Cost-effectiveness modelling of use of urea breath test for the management of Helicobacter pylori-related dyspepsia and peptic ulcer in the UK

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ABSTRACT

Objective Clinical data comparing diagnostic strategies in the management of Helicobacter pylori-associated diseases are limited. Invasive and noninvasive diagnostic tests for detecting H. pylori infection are used in the clinical care of patients with dyspeptic symptoms. Modelling studies might help to identify the most cost-effective strategies. The objective of the study is to assess the cost-effectiveness of a ‘test-and-treat’ strategy with the urea breath test (UBT) compared with other strategies, in managing patients with H. pylori-associated dyspepsia and preventing peptic ulcer in the UK.

Design Cost-effectiveness models compared four strategies: ‘test-and-treat’ with either UBT or faecal antigen test (FAT), ‘endoscopy-based strategy’ and ‘symptomatic treatment’. A probabilistic cost-effectiveness analysis was performed using a simulation model in order to identify probabilities and costs associated with relief of dyspepsia symptoms (over a 4-week time horizon) and with prevention of peptic ulcers (over a 10-year time horizon). Clinical and cost inputs to the model were derived from routine medical practice in the UK.

Results For relief of dyspepsia symptoms, ‘test-and-treat’ strategies with either UBT (£526/success) and FAT (£518/success) were the most cost-effective strategies compared with ‘endoscopy-based strategy’ (£1317/success) and ‘symptomatic treatment’ (£1,029/success). For the prevention of peptic ulcers, ‘test-and-treat’ strategies with either UBT (£1317/success) and FAT (£191/success) were the most cost-effective strategies compared with ‘endoscopy-based strategy’ (£717/success) and ‘symptomatic treatment’ (£651/success) (1 EUR≈0.871487 GBP at the time of the study).

Conclusion ‘Test-and-treat’ strategies with either UBT or FAT are the most cost-effective medical approaches for the management of H. pylori-associated dyspepsia and the prevention of peptic ulcer in the UK. A ‘test-and-treat’ strategy with UBT has comparable cost-effectiveness outcomes to the current standard of care using FAT in the UK.

INTRODUCTION

Between 20% to 30% of people in Western Europe are infected with Helicobacter pylori (H. pylori)1 and these infections play a causative role in the development of dyspepsia, peptic ulcers, gastric adenocarcinoma and gastric mucosa-associated lymphoid tissue lymphoma.2-7 However, in most cases, H. pylori infections can be successfully eliminated with appropriate antibiotic treatment.8 For this reason, timely detection of H. pylori infections in individuals presenting with symptoms of dyspepsia is an important public

Summary

What is already known about this subject?

► Cost-effectiveness studies comparing strategies used for the management of Helicobacter pylori-associated diseases are limited.

► Timely detection of H. pylori infections in individuals presenting with symptoms of dyspepsia is an important public health issue in order to prevent the development of serious long-term complications such as gastric cancer.

► In the UK, faecal antigen test (FAT) is the most widely used noninvasive screening procedure for H. pylori, but no recent data about the relative cost-effectiveness of this strategy are available.

What are the new findings?

► ‘Test-and-treat’ strategies with either UBT or FAT are the most cost-effective medical approaches for the management of H. pylori-associated dyspepsia and the prevention of peptic ulcer in the UK.

► ‘Test-and-treat’ strategy with UBT has comparable cost-effectiveness outcomes to the strategy using FAT.

How might it impact on clinical practice in the foreseeable future?

► Provide decision-makers with comparative data on the cost-effectiveness of noninvasive tests for testing and retesting for H. pylori infection.

► Confirm that noninvasive tests such as UBT represent cost-effective and practical options for use in routine clinical practice in the UK.

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health issue in order to prevent the development of serious long-term complications. Moreover, in spite of the initial cost, screening for H. pylori has been shown to generate significant reductions in total dyspepsia-related healthcare costs over the long term. Such screening programmes may also be cost-effective for the prevention of gastric carcinoma.

Historically, H. pylori infections were typically diagnosed by analysis of biopsy samples taken from the stomach during endoscopy. However, this is an invasive procedure requiring hospital attendance and is resource consuming in terms of endoscopists’ time and laboratory testing. For this reason, alternative diagnostic methods that are simpler to use and can be performed in the community are of interest. In this respect, two types of noninvasive tests have been developed. The faecal antigen test (FAT) involves collecting a faecal sample that is sent for assay of H. pylori-specific antigens using enzyme immunoassay or immunochromatography. The urea breath test (UBT) involves ingestion of [13C]-urea, which is broken down in the stomach by urease produced by H. pylori to ammonia and carbon dioxide. The presence of [13C]-CO₂ in exhaled air is then detected by mass spectroscopy or infrared technologies.

Individual patient meta-analysis has demonstrated that test-and-treat strategies using FAT or UBT provide comparable effectiveness at relieving symptoms of dyspepsia as first-line endoscopy, but at a greatly reduced cost. Similar, although less robust, conclusions may be drawn for noninvasive test-and-treat strategies compared with empirical symptomatic treatment. For this reason, noninvasive H. pylori screening is now recommended in young patients with dyspepsia who do not have alarm symptoms. In England and Wales, practice guidelines produced by the National Institute for Health and Clinical Excellence (NICE) recommend that clinicians offer patients with dyspepsia under 55 years and who do not have alarm symptoms noninvasive H. pylori testing using UBT, FAT or laboratory-based serology where its performance has been locally validated.

We have recently performed a cost-effectiveness modelling study comparing a ‘test-and-treat’ strategy with UBT, ‘test-and-treat’ using endoscopy and empirical symptomatic treatment in the Spanish treatment setting. This study demonstrated that the UBT ‘test-and-treat’ strategy was the most cost-effective medical approach for management of dyspepsia and for the prevention of peptic ulcers and gastric cancer. However, this modelling study did not compare UBT with FAT, which is not widely used in Spain. In contrast, in the UK, FAT is the most widely used noninvasive screening procedure for H. pylori, but no recent data about the relative cost-effectiveness of these different strategies are available. For these reasons, we undertook a second modelling study based on practices and costs in the UK. The objective of this study was to compare the cost-effectiveness of four different management strategies (UBT, FAT, endoscopy and empirical symptomatic treatment) in the context of the British healthcare system.

MATERIALS AND METHODS

Study design

This medicoeconomic modelling study estimated the cost-effectiveness of the ‘test-and-treat’ strategy using UBT in the diagnosis of H. pylori infection and in the subsequent prevention of H. pylori-related complications. The ‘test-and-treat’ strategy using UBT for primary detection of H. pylori was compared with three other diagnostic strategies, namely, ‘test-and-treat’ using FAT, an ‘endoscopy-based strategy’ and a ‘strategy starting directly with empirical symptomatic treatment’. Two therapeutic outcomes were evaluated, relief of symptoms of dyspepsia and prevention of peptic ulcers. Values and costs were estimated from a decision tree model simulating the four strategies. The management pathways modelled correspond to those used in routine clinical practice in the UK, and transition probabilities were based on British data whenever available. Due to uncertainty associated with the estimates of several model inputs, probabilistic simulations were used to derive estimates of costs and outcomes. The analysis was performed from a public health insurance perspective, taking into account direct medical costs only. No cost discounting was applied.

Description of the model

The decision tree model used in the study consisted of a succession of decision nodes identifying decisions to test for H. pylori, to undertake endoscopy, to initiate symptomatic treatment or antibiotic treatment for H. pylori eradication and to evaluate effectiveness. A corresponding set of event nodes identify the possible outcomes of these decisions. Each branch of the decision tree ends in a terminal node defined by the therapeutic outcome (success or failure). Independent decision trees were constructed for each of the four management strategies evaluated. These decision tree models used in the study are illustrated schematically in online supplemental material.

UBT and FAT strategies

These two strategies follow an identical management pathway. The first step is testing for H. pylori with one of the two methods. If the pathogen is detected, first-line antibiotic therapy with clarithromycin-based triple therapy is initiated to eradicate it (according to the reference guide published by Public Health England). If a switch to other first-line therapies would become necessary (ie, clarithromycin resistance >15%), costs of therapy will remain similar. At the end of the prescribed treatment course, the patient is retested by UBT or FAT. In case of persistence of the infection, a second-line eradication treatment is initiated and the patient then tested again. Therapeutic outcomes are modelled after first-line therapy in the case of successful eradication or after second-line therapy regardless of whether eradication had been achieved.

In the case of a negative H. pylori test, symptomatic treatment, including mainly a proton pump inhibitor (PPI),
is initiated for 4 weeks, and therapeutic outcome is evaluated at the end of this period. If symptoms have been relieved, the treatment is considered successful. If not, the patient undergoes endoscopy to identify any potential lesion (peptic ulcer or other macroscopic pathology).

**Endoscopy-based strategy**
In this strategy, the first step is to perform an endoscopy to detect any lesion and to take biopsies for *H. pylori* assay. If the assay result is negative, a 4-week symptomatic treatment is initiated after which outcome (symptom relief) is evaluated. If the result is positive, the patient undergoes first-line, and, if a retest is again positive, second-line, antibiotic treatment to eradicate the pathogen. As in the UBT and FAT strategies, therapeutic outcomes are modelled after first-line therapy in the case of successful eradication or after second-line therapy regardless of whether eradication had been achieved.

**Empirical symptomatic treatment strategy**
In this strategy, the first step is to start empirical symptomatic treatment with a PPI for 4 weeks. If symptoms have been relieved, the treatment is considered successful. If not, the patient undergoes endoscopy and follows the endoscopy strategy described above.

**End states**
For each management strategy, two end states were modelled. The first was the relief of dyspepsia symptoms at 4 weeks after initiation of symptomatic treatment (either following a negative *H. pylori* test in the two ‘test and treat’ and the ‘endoscopy-based’ strategies or during the first stage of the model in the ‘treat-and-test’ symptomatic treatment strategy). The second endpoint was prevention of occurrence (or recurrence) of a peptic ulcer over 10 years following a negative *H. pylori* test. Both end states were considered as binary variables (symptom relief vs no symptom relief and ulcer prevented vs ulcer not prevented). A payoff of 1 was assigned if the treatment objective was achieved and a payoff of 0 if it was not achieved.

**Model inputs**

**Analysis population**
The analysis population modelled corresponded to patients consulting a gastroenterologist for symptoms of dyspepsia.

**Transition probabilities**
Transition probabilities for the different chance nodes of the decision tree are listed in table 1.

**Cost inputs**
For certain items, a fixed cost was applied when this was known. For others, a cost range was applied, corresponding to the different treatment options available (eg, for antibiotic treatment for elimination of *H. pylori*), differences in laboratory costs for test assays or to expert opinion when the exact cost was unknown (eg, for the management of peptic ulcer). All costs used in the model are presented in euros (1 EUR=0.871487 GBP) and are listed in table 2.

For the UBT and FAT, costs include kit acquisition and test analysis. For endoscopy, two possible costs were applied. In the case when endoscopy revealed no suspect lesions, the cost applied was the procedure cost of endoscopy along with a rapid urease test. If suspect lesions were identified and biopsy samples were taken, the cost

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**Table 1** Model inputs: transition probabilities

<table>
<thead>
<tr>
<th>Event</th>
<th>Probability</th>
<th>Range</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>H. pylori</em> positivity rate by UBT</td>
<td>0.16</td>
<td></td>
<td>Allison et al.22</td>
</tr>
<tr>
<td><em>H. pylori</em> positivity rate by FAT</td>
<td>0.13</td>
<td></td>
<td>Allison et al.22</td>
</tr>
<tr>
<td>Lesion frequency during endoscopy</td>
<td>0.05</td>
<td></td>
<td>Ching et al.30</td>
</tr>
<tr>
<td><em>H. pylori</em> positivity by endoscopy (no lesion)</td>
<td>0.12</td>
<td></td>
<td>Moore31</td>
</tr>
<tr>
<td><em>H. pylori</em> positivity by endoscopy (with lesion)</td>
<td>0.51</td>
<td></td>
<td>Zullo et al.22</td>
</tr>
<tr>
<td><em>H. pylori</em> eradication rate after first line antibiotic treatment</td>
<td>0.84</td>
<td></td>
<td>Nayar33</td>
</tr>
<tr>
<td><em>H. pylori</em> eradication rate after second line antibiotic treatment</td>
<td>0.78</td>
<td></td>
<td>Lin and Hsu34</td>
</tr>
<tr>
<td>Dyspepsia relief after 4 week symptomatic treatment</td>
<td>0.3–0.4</td>
<td></td>
<td>Rabeneck et al.35</td>
</tr>
<tr>
<td>Dyspepsia relief after 48 week symptomatic treatment (<em>H. pylori</em> negative)</td>
<td>0.12</td>
<td></td>
<td>Pinto-Sanchez et al.36</td>
</tr>
<tr>
<td>Dyspepsia relief after <em>H. pylori</em> eradication</td>
<td>0.4–0.73</td>
<td></td>
<td>Du et al.37</td>
</tr>
<tr>
<td>Dyspepsia relief after <em>H. pylori</em> eradication failure</td>
<td>0.32–0.54</td>
<td></td>
<td>Ford et al.37 and Heaney et al.38</td>
</tr>
<tr>
<td>Peptic ulcer after 4 week symptomatic treatment</td>
<td>0.05–0.25</td>
<td></td>
<td>Rabeneck et al.35 and Färkkilä et al.39</td>
</tr>
<tr>
<td>Peptic ulcer after <em>H. pylori</em> eradication</td>
<td>0.07</td>
<td></td>
<td>Gisbert et al.40</td>
</tr>
<tr>
<td>Peptic ulcer after <em>H. pylori</em> eradication failure</td>
<td>0.55</td>
<td></td>
<td>Gisbert et al.40</td>
</tr>
</tbody>
</table>

Lesions detected during endoscopy are generally related to gastric or duodenal lesions such as ulceration or precancerous lesions. FAT, faecal antigen test; UBT, urea breath test.

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of histological testing for *H. pylori* was also included. It was assumed that five biopsy samples would be analysed by histology and one rapid urease test. These procedures were costed according to NHS National tariffs. If an ulcer was detected by endoscopy, then the cost of management was included.

 Acquisition costs for symptomatic treatment of dyspepsia and for antibiotic treatment for elimination of *H. pylori* were taken from the recommended retail price listed in the NHS National tariff.

**Model outputs**  
**Values**

For each treatment strategy, the expected value of each outcome of interest was computed as the product of the transition probabilities at each node of the relevant branch of the tree. Monte Carlo simulations were performed with 10000 iterations, each using a randomly selected transition probability within the prespecified range. Expected values are presented as the mean and SD of the results of the individual Monte Carlo iterations.

**Costs**

For each treatment strategy, the total cost of each outcome of interest was computed according to the probabilities at each node of the tree. Monte Carlo simulations were performed with 10000 iterations, each using a randomly selected value within the prespecified cost range. Total costs are presented as the mean and SD of the results of the individual Monte Carlo iterations.

**RESULTS**

**Value outcomes**

For dyspepsia relief, the expected value of the treatment strategy ranged from 0.38 for endoscopy to 0.58 for the FAT (table 3). For prevention of peptic ulcer occurrence/recurrence, the expected value of the treatment strategy ranged from 0.10 for symptomatic treatment to 0.15 for the UBT and for the FAT (table 3).

**Cost outcomes**

For dyspepsia relief, the total cost of the treatment strategy ranged from €298 for the FAT to €497 for endoscopy (table 3). For prevention of peptic ulcer occurrence/recurrence, the total 10-year cost of the treatment strategy

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**Table 2** Model inputs: costs

<table>
<thead>
<tr>
<th>Item</th>
<th>Fixed cost (£)</th>
<th>Cost range (£)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy with urease test</td>
<td>474</td>
<td>22–36.4</td>
<td>NHS National Tariff</td>
</tr>
<tr>
<td>Endoscopy with biopsy</td>
<td>514</td>
<td>22–36.4</td>
<td>NHS National Tariff</td>
</tr>
<tr>
<td>UBT kit and assay</td>
<td>16.7</td>
<td>13.8–21.8</td>
<td>Expert opinion</td>
</tr>
<tr>
<td>FAT kit and assay</td>
<td>19.2–27.1</td>
<td>BNF</td>
<td></td>
</tr>
<tr>
<td>Follow-up test after eradication</td>
<td>19.1–26.9</td>
<td>BNF</td>
<td></td>
</tr>
<tr>
<td>Antibiotic treatment (first line)</td>
<td>19.1–34.7</td>
<td>BNF</td>
<td></td>
</tr>
<tr>
<td>Antibiotic treatment (second line)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of peptic ulcer</td>
<td>575–1150</td>
<td>Expert opinion</td>
<td></td>
</tr>
</tbody>
</table>

UBT, urea breath test; FAT, faecal antigen test; BNF, British National Formulary.

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**Table 3** Model outputs: costs and values according to management strategy

<table>
<thead>
<tr>
<th></th>
<th>Dyspepsia relief</th>
<th>Peptic ulcer prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost/treatment</td>
<td>Value</td>
</tr>
<tr>
<td>Urea breath test</td>
<td>€302±228</td>
<td>0.57±0.03</td>
</tr>
<tr>
<td>Faecal antigen test</td>
<td>€298±227</td>
<td>0.58±0.02</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>€497±14</td>
<td>0.38±0.03</td>
</tr>
<tr>
<td>Symptomatic treatment</td>
<td>€479±342</td>
<td>0.47±0.02</td>
</tr>
</tbody>
</table>

Values are presented as mean values±SD.
The UK is considered a low-prevalence country for *H. pylori*, and the proportion of patients with dyspepsia who are tested positive for this organism is likely to be around 15%. It should be noted that the actual prevalence of *H. pylori* infection in dyspeptic patients in the UK has not recently been comprehensively assessed and that any estimate higher than 15% in *H. pylori* prevalence would benefit test-and-treat strategy cost-effectiveness outcomes. In addition, diagnostic tests need to have high performance rates and to be cheap, in order to be cost effective. The UBT fulfils both these conditions, with sensitivity, specificity, positive predictive value and negative predictive value all being >95%, comparable to the performance of the FAT.

In spite of the fact that UBT is the most accurate noninvasive test for *H. pylori* and is recommended by NICE, it remains relatively underused compared with FAT in the UK. A survey of all accredited microbiology laboratories in England, conducted in 2015, found that >90% of laboratories proposed FAT as the first-line diagnostic test compared with <5% who proposed the UBT. Since UBT, unlike FAT, requires prescription of the labelled reagent, the authors of this study speculated that physicians were not encouraged to prescribe by their local funding body.

Compared with our previous cost-effectiveness modelling study in the Spanish setting, and despite the differences between healthcare systems and the prevalence of *H. pylori*, the results were similar. In both Spanish and British settings, the cost per treatment success was higher for the endoscopy and empirical treatment strategies than for the UBT strategy.

The currently available noninvasive strategies for *H. pylori* assessment do not provide information about antibiotic susceptibility. However, real-time PCR tests have been developed that permit assessment of clarithromycin susceptibility using faecal samples. These may be helpful in the future, but at present are not readily available in the UK and elsewhere. If these tests are used for additional characterisation of *H. pylori*-positive patients in the future, this would potentially increase the cost of a stool-based testing strategy but will comply with the demands for a proper antibiotic stewardship in management of *H. pylori* infection.

The study has a number of limitations. In particular, the transition probabilities and certain costs used in the model are not known with precision for the UK context, and a range of values has been tested for most variables using a probabilistic approach. In consequence, the model outputs (costs and values) are also limited in their precision. Second, the model assumes that all patients offered FAT, UBT or endoscopy will actually undertake them. Any differences in test acceptability and patient uptake will not be reflected in the model.

In conclusion, this health economic modelling study predicts that ‘test-and-treat’ strategies with either UBT or FAT are the most cost-effective medical approaches for the management of *H. pylori*-associated dyspepsia and the...
prevention of peptic ulcer in the UK. The ‘test-and-treat’ strategy with UBT has comparable cost-effectiveness outcomes to the current standard of care using FAT in the UK.

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