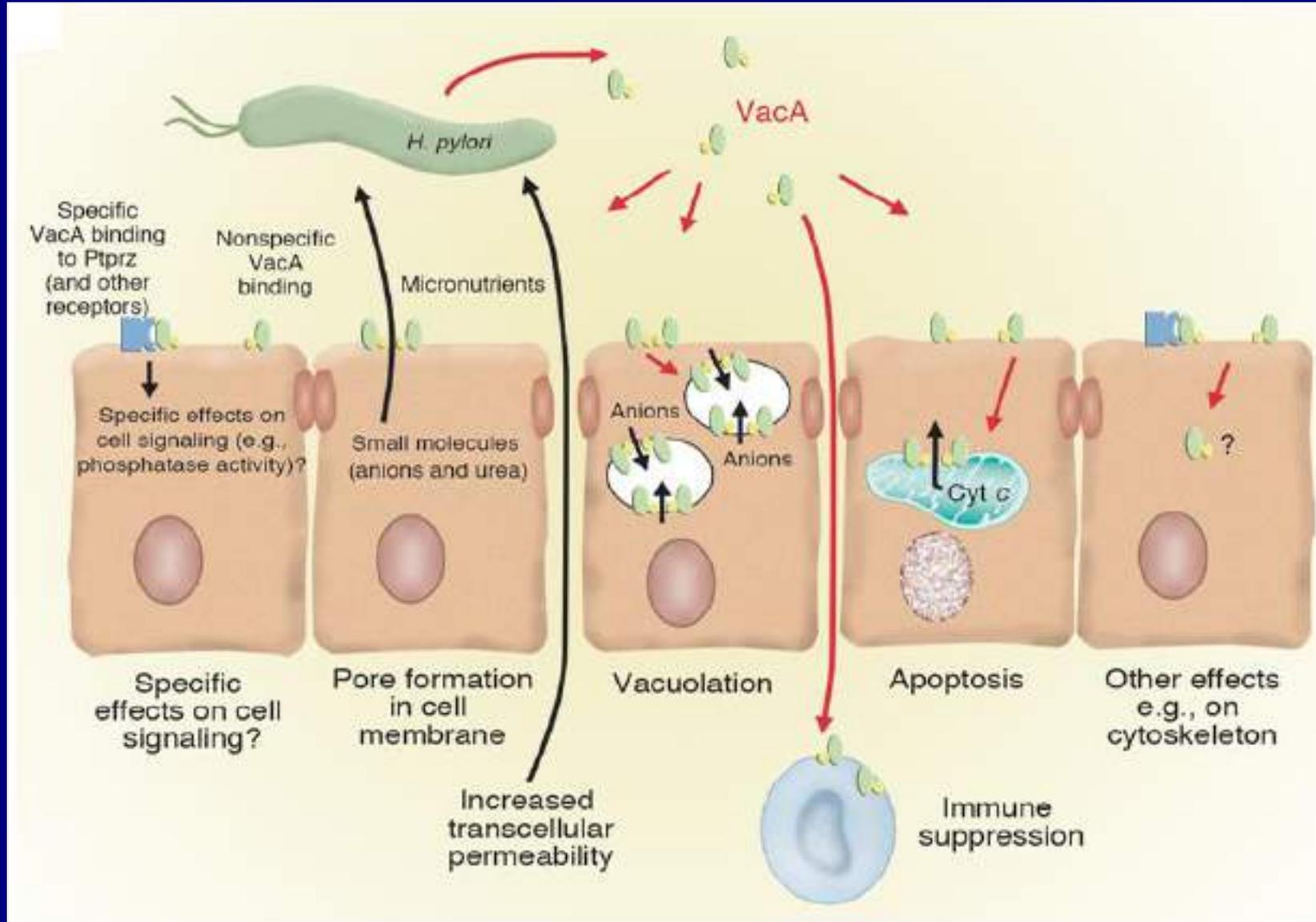
Cell growth and proliferation



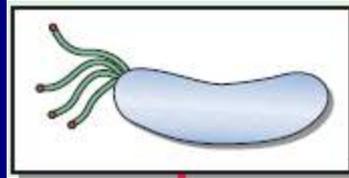
Cell growth and proliferation

Pathology and Pathogenesis

The effects of VacA protein on the fate of cells



Pathology and Pathogenesis



Primary phenomenon:

Tissue response (inflammation)

Secondary phenomenon:

Hyperacidity

Antigenic stimulation

Atrophic gastritis

Clinical outcome:

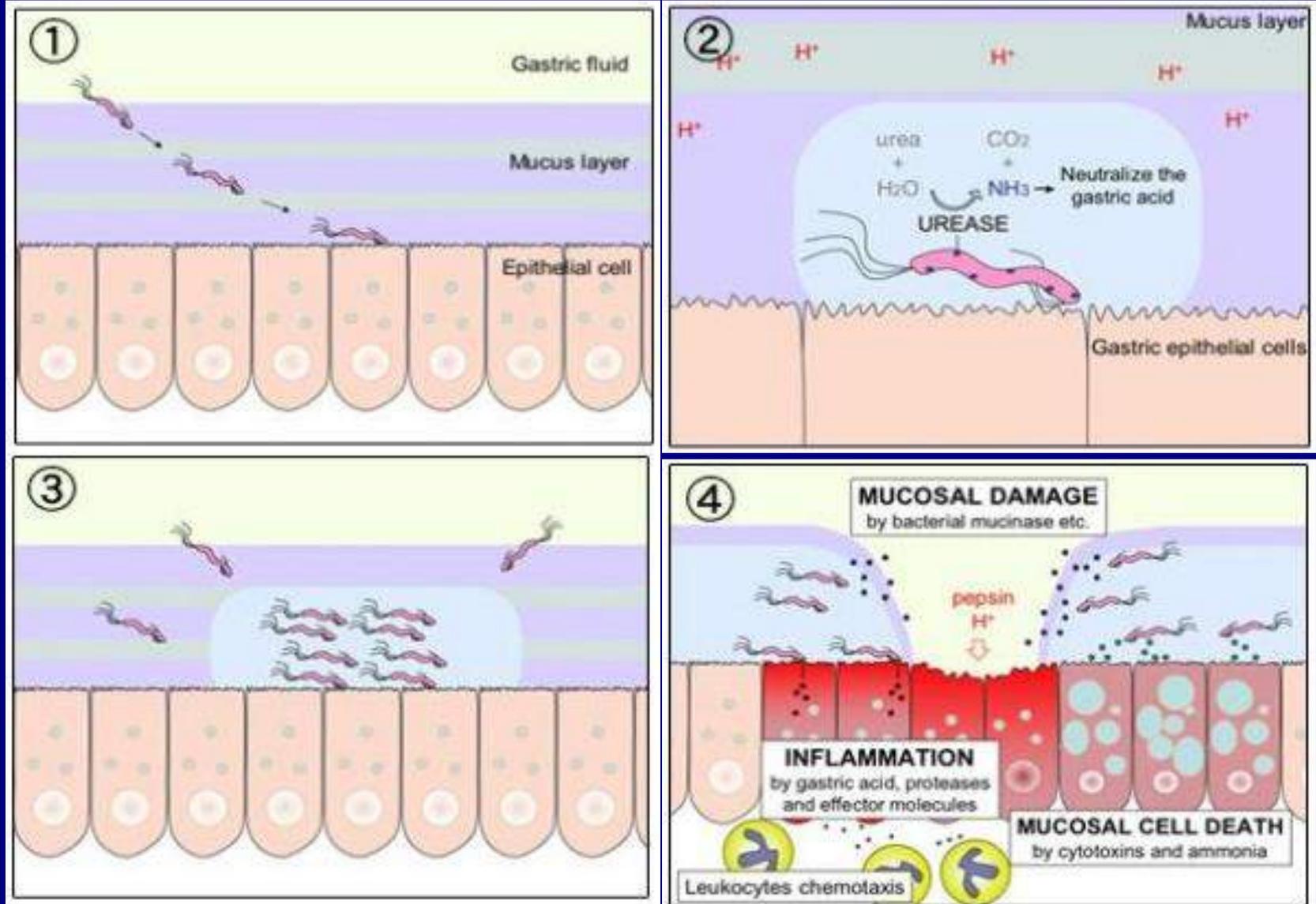
Duodenal ulceration

B-cell lymphoma

Noncardia gastric adenocarcinoma

Reflux esophagitis and sequelae

Pathology and Pathogenesis



H. Pylori / Diagnosis

Definitive tests for *H. pylori* infection depend on finding the Organism in specimens of gastric mucosa obtained by biopsy. (In practice, non-invasive tests are used for initial screening).

Non-invasive tests:

1. Urea breath test
2. Faecal antigen
3. PCR
4. Serology

H. Pylori / Diagnosis

1. Urea breath test

- Detects bacterial urease activity in the stomach by measuring the output of carbon dioxide resulting from the splitting of urea into carbon dioxide and ammonia
- A capsule of urea labelled with carbon-14 or (13) is fed to the patient, and the emission of the isotope in carbon dioxide subsequently exhaled in the breath is measured
- Carbon-14 is radio-active so it is not used in children

H. Pylori / Diagnosis

Urease breath test cont'd:

The breath test is expensive but is becoming increasingly more available.

Other problems include false-negative results due to infection with coccoid forms of *H pylori* that do not produce as much urease or intake of antibiotics, bismuth, histamine 2 (H2) blockers, or proton pump inhibitors.

H. Pylori / Diagnosis

2. Faecal antigen test :

Tests based on the use of monoclonal antibodies are more accurate than polyclonal antibody tests and have the potential to supplant serology for routine screening

3. Polymerase chain reaction (PCR):

- DNA probes for the direct detection of *H. pylori* in gastric juice, faeces, dental plaque and water supplies have been developed
- Some can also detect genes expressing antibiotic resistance and presence of the *cagA* pathogenicity island

4. Serology:

- mostly based on ELISA or latex agglutination
- detect IgG antibodies to *H. pylori*
- Indicates previous exposure
- Not good for follow up or as a test of cure

H. Pylori / Diagnosis

2. Invasive tests (endoscopy guided biopsies):

- Ideally, patients for endoscopy should not have received antibiotics or proton pump inhibitors for 1 month before the test.
 - Mucosal biopsy specimens are taken from the gastric antrum within 5 cm of the pylorus, and preferably also from the body of the stomach
 - For maximum sensitivity, duplicate specimens are taken: one for histopathology , the other for culture
- > Specimens for culture must be processed as soon as possible, certainly on the same day, or placed in transport medium.

H. Pylori / Diagnosis

1. Biopsy urease test :

This is a simple and cheap test that can be performed at the bedside.

A biopsy specimen is placed into a small quantity of urea solution with an indicator that detects alkalinity resulting from the formation of ammonia.

Most infected patients (70%) give a positive result within 2 h; 90% after 24 h

H. Pylori / Diagnosis

2. Histopathology and microscopy :

Histopathology provides a permanent record of the nature and grading of a patient's gastritis as well as detecting *H. pylori*.

Organisms can be seen in sections stained with haematoxylin and Eosin stain

The bacteria can also be seen in smears of biopsy material stained with Gram's stain

H. Pylori / Diagnosis

3. Culture

- Is no more sensitive than skilled microscopy of histological sections,
- but has several advantages:
 - > isolates can be tested for antimicrobial resistance and typed for epidemiological studies;
 - > information about the presence of virulence factors can inform clinical outcome
- Plates are left undisturbed for 3 days and incubated for a week before being discarded as negative

Treatment

Life style:

Ttriple therapies:

- Have reported cure rates from 85-90%.
- Administered for 10-14 days.
- The treatment regimens are (use one of them):
 1. Omeprazole, amoxicillin, and clarithromycin (OAC) for 10 days;
 2. Bismuth subsalicylate, metronidazole, and tetracycline (BMT) for 14 days;
 3. Lansoprazole, amoxicillin, and clarithromycin (LAC), which has been approved for either 10 days or 14 days of treatment.

Diagnosis

Diagnosis of suspected gastric carcinoma, this includes:

- Physical exam
- Blood tests to check for anemia, when your body doesn't have enough red blood cells. It could happen if you have a tumor that bleeds.
- Fecal occult blood test, which checks your stool for blood that's not visible to the naked eye
- Endoscopy
- Biopsy, when a doctor takes a small piece of tissue from your stomach to look for signs of cancer. Your doctor may do this during an endoscopy.
- Tests that make detailed pictures of the insides of your body, such as a CT scan or magnetic resonance imaging (MRI)

Prevention

- Wash your hands after you use the bathroom and before you prepare or eat food. Teach your children to do the same.
- Avoid food or water that's not clean.
- Don't eat anything that isn't cooked thoroughly.
- Avoid food served by people who haven't washed their hands.
- Avoid food served by people who haven't washed their hands.

Prevention

- Though stress, spicy foods, alcohol, and smoking don't cause ulcers, they can keep them from healing quickly or make your pain worse. Talk to your doctor about ways to manage your stress, improve your diet, and, if you smoke, how you can get help to quit.

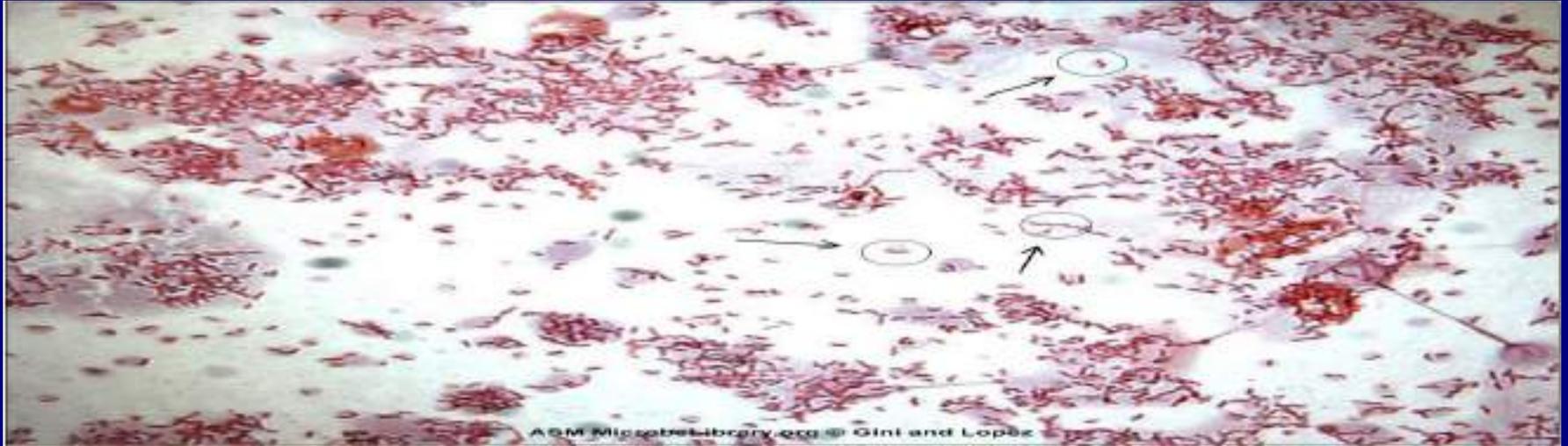
What can I expect after *H. pylori* infection?

- Most ulcers caused by *H. pylori* will heal after a few weeks of treatment. If you've had one, you should avoid taking NSAIDs for pain, since these drugs can damage your stomach lining. If you need pain medicine, ask your doctor to recommend some.

Campylobacter

- The main human pathogenic is *campylobacter jejuni* (*C. jejuni*)
- Other species occasionally found in human gastrointestinal disease include *C. coli* and *C. fetus*
- **Habitat:**
 - Guts of various animal species such as chickens, domestic animals and **seagulls**
- **Pathogenesis:**
 - Enterocolitis, may penetrate beyond the mucosa

Laboratory:



- Small gram negative, curved or spiral rods (Figure/seagull appearance)
- Highly motile (darting, corkscrew like movement), with a flagellum at one or both ends
- Microaerophilic (5% O₂, 10-15% CO₂, 80% Nitrogen)
- Growth at 42°C for 2 days (25°C no growth, 37°C some growth, 42°C enhanced growth).
- Needs a special media (Skirrow's)

Campylobacter

- **Clinically:**

- Incubation period: 1-10 days

- Route of transmission:

Eating contaminated poultry, other meat or drinking milk

Faecal –oral between humans can occur

- Symptoms vary from asymptomatic to severe
- With or without prodromal phase (flu-like)

Campylobacter / clinically

- Bloody diarrhoea with mucus (up to 20 stools a day > faecal incontinence)
- Abdominal pain is a prominent feature (mimicking appendicitis)
- Septicaemia with fever and rigors in severe cases
- Symptoms may last several days and relapses are common (usually self limiting)
- Guillain-Barre syndrome as a complication.

Campylobacter

- Diagnosis
- Hx & Ex
- Stool sample for culture on Skirrow's medium

- Treatment:
- Erythromycin in severe cases.
- Ciprofloxacin as an alternative but resistance is increasing

- Control:
- Properly cooked food and personal hygiene
- Animals: N/A as usually harboured asymptotically

The End