

Childhood recurrent abdominal pain and *Helicobacter pylori* infection, Islamic Republic of Iran

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الألم البطني المتكرر في مرحلة الطفولة والعدوى بالملووية البوابية في جمهورية إيران الإسلامية حسين علي محمدی، نسرين فولادی، فرهاد صالح زاده، شیرین علی بور، مهري جوادى

الخلاصة: لقد درسنا دور العدوى بالملووية البوابية كسبب للألم البطني المتكرر عند الأطفال الإيرانيين في دراسة حالات وشواهد سكانية المرتكز لتحديد العلاقة بين العدوى بالملووية البوابية وبين الألم البطني المتكرر عند تلاميذ المدارس. حيث جرى فحص ما مجموعه 1558 طفلاً تراوح أعمارهم بين 6 و13 سنة. وجرى اختبار الأطفال الذين يعانون من ألم بطني متكرر مؤكّد بحسب معيارَي آلي ونيش؛ فاخترت 145 حالة لإدراجها في الدراسة، وقورنت مع 145 من الأطفال الأصحاء الذين تم اختيارهم من نفس المنطقة. وخضعت كلا الفئتين لاختبار التحري عن المستضد في البراز. فكان معدل وقوع الألم البطني المتكرر عند الأطفال الذين فُحصوا 9.3%. وكانت نسبة العدوى بالملووية البوابية عند الأطفال الذين يعانون من ألم بطني متكرر أعلى مما هي عليه عند الفئة الشاهدة (58.6% مقابل 44.8%) (OR=1.744; 95% CI: (1.095-2.776). ولم يكن هناك فرق كبير بين أعراض الألم البطني المتكرر عند الأطفال الذين كان البراز لديهم إيجابياً - أي: المصابين بعدوى الملووية البوابية - وبين أولئك الذين كانت الاختبارات لديهم سلبية. ولقد تعرفنا على وجود عدوى بالملووية البوابية عند أكثر من 55% من فئة الحالات. وبالتالي يمكن اعتبار العدوى بالملووية البوابية عاملاً مهماً من عوامل الإصابة بألم بطني متكرر عند الأطفال.

ABSTRACT We examined the role of *Helicobacter pylori* infection as a cause of recurrent abdominal pain (RAP) among Iranian children in a population-based case-control study to determine the association between *H. pylori* infection and RAP among schoolchildren. A total of 1558 children aged 6–13 years were examined. Children with RAP confirmed by the Apley and Naish criteria were selected; 145 cases were selected for inclusion and were compared with 145 healthy children recruited from the same area. Both groups underwent stool antigen testing. The prevalence of RAP in the children tested was 9.3%. Children with RAP had a higher *H. pylori* infection rate than the control group (58.6% vs 44.8%) (OR = 1.744; 95% CI: 1.095–2.776). There was no significant difference between the RAP symptoms in children with positive stool test, i.e. infected with *H. pylori*, and those whose tests were negative. We identified *H. pylori* infection in more than 55% of the case group. Therefore, *H. pylori* infection can be considered an important factor for RAP in children.

Douleur abdominale récurrente chez l'enfant et infection par *Helicobacter pylori*, République islamique d'Iran

RÉSUMÉ Nous avons examiné le rôle de l'infection par *Helicobacter pylori* en tant que cause de douleur abdominale récurrente parmi des enfants iraniens au cours d'une étude cas-témoin populationnelle afin de déterminer l'association entre cette infection et la douleur abdominale récurrente chez les enfants scolarisés. Au total, 1558 enfants âgés de 6 à 13 ans ont été examinés. Des enfants souffrant d'une douleur abdominale récurrente confirmée selon les critères définis par Apley et Naish ont été sélectionnés : 145 cas répondant au critère d'inclusion ont été comparés avec 145 enfants en bonne santé de la même région. Les deux groupes ont été soumis à un test de recherche d'antigènes dans les selles. L'incidence de la douleur abdominale récurrente testée était de 9,3 %. Les enfants ayant une douleur abdominale récurrente présentaient un taux d'infection par *H. pylori* plus élevé que le groupe témoin (58,6 % contre 44,8 % ; OR = 1,744 et IC à 95 % : 1,095-2,776). Il n'y avait pas de différence significative entre les symptômes de douleur abdominale récurrente chez les enfants ayant des coprocultures positives, donc une infection par *H. pylori*, et ceux dont les tests étaient négatifs. Nous avons identifié une infection par *H. pylori* chez plus de 55 % d'enfants du groupe témoin. Par conséquent, l'infection par *H. pylori* peut être considérée comme un facteur important de douleur abdominale chez l'enfant.

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Introduction

Recurrent abdominal pain (RAP) is a prevalent gastrointestinal problem among preschool children and school-children (1). It is defined as sudden abdominal pain that occurs in the child at least 3 times over a span of 3 months or more, and is severe enough to affect his/her daily activity (2,3). Around 10–15% of schoolchildren experience RAP, and most often the pain does not interfere with their school attendance, their efficiency, their interaction with other students, their activities while exercising or their personal and family affairs. Children who have RAP are usually at risk of anxiety, depression and loss of self-esteem (4–6). The difference in etiology of RAP in children can arise from functional gastrointestinal disorders or organic diseases (7).

Helicobacter pylori infection commonly occurs in childhood and lasts for a number of years (1,4,5,8). There is some evidence of a positive association between *H. pylori* infection and RAP. Several studies have demonstrated that between a quarter and a third of children with RAP had positive *H. pylori* infection (9–11). However, other studies did not support a causal association (6,12,13).

The association between *H. pylori* colonization and RAP is still controversial. Therefore, further studies need to be conducted to examine whether the role of *H. pylori* is causal. Considering the regional conditions and the high incidence of *H. pylori* colonization in the population under study (14), the present study aimed to explore the association between *H. pylori* infection and RAP in children in Ardabil, in the north west of the Islamic Republic of Iran.

Methods

Study design and population

We conducted a population-based, case–control study to investigate the relationship between *H. pylori* infection and RAP in children in Ardabil.

In the first phase of the study, because there is a wide variation in the socioeconomic conditions of the population in different areas of the city, the city was classified into 4 zones, north, south, east and west, and 4 schools were randomly selected in each zone. In each school, based on student numbers, 90–100 students were randomly chosen and examined according to Apley and Naish criteria (3).

Of 1556 students in the 16 schools surveyed from November 2012 to July 2013 in Ardabil city, we identified 155 children with confirmed RAP (all patients were assessed by a consultant paediatrician) (3).

Children who had received antibiotics, acid suppression drugs or anti-*H. pylori* therapy during the 3 months prior to the study, were excluded from the *H. pylori* sub-analysis. A total of 10 children had received these treatments and were excluded; so the total number of children in the study group was 145.

In the second phase of the study, 145 healthy children from the same area who had no clinical manifestations of RAP, who met the exclusion criteria and were normal on physical examination were recruited as the control group. The controls were selected to match in terms of age and residential status with the case group. Both groups underwent stool antigen tests using the HpSA enzyme-linked immunosorbent assay.

The study was approved by the ethics board of Ardabil University of

Medical Sciences. Informed consent was obtained from the parents of each child.

Helicobacter pylori stool antigen test

A microwell-based enzyme immunoassay was used to detect *H. pylori* antigens in stools (FemtoLab *H. pylori*; Astra, Italy). The stool samples were collected from each participant in clean containers and analysed according to the manufacturer's instructions. Spectrophotometric determination was performed using an enzyme immunoassay microplate reader at wavelength 450 nm (Stat Fax 2002, USA). Specimens with absorbance values ≥ 0.4 were defined as positive.

Statistical analysis

The results were analysed using SPSS, version 16, using chi-squared, Fisher exact test and the *t*-test to examine the relationship between *H. pylori* infection and RAP. Statistical significance was set at the 5% level.

Results

We examined 1556 children from 16 schools, and 145 were observed to have RAP, 71 (49%) boys and 74 (51%) girls. The prevalence of childhood RAP in our sample was 9.3%.

The stool antigen test for *H. pylori* was positive for 85 individuals in the case group (58.6%) and 65 individuals in the control group (44.8%). The relationship between RAP and *H. pylori* infection was statistically significant (OR = 1.744; 95% CI: 1.095–2.776, $P = 0.01$).

The age and sex distribution of the children in the 2 groups was comparable (Table 1). The average age was 8.77 [standard deviation (SD) 1.85] years in the case group and 8.81 (SD 1.90) years in the control group. There

Table 1 Demographic characteristics of children with recurrent abdominal pain (RAP) ($n = 145$) and a control group ($n = 145$) in Ardabil, November 2012–July 2013

Characteristic	Children with RAP		Controls		P-value
	<i>H. pylori</i> positive	<i>H. pylori</i> negative	<i>H. pylori</i> positive	<i>H. pylori</i> negative	
Age (years) mean (SD)	8.70 (1.80)	8.83 (1.94)	8.98 (1.91)	8.67 (1.88)	0.8
	No. (%)	No. (%)	No. (%)	No. (%)	
Stool antigen test	85 (58.6)	60 (41.4)	65 (44.8)	80 (55.2)	0.01
Age (years)					
6–7	28 (62.2)	17 (37.8)	21 (45.7)	25 (54.3)	0.9
8–9	25 (58.1)	18 (41.9)	14 (34.1)	27 (65.9)	
10–11	28 (59.6)	19 (40.4)	24 (53.3)	21 (46.7)	
12–13	4 (40)	6 (60)	6 (46.2)	7 (53.8)	
Sex					
Male	49 (69.0)	22 (31.0)	36 (52.2)	33 (47.8)	0.8
Female	36 (48.6)	38 (51.4)	29 (38.2)	47 (61.8)	
Source of drinking water					
Mineral water	9 (75.0)	3 (25.0)	8 (44.4)	10 (55.6)	0.6
Municipal tap water	63 (58.3)	45 (41.7)	40 (47.1)	45 (52.9)	
Boiled water	13 (52)	12 (48)	17 (40.5)	25 (59.9)	
Socioeconomic status*					
Under poverty line	37 (71.2)	15 (28.8)	34 (55.7)	27 (44.3)	0.02
Above poverty line	48 (51.6)	45 (48.4)	31 (36.9)	53 (63.1)	

*Self reported (monthly income verified with parents then classified in accordance with official poverty line by researcher)

was no statistically significant difference between these groups in terms of age ($P \geq 0.05$).

The relationship observed between the rate of *H. pylori* infection and socioeconomic status was statistically significant, with a greater proportion of children from poorer families being infected ($P = 0.02$; CI: 1.29–3.4) (Table 1). There was no statistically significant correlation between the rate of *H. pylori* infection and source of drinking water ($P = 0.6$).

The characteristics of RAP in children are shown in Table 2. Duration of abdominal pain was 3–6 months in 101 children (69.65%) had. In 55 cases, the pain was periumbilical.

In 30 cases (20.7%) had abdominal pain within 30–60 min following the consumption of milk, yoghurt or ice cream. Defecation reduced pain in 109 (75.2%) children with RAP.

Over 75% of children had visited a paediatrician for RAP, and over 95% reported that the pain inhibited and

interfered with their daily activities (Table 2).

The main concomitant gastrointestinal symptoms in children were constipation in 25 children (17.24%), and pain as a result of hunger in 53 children (36.5%). In these cases also the pain subsided with defecation.

The pain occurring as a result of hunger is one of the commonest symptoms in children, thus, it should be noted that the majority of cases in this study presented with other symptoms along with abdominal pain.

Discussion

Recurrent abdominal pain is the clinical manifestation of a series of disorders. Abdominal pain is the main gastrointestinal complaint in preschool and school children with a prevalence of about 10% (1). In the present study, the prevalence of RAP in children was 9.3%; in some previous studies this ranged from 10%

to 15% among 4–16-year-old children (6,14). Also, Yang et al. demonstrated a prevalence of 9.8% in schoolchildren (1), which is in concordance with our findings. The mean age of children suffering from RAP in the present study was 8.7 years, whereas in several previous Iranian studies on RAP in children, carried out in other areas of the country, a mean age of 12.7 years was reported (5,15). Similarly, in a study performed by Ukarapol et al., mean age was 10.5 years for children with RAP (16).

No statistically significant difference was observed between the sexes in terms of RAP incidence. These findings are in line with studies conducted on Iran, European and Sri Lankan children (5,6,17,18). To date, in almost all studies conducted on children with RAP, around half were male and half female.

In this study, a positive relationship between *H. pylori* infection and RAP was observed, which is in agreement with the findings of Wewer et al. (9), Özen et al. (10) and Das et al. (11).

Malaty et al. have shown that *H. pylori* infection occurs in about 81% of children suffering from RAP (14). The infection mainly develops during childhood and varies across populations.

We found a higher prevalence of *H. pylori* infection in males compared with female children, i.e. male gender is associated with a statistically higher risk of being infected. However, Ertem et al. (19), Iranikhah et al. (20) and Bode et al. (6) found no statistically significant relationship between sex and *H. pylori* infection. Our findings also diverge from the results of Özen et al. (10). The inconsistency among these finding could be ascribed to geographical variation and differences in sample size.

The present study revealed that there was no statistically significant relationship between different age groups with positive stool antigen, while studies carried out by Ertem et al. (19) in Turkey and Nakayama et al. (21) in Japan, indicated a significant relationship between age and *H. pylori* infection. Their findings suggested infection rate increased with age; however, a previous Iranian study found no significant relationship between *H. pylori* infection and age (5). In a study in Texas, USA, it was shown that the greater the age, the lower the infection rate (14). The discrepancies could arise from geographical and genetic variation among the individuals under study.

Table 2 Clinical data for schoolchildren (n = 145) with recurrent abdominal pain (RAP) in Ardabil, November 2012–July 2013

Characteristic	No. (%)
Duration of RAP	
2 weeks–3 months	3 (2.1)
3–6 months	101 (69.5)
6–12 months	20 (13.9)
> 12 months	21 (14.5)
Frequency of pain	
More than 1 attack per week	109 (75.2)
More than 1 attack per month	36 (24.8)
Location of pain	
Epigastric	49 (33.8)
Periumbilical	55 (37.9)
Infraumbilical	6 (4.2)
Undefined	35 (24.1)
Previous consultation for abdominal pain	
Yes	111 (76.6)
No	34 (23.4)
Pain relieved with defecation	
Yes	109 (75.1)
No	36 (24.9)
Interferes with normal daily activities	
Yes	139 (95.9)
No	6 (4.1)
Pain attack 30–60 min after consuming milk or milk products	
Yes	30 (20.7)
No	115 (79.3)

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