The 2026 Iranian Clinical Blueprint for H. Pylori Management

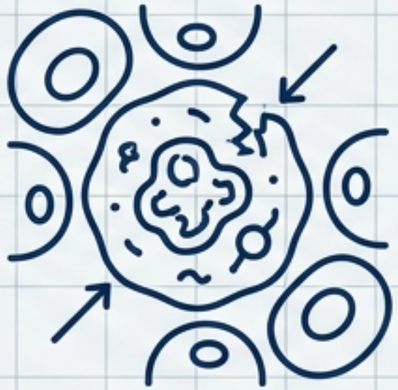
The First National Consensus Guidelines for Diagnosis and Treatment

Formulated by the Foodborne and Waterborne Diseases Research Center, Shahid Beheshti University of Medical Sciences.

Iran faces a compounding triad of epidemiological threats

High Endemic Prevalence

A major, persistent public health concern.



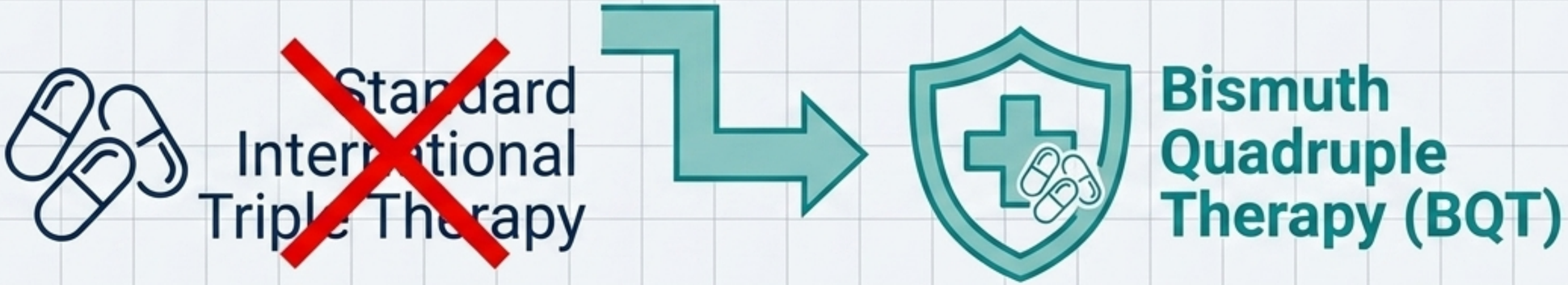
Significant Gastric Cancer Burden

H. pylori remains a primary oncogenic driver.

Alarming Antimicrobial Resistance

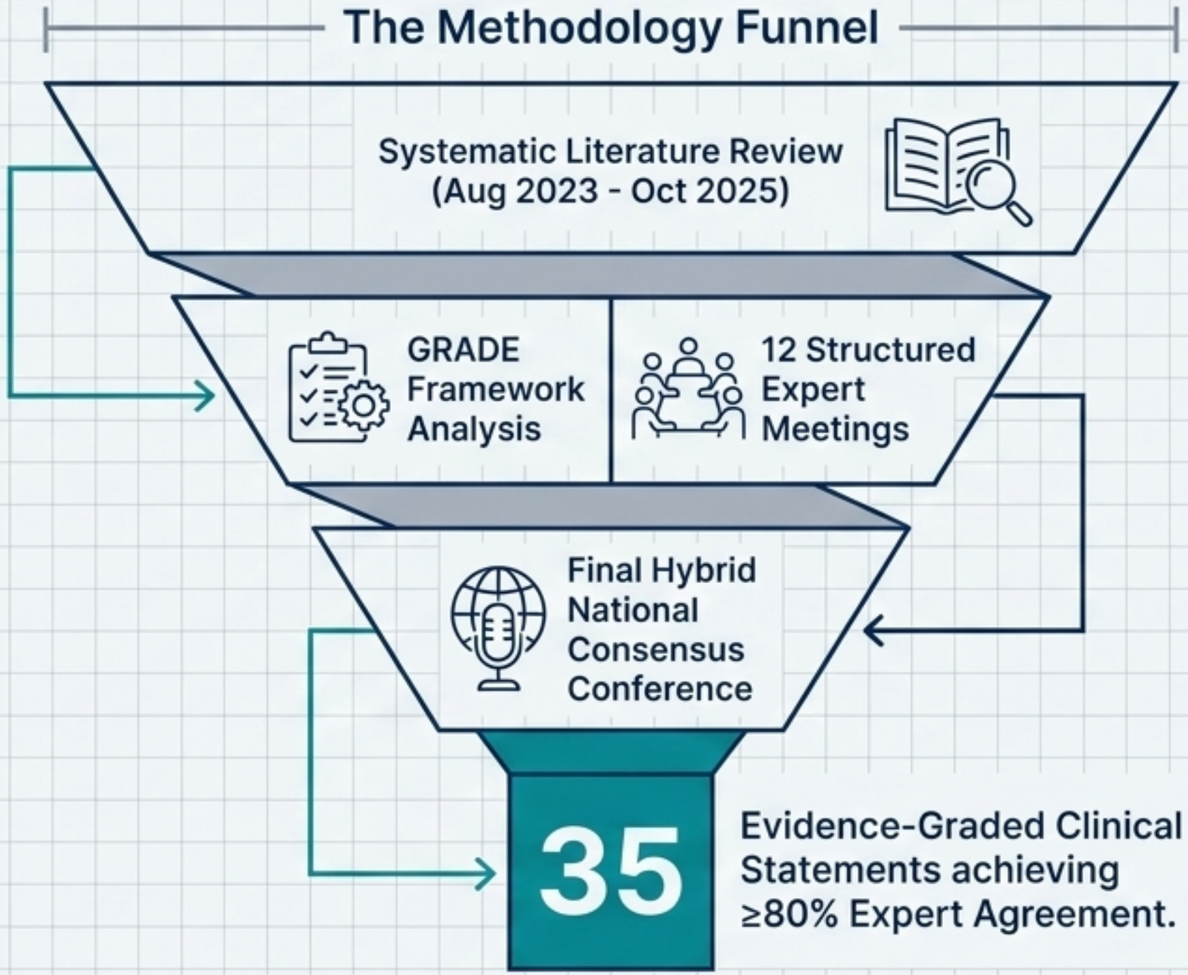
International guidelines fail to clear local strains.

Clarithromycin resistance dictates a structural shift in first-line therapy.

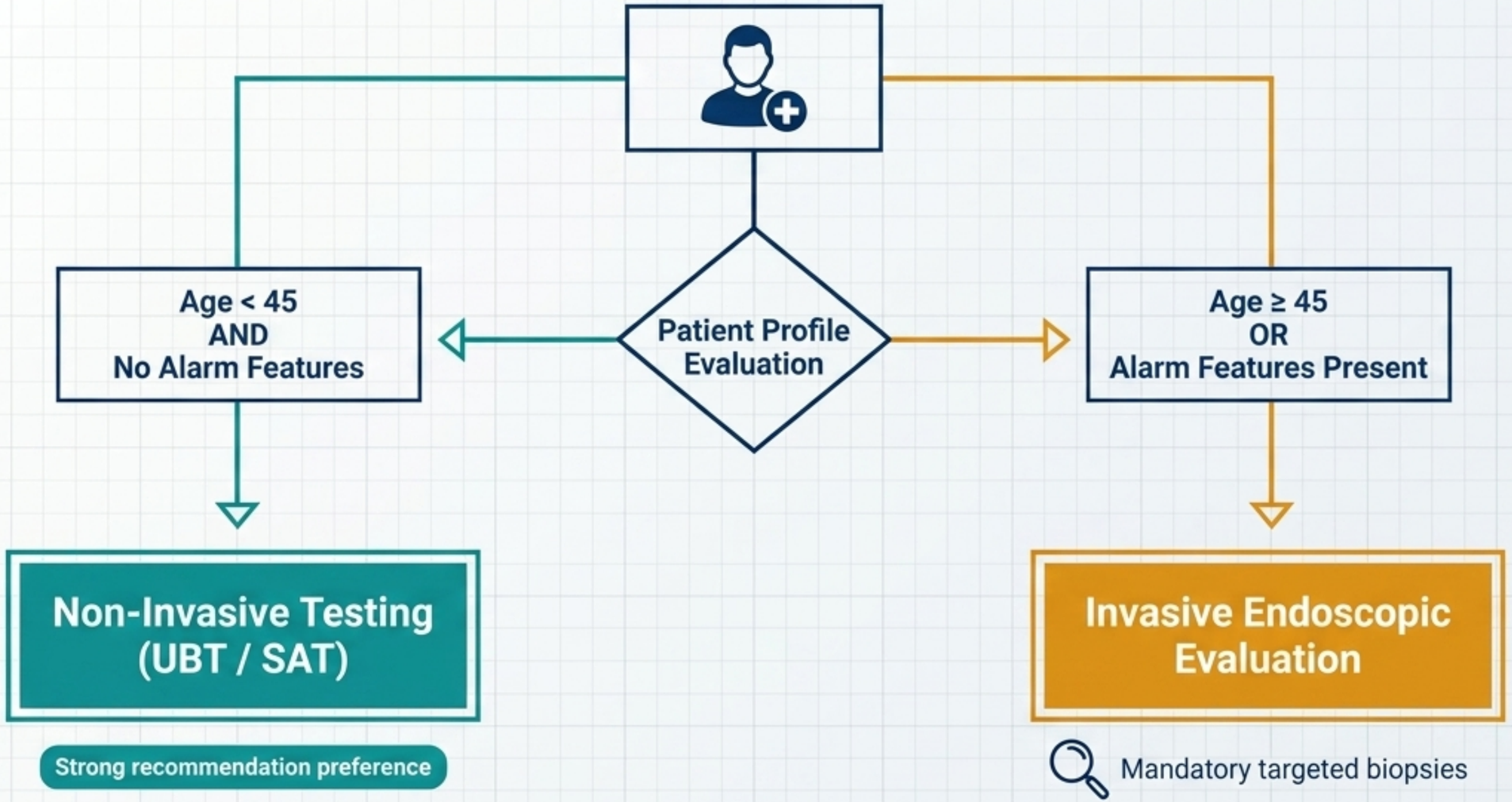


Local Iranian epidemiology demonstrates Clarithromycin resistance exceeding 20%, rendering standard international triple therapies clinically ineffective.

Thirty-five evidence-graded statements forged through multidisciplinary consensus.



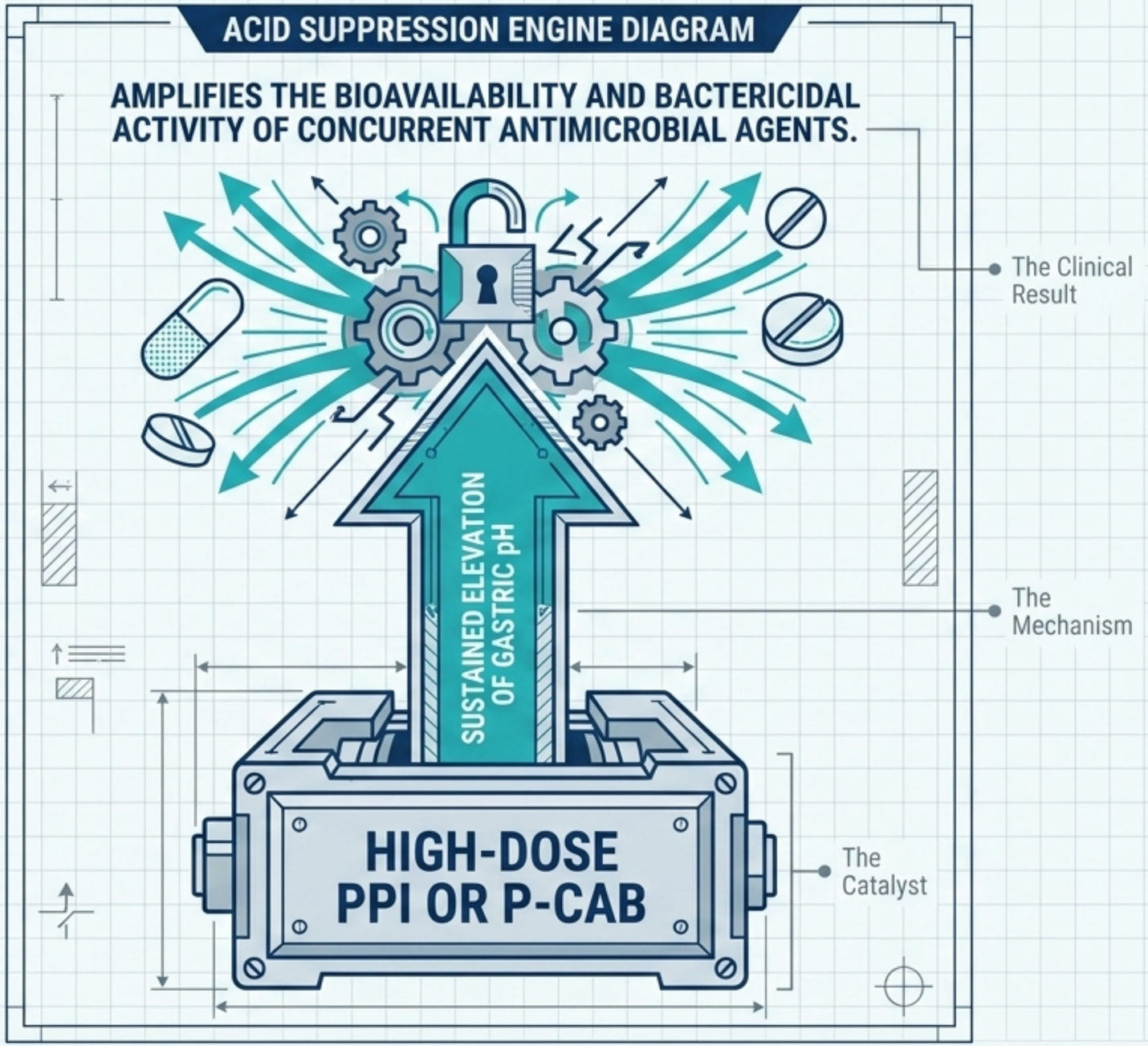
Diagnostic strategy branches strictly on age and the presence of alarm features



Selecting the precise diagnostic tool for the appropriate clinical risk tier

Diagnostic Modality Matrix	NON-INVASIVE	INVASIVE
Target Patient	Under 45, low risk	Over 45, high risk
Primary Modalities	Urea Breath Test [UBT], Monoclonal Stool Antigen Test [SAT]	Endoscopy with Targeted Biopsy
Clinical Utility	Rapid, high-accuracy screening and eradication confirmation	Direct visualization, malignancy rule-out, histological confirmation

Aggressive acid suppression acts as the engine for eradication efficacy.



Bismuth Quadruple Therapy stands as the definitive first-line standard.

First-Line Therapy Showdown

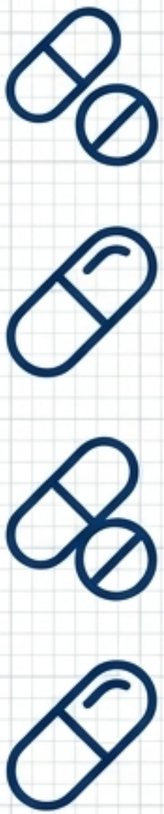
Bismuth Quadruple Therapy (BQT)

- **Duration:** 10-14 Days.
- **Resistance Profile:** Highly effective in Iran's >20% clarithromycin resistance environment.

Non-Bismuth Concomitant Therapy

- **Duration:** 10-14 Days.
- **Role:** Acceptable secondary option when BQT is unavailable or contraindicated.

The 10-14 day BQT regimen requires strict patient adherence.



Bismuth, Acid Suppressor, Antibiotic 1, Antibiotic 2

10 to 14 Days Continuous Therapy

⚠ Given the high pill burden, **active patient counseling on adherence is critical to preventing secondary resistance.**

Treatment parameters must adapt to baseline organ function and concurrent therapies.

Hepatic Impairment

Dose adjustments or alternate regimens required based on severity.

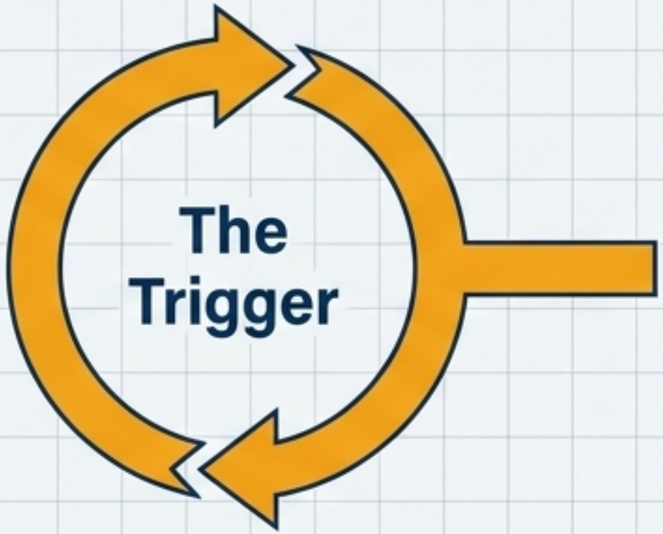
Renal Impairment

Strict clearance monitoring required for specific antimicrobial components.

Drug Interactions

Acid suppression (PPIs/P-CABs) dramatically alters gastric absorption profiles of concurrent medications.

Treatment failure necessitates a pivot to susceptibility-guided salvage therapy.



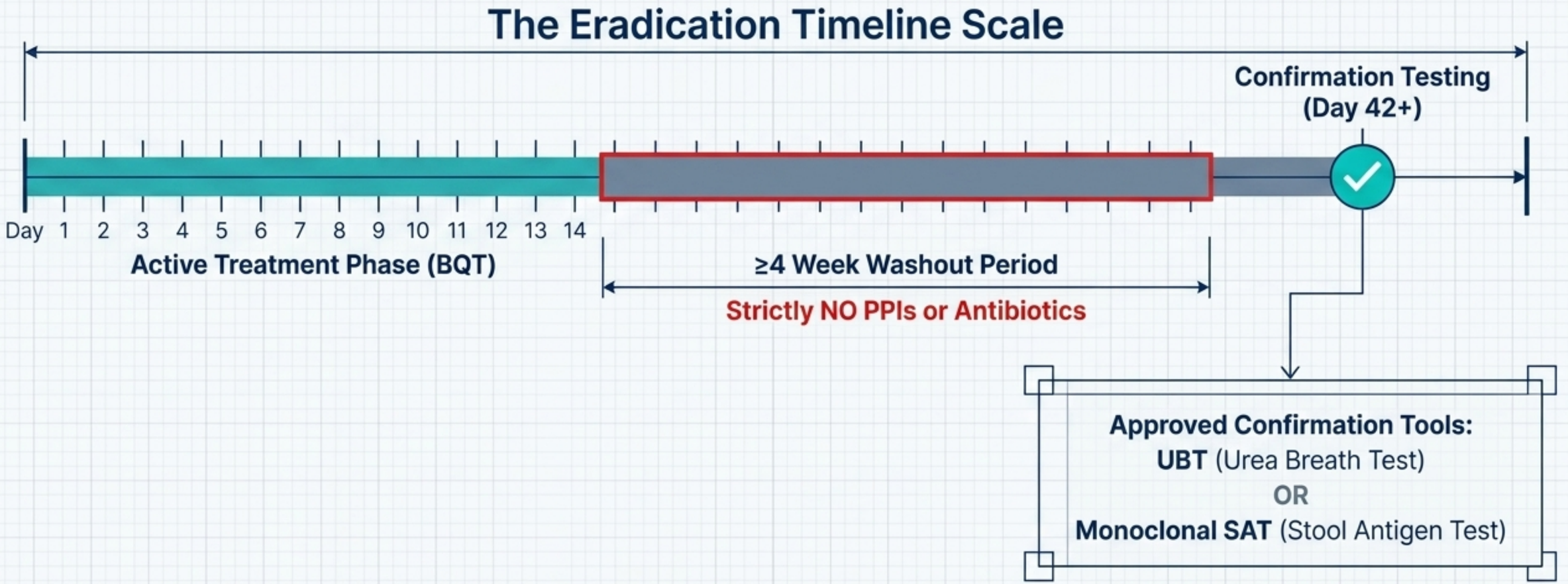
Documented failure of initial 10-14 day empirical BQT or Concomitant therapy.

The Action: Transition from empirical selection to precision targeting.

The Guideline

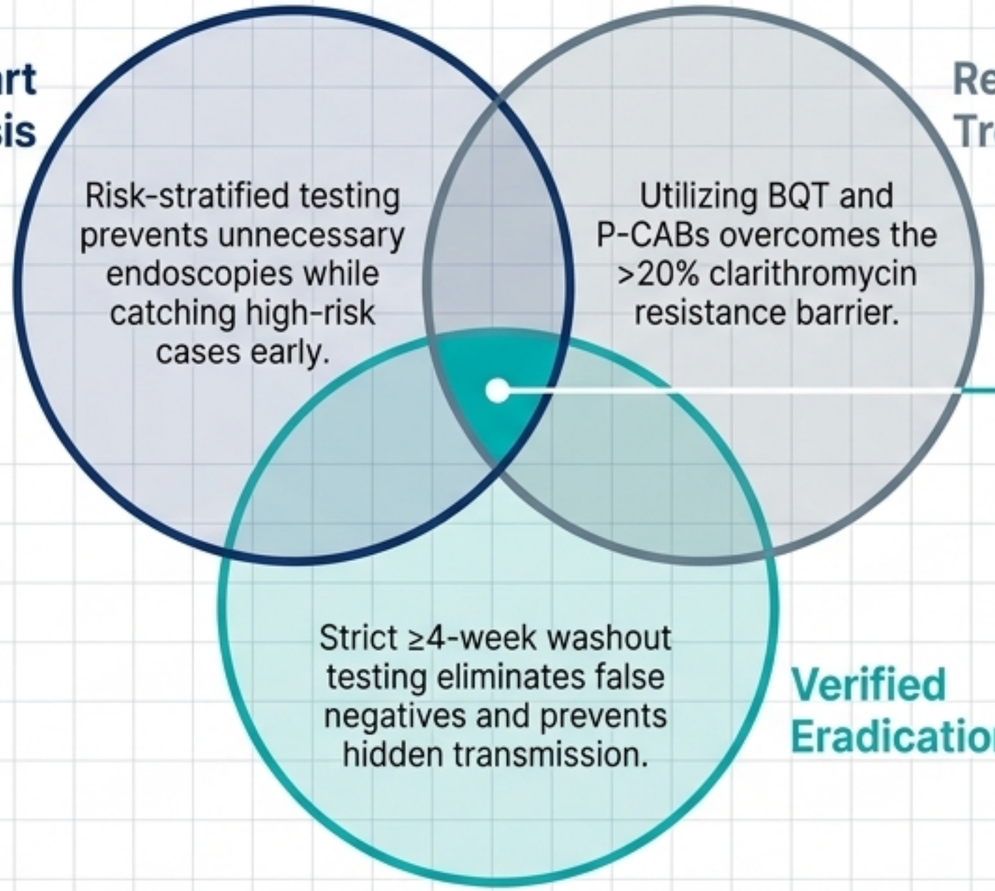
Susceptibility-guided therapy is strongly encouraged whenever feasible to map specific local strain vulnerabilities.

Eradication confirmation relies on a strict mandatory washout period.



Clinical adherence to the 2026 guidelines drives macro-level public health defense.

The Tripartite Impact



Optimized Eradication Rates + Antibiotic Stewardship + National Gastric Cancer Prevention.