INTRODUCTION
INTRODUCTION

Dyspepsia, which has been defined as recurrent upper abdominal or retrosternal pain, vomiting or other symptoms felt to be referable to the upper GI tract [1], is by far the commonest ailment, demanding maximum consultation in any outpatients department of Gastroenterology.

A multitude of causes have been implicated in the symptoms of dyspepsia of which gastritis, peptic ulcer, esophagitis and cancer are only to name some.

The first reports of the association of dyspepsia with *Helicobacter pylori* came in the late seventh and early eighth decades when Steer HW (1975) reported a spiral bacterium in 80% of specimens resected from patients with gastric ulceration [2]. These bacteria were microaerobic, curved, Gram negative and resembled Campylobacters; they were therefore called *Campylobacter pylori*. The genus *Helicobacter* was suggested in 1989 when the organisms showed differences with *Campylobacter*.

Upper gastrointestinal tract abnormalities ranging from gastroparesis to minor dyspeptic symptoms are frequent in patients suffering from long standing Diabetes mellitus [3]. The pathogenesis of these symptoms is poorly understood. But it is thought that
gastrointestinal motility disturbances related to autonomic and vagal neuropathy may be involved.

*Labenz J et al and Fisher RS et al* in different studies speculated that *Helicobacter pylori* infection could play a role [4, 5].

Data concerning the prevalence of *Helicobacter pylori* infection in patients with diabetes are scanty and controversial; various studies have however been conducted to establish this association.

*Gasbarrini A et al (1998)* noted that patients affected by insulin dependent diabetes mellitus show a high prevalence of *Helicobacter pylori* infection.

The reason for this association may be multifold. One of these may be the increased susceptibility of diabetics to be infected by bacteria and fungi far more than healthy subjects [6].

This susceptibility may also be due in part to neutrophil dysfunction with failure of chemotaxis, phagocytosis and in part to the reduction of lymphocytic activity so commonly associated with diabetes [7].

Diabetes is characterized by autonomic neuropathy and microvascular disorders. In particular 40-50% of diabetes patients have gastric motility disturbances such as delayed gastric emptying.

Together with neuropathy, another important feature of diabetes is the development of microvascular complications that could be the result of long-standing functional abnormalities in the microcirculation such as altered capillary pressure, blood flow and permeability, which are present from an early stage in the course of diabetes. These factors may again predispose to an increased prevalence of *Helicobacter pylori* infection.

The current approach in diabetes management is to give the patient a symptom free life with adequate blood sugar control and prompt and active management of complications.

In accordance with this approach it is desirable to finely scrutinize these symptoms and their etiology. Awareness of the correct etiology is central to the management of any ailment. Establishment of an association of *Helicobacter pylori* with dyspepsia in diabetes will therefore revolutionize its treatment; as the treatment of *Helicobacter pylori* infection is increasingly becoming simple and effective. “Standard triple therapy” given for two weeks eradicates *Helicobacter pylori* in 90% of cases [8].
The present study aims at accumulating evidence for an association of *Helicobacter pylori* with dyspepsia in diabetes by comparing the prevalence of *Helicobacter pylori* in diabetic dyspeptic and non-diabetic dyspeptic patients.