Transmission of *Helicobacter pylori* and the role of water and biofilms

Steven L. Percival and John G. Thomas

**ABSTRACT**

Documented evidence relating to the survival of *Helicobacter pylori* outside the gastric niche is extremely limited. To date the primary transmission routes of *H. pylori* have yet to be confirmed and when this is achieved preventive infection control measures can be implemented to reduce and ultimately prevent human infection from this pathogen. There is mounting evidence which suggests that the prevalence of *H. pylori* infection has a strong correlation with access to clean water, suggesting a transmission route to the host. However, there are no established culture methods for the detection of viable *H. pylori* in the environment, in particular drinking water supplies, preventing the development of true epidemiological and risk assessments. The aim of this review is to highlight the available data to date that suggests drinking water and possible survival in biofilms as a probable transmission mode for *H. pylori*.

**Key words** | biofilm, drinking water, *Helicobacter pylori*, viable but non-cultur able (VBNC)

**INTRODUCTION**

*Helicobacter pylori* are micro-aerophilic spiral-shaped bacteria that efficiently colonize the human gastric mucosa (Moreno *et al.* 2007). They were first identified in autopsied rabbits in 1893 (Rothenbacher & Brenner 2003), described in humans in 1906 (Rothenbacher & Brenner 2003), and successfully cultured in 1983 (Warren & Marshall 1983). Initially, research-based studies classified *H. pylori*, based on its ‘*Campylobacter* like’ morphology and biochemistry, as *Campylobacter pyloridis* (Warren & Marshall 1983). Later the name of the bacterium was changed to *Campylobacter pylori* and then finally classified as *Helicobacter pylori* some years later (Owen 1995).

*Helicobacter pylori* is Latin for ‘spiral rod of the lower part of the stomach’. It is known to cause inflammation in the form of chronic active gastritis, specifically in certain humans. In addition, *H. pylori* has been linked to a diverse spectrum of gastrointestinal disorders which include peptic ulcer disease, gastric adenocarcinoma and gastric mucosa-associated lymphoid tissue (MALT) lymphoma (Farinha & Gascoyne 2005). MALT lymphoma is a relatively rare condition caused by *H. pylori* and only very small percentages (1–2%) of infected individuals develop a malignant disease.

Clinical disease typically occurs decades after initial acquisition of infection. However, gastritis may progress over time from an initially superficial nonatrophic form to a more severe atrophic gastritis, with intestinal metaplasia, leading to duodenal ulceration, gastric adenocarcinoma and gastric MALT lymphoma (Farinha & Gascoyne 2005). Because of the vast array of conditions and public health concerns that surround *H. pylori*, the World Health Organization International Agency for Research on Cancer classified *H. pylori* as a class I carcinogen in humans (Sherman 2004). While only a small percentage of individuals carrying *H. pylori* ever develop clinical sequelae, asymptomatic carriage is common (Peterson & Krogfelt 2003) and if left untreated *H. pylori* infection is lifelong (Czinn 2005).

Although it is estimated that approximately 50% of the world’s population is colonized with *H. pylori*, prevalence varies widely by age as well as country, ethnic background and socio-economic conditions (Czinn 2005).
The developing world carries the greatest burden, with over 70% of children infected by age 15 (Czinn 2005). In contrast the developed world has, since the 1950s, experienced a decrease in the prevalence of *H. pylori* with each successive generation; hence at present approximately 20% to 30% of individuals harbour *H. pylori* (Rothenbacher & Brenner 2005). This reduction has been attributed to improved socio-economic status and personal hygiene but may equally have transpired because of improvements in drinking water quality.

The aim of this review is to critically evaluate published data and determine whether water and biofilms may constitute possible transmission and environmental niches for *H. pylori*. Consequently, by establishing water and biofilms as a transmission route for *H. pylori* the development of appropriate control measures to reduce the incidence and prevalence of *H. pylori* even further is of great significance, particularly in developing countries.

**TRANSMISSION ROUTES OF H. PYLORI AND ACQUISITION**

Although the natural niche for *H. pylori* is the human stomach, for widespread infection to occur the organism may need to survive in the external environment (Brown 2000). To date the precise mechanism/s involved in the transmission of *H. pylori* is/are unknown, but clearly any approach that introduces the organism into the stomach of a susceptible person may lead to that individual acquiring an infection. Many transmission routes for *H. pylori* have been proposed and have included gastric-oral (Raymond et al. 2008), oral-oral (Mégraud 1995), faecal-oral (Raymond et al. 2008), zoonotic (Fox 1995) and water/food-borne (Hulten et al. 1996; Herrera 2004). Clearly these proposed transmission routes indicate that *H. pylori* infection occurs through multiple acquisition pathways (Goodman & Correa 1995; Velazquez & Feirtag 1999). Despite these proposals, contamination of food by human faecal material has been found to be one of the major risk factors for the acquisition of *H. pylori* (Hopkins et al. 1993).

*H. pylori* has been cultured from the faeces of infected individuals (Thomas et al. 1992; Kelly et al. 1994) and specific DNA sequences have been amplified from raw sewage (Forrest et al. 1998) providing possible evidence for the faecal-oral route of transmission. However, the faecal-oral route of transmission and its interpretation has been questioned, as the concentration of *H. pylori* cells present in faecal material is considered to be low, particularly when compared with other faecal pathogens of public health significance (Vincent 1995). Furthermore, the prevalence of *H. pylori* IgG antibodies in sewage workers, compared with a control group, matched for age and socio-economic status, has demonstrated no increased risk of infection when exposure to human faecal material has occurred (Friis et al. 1996). Despite controversy in this area there is growing evidence that suggests a faecal-oral transmission route for *H. pylori* (Mladenova et al. 2006). Consequently, if *H. pylori* is excreted within faeces they may well go on to colonize surfaces present in water sources. Such surfaces subsequently then become transmittable sources of *H. pylori* (Xia & Talley 1997).

The age at which humans are exposed to *H. pylori* may influence its route of transmission. For example, in an Argentinian study, the key risk factor for acquisition of *H. pylori*, specifically in childhood, was the nature of the water source (Olmos et al. 2000). In developing countries, many children are infected with *H. pylori* by the age of ten, and relapses are known to occur (Dooley et al. 1989; Gurel et al. 1999). In Peruvian children *H. pylori* prevalence was found to strongly correlate with socio-economic status: children were found to be three times more likely to be infected with *H. pylori* when they drank from an external water source than those exposed to water from an internal water source (Klein et al. 1991). However, no difference was found when those children from high- and low-income families with an internal water source were compared (Klein et al. 1991). Children born into high-income families supplied with municipal water are considered 12 times more likely to become colonized with *H. pylori* than those supplied from community wells (Frenck & Clemens 2003). This suggests that municipal water is a possible risk factor in the transmission and acquisition of *H. pylori*. It is plausible to suggest that breaks in municipal pipes allow for infiltration of contaminated surface water (Frenck & Clemens 2003). A group of 3,289 residents in Italy were screened for the prevalence of *H. pylori* IgG antibodies (Dominici et al. 1999). The conclusion drawn from this
study was that there was a common source of exposure to \textit{H. pylori} in the environment (Dominici et al. 1999).

Some research findings have shown that hands and fingernails contaminated with \textit{H. pylori} may transfer bacteria into a water source (Dowsett et al. 1999; Frenck & Clemens 2003). Evidence of \textit{H. pylori} presence in dental plaque has led to the suggestion by a number of researchers that the oral cavity may be a potential reservoir for this bacteria in the adult population (Luman et al. 1996; Cave 1997; Kamat et al. 1998; Oshowo et al. 1998a,b). Souton & Colombo (2008) found that the prevalence of \textit{H. pylori} can be as high as 33.3\% in subgingival biofilms and 20\% in saliva. Despite this it still remains unclear whether the oral cavity acts as a permanent reservoir for \textit{H. pylori} specifically as within this oral ecosystem \textit{H. pylori} is considered to be transient.

In addition to humans, domestic cats and Old World macaques have been found to be colonized with \textit{H. pylori} but it is doubtful whether these animals provide an important reservoir for human infection (Osata et al. 1997; Baker & Hegarty 2001). Flies have also been considered as having a potential role in the vectorial spread of \textit{H. pylori} from human faeces to food (Grubel et al. 1998).

**TRANSMISSION OF \textit{H. PYLORI} IN WATER**

In developing countries, water rather than person-to-person spread plays a significant role in the transmission of \textit{H. pylori} (Akcam et al. 2000). Water from streams, rivers and wells has been considered as a common source (Hulten et al. 1991, 1996; Klein et al. 1991; Mackay et al. 1998; Hegarty et al. 1999; Engstrand 2001; Mackay et al. 2001; Mazari-Hiriart et al. 2001; Lu et al. 2002; Imanishi et al. 2003; Karita et al. 2003; Azevedo et al. 2004; Gomes & De Martinis 2004; Rolle-Kampczyk et al. 2004). In Brazil, Zaterka & colleagues (2007) confirmed that the source of drinking water in childhood was a risk factor for \textit{H. pylori} infection and that the prevalence of \textit{H. pylori} infection was higher when a local river was the source of drinking water and lower when this water was filtered or boiled. In addition, Goodman & colleagues (1996) found that swimming in streams, using streams as a drinking water source, and frequent consumption of raw vegetables, cleaned in contaminated water, increased the likelihood of infection with \textit{H. pylori}. Other research also supports an association between \textit{H. pylori} infection and consumption of untreated well or spring water (Carballo et al. 1997; Benson et al. 2004; Reavis 2005). Further evidence concerning the importance of water as a transmission route of \textit{H. pylori} was stressed by Fujimura & colleagues (2004) who collected and analysed a total of 24 water samples from the upper, middle and downstream reaches of four Japanese rivers for evidence of \textit{H. pylori} by nested polymerase chain reaction (PCR). The conclusion from this study suggested that water, in the natural environment, could be a risk factor for \textit{H. pylori} transmission (Fujimura et al. 2004).

**PERSISTENCE, DETECTION AND CULTURABILITY OF \textit{H. PYLORI}**

Despite the numerous research findings identifying \textit{H. pylori} in water, it is important to consider the fact that the use of PCR and other molecular methods for the detection of pathogens in environmental samples has limitations. This is principally due to the inability of PCR to differentiate between naked DNA from dead and living cells. Furthermore, the natural environment contains many microorganisms which have not yet been identified or cultured, which may interfere with molecular technologies. Consequently, to scientifically interpret data regarding the epidemiology of \textit{H. pylori}, cultured bacteria from appropriate water sources are necessary.

The first successful isolation of \textit{H. pylori}, by culturable methods, occurred in a municipal wastewater canal on the US–Mexico border (Lu et al. 2002). This canal was found to be heavily contaminated with untreated raw sewage, in an area known to have a high \textit{H. pylori} prevalence (Lu et al. 2002). Aside from this study, positive culture of \textit{H pylori} from drinking water has not been successful, despite efforts to produce a culture-specific media sensitive and selective enough to isolate and grow this organism. A simple plating medium for the detection of \textit{H. pylori} in the environment was investigated by Degnan et al. (2005) and Fernández et al. (2007). However, the culturable methods employed were unsuccessful in the culturing of \textit{H. pylori}.

\textit{H. pylori} rapidly transforms into a viable but non-culturable state (VBNC). This state is induced by low
nutrient and hyperosmotic conditions (Mizoguchi et al. 1999; Zheng et al. 1999; Moreno et al. 2003). Such stressed conditions are commonly found in water and the environment. Fluorescent in situ hybridization (FISH) with rRNA oligonucleotide probes has been used for detection and identification of VBNC forms of bacteria (Rowan 2004). The role of the VBNC of H. pylori, and its associated forms, in infection and transmission remains unclear (Rowan 2004). However, what is significant is that within the VBNC state H. pylori cells are still alive (Moreno et al. 2003; Rolle-Kampczyk et al. 2004; Rowan 2004). Ultimately this may, when evidence becomes available, have important implications for the survival and therefore the potential infectivity of H. pylori. To date, little or no evidence exists regarding the resuscitation of VBNC cells of H. pylori or on the ability of the VBNC cells to cause infection.

Initial evidence of H. pylori presence in environmental water samples has come from PCR amplification of samples obtained from Colombia, where infection rates are over 90% (Handwerker et al. 1995). In addition to this a number of PCR assays have been utilized over the years for the detection of H. pylori in water (Engstrand et al. 1992; Weiss et al. 1994; Hulten et al. 1996; Sasaki et al. 1999; Benson et al. 2004; Gomes & De Martinis 2004; Shahamat et al. 2004). Furthermore, in the United States, actively respiring H. pylori from surface and well water has been detected using fluorescent antibody-tetrazolium reduction (FACTC) microscopy (Hegarty et al. 1999) and confirmed using species-specific PCR (Azevedo et al. 2006a). Sen et al. (2007) investigated the development of internal controls for PCR assays by spiking drinking water with 100 cells of H. pylori and demonstrated similar cycle thresholds to those of recombinant Escherichia coli during chlorine disinfection. In addition to PCR, FISH was validated as a quick and sensitive method for detection of H. pylori in environmental samples (Moreno et al. 2003). These findings suggest the presence of H. pylori in the natural environment and a possible waterborne route of transmission. Nayak & Rose (2007) demonstrated that quantitative polymerase chain reaction (qPCR) could determine H. pylori concentrations in water. In this study real time qPCR was shown to be a specific, sensitive and rapid method to quantify H. pylori in sewage. Prior to these studies a two-stage in vitro method for detection of H. pylori in spiked water and faecal samples using immunomagnetic separation followed by PCR detection (IMS/PCR) has been described (Enroth & Engstrand 1995).

Numerous studies have shown that H. pylori may survive for prolonged periods in water over a range of physical variables (West et al. 1992). In fact H. pylori strains have been shown to survive for long periods under physiological saline concentrations, low temperatures and a pH range of 5.8 to 6.9. A study by Shahamat & colleagues (1995) has found that H. pylori were able to remain viable for periods ranging from 48 hours to between 20 and 30 days when exposed to different temperatures.

A study in Leipzig, Germany, showed a positive correlation between the drinking of H. pylori-contaminated well water and the acquisition of a H. pylori infection (Rolle-Kampczyk et al. 2004). H. pylori DNA has been amplified from drinking water samples in Japan (Sasaki et al. 1999), Mexico (Mazari-Hiriart et al. 2001) and Peru (Hulten et al. 1996), from water samples taken from a delivery truck in the Canadian Arctic (McKeown et al. 1999) and from drinking water storage pots in the Gambia (Bunn et al. 2002). A study by Hulten et al. (1998) used two PCR assays to examine municipal treated and well water samples from all 25 counties of Sweden for the presence of Helicobacter DNA: 37.5% of wells, 12% of municipal sources and 12% of wastewater samples were found to be positive for Helicobacter DNA.

The argument for a waterborne route of H. pylori transmission is supported by the maintenance of viability in spiked natural water (West et al. 1990, 1992; Shahamat et al. 1993; Hunter 1997; Fan et al. 1998; Jiang & Doyle 1998; Sato et al. 1999; MMWR 1999). While attempts to culture H. pylori from environmental water samples have been largely unsuccessful, closely related microaerophilic organisms, Campylobacter jejuni and Arcobacter butzleri, have been cultured from ground and surface waters (Arvanitidou et al. 1994; Stanley et al. 1998; Rice et al. 1999) and associated with waterborne outbreaks (MMWR 1999). As mentioned previously, viable H. pylori cells could be transmitted through faecal material (Thomas et al. 1992), which may well provide a route for contaminating drinking water. H. pylori have been shown to survive for short periods in water when present in their coccoid morphology (Mizoguchi et al. 1999; She et al. 2003). This coccoid form of H. pylori, because of its increased tolerance to outside
perturbations, may allow the bacteria to survive the extremes of conditions associated with drinking water and water distribution systems. In addition, it has been speculated that *H. pylori* coccoid cells may be able to tolerate the levels of disinfectant normally used in distribution systems and therefore remain viable (Azevedo et al. 2008). To date the survival of *H. pylori* is poorly understood in the aquatic environment; likewise we do not know how this environment affects its viability.

**DISINFECTION DATA**

Present data concerning the effectiveness of standard drinking water disinfection processes on *H. pylori* are limited by the number of published articles in this area. Baker & colleague (2002) found that *H. pylori* were more resistant to low levels of free chlorine than *E. coli* or *C. jejuni*. Conclusions from this research have highlighted the fact that it was possible, under conditions of inadequate disinfection, for *H. pylori* to persist in water. Based on the studies by Johnson et al. (1997) and Baker et al. (2002) it is possible that reduced chlorine residuals might not provide adequate inactivation of *H. pylori*. Consequently this would not prevent the entry and persistence of *H. pylori* in drinking water systems. This may be particularly so if the bacterium grows within a biofilm state.

A number of drinking water studies have identified *H. pylori* in water pre- and post-chlorination (Mazari-Hiriart et al. 2003). Moreno & colleagues (2007) have shown that *H. pylori* could survive disinfection practices that are normally used in drinking water treatment when *H. pylori* are found in the VBNC state. However, they did find that culture of *H. pylori* was lost after 5 min in water despite free chlorine levels of 0.96 mg l\(^{-1}\).

**BIOFILMS**

It is possible that there are environmentally adapted forms of *H. pylori* within a biofilm community. *H. pylori* readily form biofilms (Carron et al. 2006) and in so doing produce a novel antibacterial peptide, which may confer increased persistence in a heterogeneous biofilm environment (Putsep et al. 1999). *H. pylori* is also known to produce a water-insoluble biofilm when grown under high carbon:nitrogen ratio conditions (Stark et al. 1999). However, environmentally adapted *H. pylori* have to be isolated and cultured for an evaluation of their true environmental persistence, virulence and ability to be transmitted in water (Vincent 1995).

It is well known that waterborne bacteria can attach to surfaces by aggregating in a hydrated exopolymer known as a biofilm (Costerton et al. 1999; Percival et al. 2000). The association of bacteria, particularly pathogens, with biofilm communities within a water distribution system may offer vulnerable and susceptible bacteria protection from disinfection and protozoan predation (Sibille et al. 1998). In fact microorganisms in drinking water are predominantly associated with biofilms rather than in the planktonic state (Costerton et al. 1999; Percival et al. 2000, 2004). Consequently, for *H. pylori* to survive the extremes of water it is probable that it would have to reside within a biofilm. In addition to this, *H. pylori* has recently been shown to remain viable and proliferate inside *Acanthamoeba castellanii* for up to 8 weeks when evident in a co-culture (Winiecka-Krusnell et al. 2002). Various species of Acanthamoebae are common components of drinking water biofilms and have been shown to shield bacteria from disinfectants and enhance their proliferation when evident in biofilms (Greub & Raoult 2004).

There is evidence that biofilms in water distribution systems may harbour *H. pylori* (Mackay et al. 1999; Mackay et al. 2001; Park et al. 2001). In addition a study undertaken in Western Africa, utilizing 16S rDNA sequences, has shown evidence that *H. pylori* can be detected in natural biofilms (Bunn et al. 2002). A more recent study by Watson & colleagues (2004) showed a close link between *Helicobacter* DNA in showerhead biofilm used in domestic households. Furthermore *H. pylori* has been found to have the ability to incorporate itself into lab-grown biofilms (Mackay et al. 1999; Azevedo et al. 2003). The study by Mackay & colleagues (1999) concluded that *H. pylori* could incorporate itself, and persist in a laboratory-based, mixed-species heterotrophic biofilm, for over 8 days. However, Watson et al. (2004) concluded from their study that monitoring the cold water supply to a particular property did not appear to be a reliable means of predicting the *Helicobacter* status of the water distribution system in that property. Azavedo et al. (2006a,b) and Bragança et al. (2007) have also shown that *H. pylori* may
be present as biofilms on pipe work in drinking water systems. In the study by Azavedo & colleagues (2006a) *H. pylori* was shown to have the ability to adhere to different plumbing materials, namely copper and stainless steel. Copper surfaces were found to be especially suitable for the maintenance of the bacteria in the spiral form.

**CONCLUSION**

Although inconclusive, epidemiological studies strongly suggest person-to-person transmission of *H. pylori* (Raymond et al. 2008). However, recent experimental findings suggest that *H. pylori* transmission may involve the consumption of contaminated drinking water (Bellack et al. 2006). Although *H. pylori* is not classified as a food or waterborne pathogen, it is acknowledged as an important pathogen. The ability of *H. pylori* to survive in a coccoid VBNC form and its survival correlated with water should be of interest and possible concern to epidemiologists and public health microbiologists.

Outside the developing world the evidence for waterborne transmission of *H. pylori* is sparse. However, recent evidence has shown that *H. pylori* can survive in water for over 96 hours at 25°C (Azvedo et al. 2008). While this timescale is relatively short, it is evident in the developing world that this would be long enough for *H. pylori* transmission and possible infection of a compromised individual to occur.

*H. pylori* remains a significant problem in the developing world and will continue to be a concern as a result of the poor level of sanitation and hygiene that exists in these regions of the world. Subsequently the importance of *H. pylori* as a primary pathogen is unlikely to diminish in the foreseeable future in these vulnerable areas. Consequently, it remains important that we acquire a better understanding of the risk factors associated with the acquisition of *H. pylori* infection but at the same time we should not overlook the increasing potential that *H. pylori* can be transmitted via a waterborne pathway. Accordingly the ‘environmental’ biofilm in which *H. pylori* may reside, resuscitate, proliferate, interact socially with other sessile microorganisms and then disseminate warrants further investigation as a source of infection (Gia˜o et al. 2008).

**REFERENCES**


Carballo, F., Caballero, P., Parra, T., Aldeguer, J. M. & Pajares, J. M. 1997 Untreated drinking water is a source of *H. pylori*.


Cave, D. R. 1997 How Helicobacter pylori transmitted? 
Gastroenterology 113, S14.


Hulton, K., Han, S. W., Enroth, H., Klein, P. D., Opekun, A. R., Gilman, R. H., Evans, D. G., Engstrand, L., Graham, D. Y. &


Raymond, J., Bergeret, M. & Kalach, N. 2008 Helicobacter pylori
Reavis, C. 2005 Rural health alert: Helicobacter pylori in well water.
Rice, E. W., Rodgers, M. R., Wesley, I. V., Johnson, C. H. &
Tanner, S. A. 1999 Isolation of Arcobacter butzleri from
Rolle-Kampczyk, U. E., Fritz, G. J., Diez, U., Lehmann, I., Richter,
M. & Herbarth, O. 2004 Well water: one source of
Helicobacter pylori colonisation. Int. J. Hyg. Environ. Health
207, 363–368.
Rothenbacher, D. & Brenner, H. 2003 Burden of Helicobacter pylori
and H pylori-related diseases in developed countries: recent
development and future implications. Microbes Infect. 5, 693–703.
Rowan, N. J. 2004 Viable but non-culturable forms of food and
waterborne bacteria: quo vadis? Trends Food Sci. Technol. 15,
462–467.
Sasaki, K., Tajiri, Y., Sata, M., Fujiy, F., Matsubara, F., Zhao, M.,
Shimizu, S., Toyonaga, A. & Tanikawa, K. 1999 Helicobacter pylori
Sato, F., Saito, N., Shouji, E., Rani, A., Takeda, H., Sugiyama, T. &
Asaka, M. 1999 The maintenance of viability and spiral
morphology of Helicobacter pylori in mineral water. J. Med.
Microbiol. 48, 971.
Sen, K., Schable, N. A. & Lye, D. J. 2007 Development of an
internal control for evaluation and standardization of a
quantitative PCR assay for detection of Helicobacter pylori in
Shahamat, M., Mai, U., Paszko-Kovla, C., Kessel, M. & Colwell, R. R.
1995 Use of autoradiography to assess viability of Helicobacter pylori
Shahamat, M., Alavi, M., Watts, J. E., Gonzalez, J. M., Sowers, K. R.,
Maeder, D. W. & Robb, F. T. 2004 Development of two PCR-
based techniques for detecting helical and coccoid forms of
She, F. F., Lin, J. Y., Liu, J. Y., Huang, C. & Su, D. H. 2003 Virulence of
water-induced coccoid Helicobacter pylori and its experimental
infection in mice. World J. Gastroenterol. 9, 516–520.
Sherman, P. M. 2004 Appropriate strategies for testing and treating
Sibille, I., Sime-Ngando, T., Mathieu, L. & Block, J. C. 1998
Protozoan bacteriervy and Escherichia coli survival in
drinking water distribution systems. Appl. Environ. Microbiol. 64,
197–202.
Souto, R. & Colombo, A. P. 2008 Detection of Helicobacter pylori
by polymerase chain reaction in the subgingival biofilm and
saliva of non-dyspeptic periodontal patients. J. Periodontol. 79,
97–103.
Stanley, K., Cunningham, R. & Jones, K. 1998 Isolation of
Stark, R. M., Gerwig, G. J., Pitman, R. S., Potts, L. F., Williams,
Thomas, J. E., Gibson, B. R., Darboe, M. K., Dale, A. & Weaver,
L. T. 1992 Helicobacter pylori from human faeces. Lancet 340,
1194–1195.
Velazquez, M. & Feirtag, J. M. 1999 Helicobacter pylori:
characteristics pathogenicity detection methods and mode
of transmission implicating foods and water. Int. J. Food
Microbiol. 53, 95–104.
Vincent, P. 1995 Transmission and acquisition of Helicobacter pylori
infection: evidences and hypothesis. Biomed. Pharmacother. 49,
11–18.
Warren, J. R. & Marshall, B. 1985 Unidentified curved bacillus on
gastric epithelium in active chronic gastritis. Lancet 1,
1273–1275.
Watson, C. L., Owen, R. J., Sait, B., Lai, S., Lee, J. V., Surman-Lee,
S. & Nichols, G. 2004 Detection of Helicobacter pylori by PCR
but not culture in water and biofilm samples from drinking
water distribution systems in England. J. Appl. Microbiol. 97,
690–698.
Weiss, J., Mecca, J., da Silva, E. & Gassner, D. 1994 Comparison
of PCR and other diagnostic techniques for detection of
Microbiol. 32, 1663–1668.
West, A. P., Millar, M. R. & Tompkins, D. S. 1990 Survival
of Helicobacter-pylori in water and salmon. J. Clin. Pathol. 43,
669.
West, A. P., Millar, M. R. & Tompkins, D. S. 1992 Effect of physical
environment on survival of Helicobacter pylori. J. Clin. Pathol. 45,
228–231.
Winiecka-Krusnell, J., Wreiber, K., von Euler, A., Engstrand, L. &
Linder, E. 2002 Free-living amoebae promote growth and
survival of Helicobacter pylori. Scand. J. Infect. Dis. 34,
253–256.
Xia, H. H. & Talley, N. J. 1997 Natural acquisition and spontaneous
elimination of Helicobacter pylori infection: clinical
implications. Am. J. Gastroenterol. 92, 1780–1787.
Zaterka, S., Eisig, J. N., Chinzon, D. & Rothstein, W. 2007 Factors
related to Helicobacter pylori prevalence in an adult
population in Brazil. Helicobacter 12, 82–88.
Zeng, P. Y., Hua, J., Ng, H. C. & Ho, B. 1999 Unchanged
characteristics of Helicobacter pylori during its morphological
First received 2 July 2008; accepted in revised form 6 December 2008. Available online May 2009