

Prevalence of *Helicobacter pylori* in Indigenous Western Australians: comparison between urban and remote rural populations

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TO THE EDITOR: We read with interest the recent cross-sectional survey of *Helicobacter pylori* infection in remote and urban Aboriginal populations in Western Australia.¹ The prevalence of *H. pylori* was shown to be consistent with that in developing countries. This is not surprising, given the high prevalence of diseases such as chronic suppurative otitis media, rheumatic fever, scabies, and tuberculosis affecting Aboriginal peoples — all of which relate to poverty and overcrowding.² Aboriginal and Torres Strait Islander people have a massively disproportionate share of the overcrowded households in Australia. In the 2001 Census, Aboriginal people in WA accounted for 53% and 93% of the two-bedroom and three-bedroom households that accommodated seven to nine and ten or more people, respectively (from 3% of the population).³

Windsor et al speculate that high *H. pylori* infection rates may be the result of children not wearing nappies and of poor personal hygiene — even though these matters (and housing standards, the presence of functional washing facilities and the degree of overcrowding) were not investigated. We are concerned that such conclusions reflect negatively on the Aboriginal population who took part in the survey in good faith with good will.



Moreover, it is misleading to suggest that *H. pylori* is a cause of poor growth among Aboriginal children. There is insufficient evidence to support screening for *H. pylori* infection in children, as no studies have demonstrated that treating *H. pylori* infections improves their growth.

It is expected that “some of the participants who tested positive for *H. pylori* have asked to be treated with antibiotics”. We assign considerable importance to research protocols that adhere to the criterion “no research proceeds without service”.⁴ Did those who were *H. pylori* positive with dyspepsia, a history of peptic ulcer complications, or a family history of gastric cancer⁵ receive treatment? Windsor et al do not describe what follow-up their survey participants received. Without clarity on this point (especially appropriate advice to those who were asymptomatic), we wonder what negative impacts a positive *H. pylori* finding had on participants’ social and emotional well-being.

We are concerned by the authors’ anthropological musings: “Indigenous people may have their own *H. pylori* strains”. Given Australia’s heterogeneous Indigenous population, this potential research question is of no strategic relevance.⁴ The promotion of expanded testing for *H. pylori* is not supported by the evidence.

Talley’s accompanying editorial prioritises a “randomised controlled trial to test the health benefits (and risks) of population-based screening and antibiotic treatment [for *H. pylori*] in Indigenous Australians”.⁵ In the absence of a clinical endpoint for an as-yet undefined health problem, there is no convincing argument for such a trial.

Narrow medical answers to health problems that ignore economic and environmental solutions are not evidence-based. Both articles should have argued strongly for political commitment to these solutions to address a wide range of existing poverty-related diseases which currently affect Aboriginal and Torres Strait Islander people on a massive scale.

1. Windsor HM, Abioye-Kuteyi EA, Leber JM, et al. Prevalence of *Helicobacter pylori* in Indigenous Western Australians: comparison between urban and remote rural populations. *Med J Aust* 2005; 182: 210-213.
2. Couzos S, Murray R, editors, for the Kimberley Aboriginal Medical Services Council. Aboriginal primary health care: an evidence-based approach. 2nd ed. Melbourne: Oxford University Press, 2003.
3. Australian Bureau of Statistics. Census of population and housing 2001. Indigenous profile. Community profile series. Canberra: ABS, 2002. (ABS Catalogue No. 2002.0)

4. Couzos S, Lea T, Murray RB, Culbong M. “We are not just participants, we are in charge”: the NACCHO ear trial and the process for Aboriginal community-controlled health research. *Ethn Health* 2005; 10: 91-111.
5. Talley NJ. *Helicobacter pylori* infection in Indigenous Australians: a serious health issue? [editorial] *Med J Aust* 2005; 182: 205-206. □

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IN REPLY: We agree with Mayers and colleagues that the vexing issue of Indigenous health is a political one.

We undertook this study because we thought it very strange that the prevalence of *Helicobacter pylori* was known in most populations on the globe, but not in Australian Indigenous people. Results from each participant in the study were forwarded to the clinicians at the test sites. These results were discussed with the participants and those who needed, or asked for, treatment received antibiotic therapy.

In a previous editorial in the Journal, Mayers and Couzos state that “preventive health assessments are obviously needed earlier, given the occurrence of preventable chronic disease at younger ages and higher rates than in other Australians”.¹ We agree with this, and it is to be hoped that our data will encourage further assessment and awareness of *H. pylori* infection in people of all ages in the Australian Indigenous community.

1. Mayers NR, Couzos S. Towards health equity through an adult health check for Aboriginal and Torres Strait Islander people: an important Australian initiative that sets an international precedent. [editorial] *Med J Aust* 2004; 181: 531-532. □

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