Letters to the Editor

Helicobacter pylori – our knowledge is growing

Sir,

I enjoyed the leading article on *Helicobacter pylori* by Dr Colin-Jones published in your October 1990 issue.¹ However, the statement that Marshall and Warren were the first to describe these organisms in the stomach is inaccurate. They were indeed the first to associate these organisms with gastritis and generate the current interest in this organism.

Spiral bacteria in animal stomachs was probably first reported by Bizzozero² in 1893. The presence of these organisms in human stomachs was confirmed by Krientz³ in 1906. In 1938 Doenges⁴ found these organisms to be present in 43% of 242 human autopsy specimens of the stomach. Recently they have also been detected in ectopic gastric mucosa in Meckel's diverticulum.⁵

These organisms became known as campylobacter-like organisms because of their similarity to other members of the genus following the work of Marshall and Warren^{6,7} in 1983–84. Later the name *Campylobacter pyloridis* was used and shortly afterwards was changed to *Campylobacter pylori*. More recently the name *Helicobacter pylori* has been suggested⁸ due to the findings of fundamental structural differences between this organism and members of the campylobacter genus.

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Helicobacter pylori – our knowledge is growing

Sir,

Dr Colin-Jones gives a good summary of present knowledge of *H. pylori* infection in the 'West' in his leading article.¹ However, it is important to remember that *H. pylori* infection is worldwide and recommendations made for 'Western' populations cannot necessarily be applied to other populations.

In Africa, over 70% of the population have antibodies to *H. pylori*, with 45–82% infected before the age of 10.^{2,3} The latter findings are from the northern savannah of Nigeria where peptic ulcer is uncommon.⁴ The pathological role, if any, of *H. pylori* in this population is unclear.

The *H. pylori* status has only been determined in a small number of Africans with peptic ulcers, so far all have been infected. However, with such a high prevalence of infection in the normal population, the problem of eradication and an unknown reinfection rate it is difficult to recommend anti-*H. pylori* therapy.^{5–7}

The largely rural population in Africa often does not attend for outpatient follow-up, and may not re-present until they have a life-threatening ulcer complication. Operation is probably the best definitive treatment for those with proven ulceration.

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Testicular teratoma and peripheral neurofibromatosis

Sir,

We were interested in the case recently reported by Hilton *et al.*¹ of a patient with neurofibromatosis developing