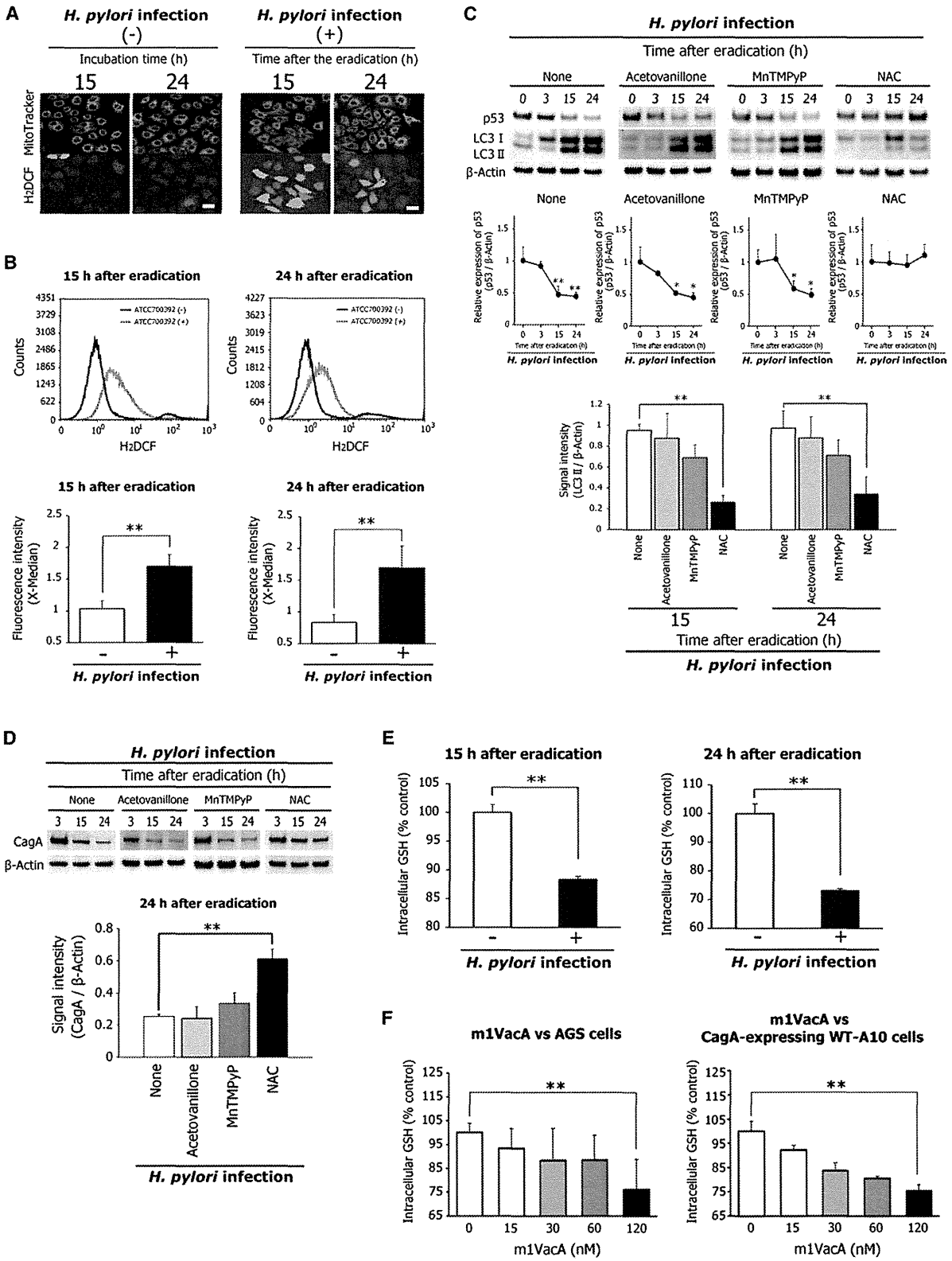


**Figure 5. Reduced Intracellular GSH Levels Trigger Autophagy, Causing CagA Degradation**

(A) AGS cells at 24 hr after *H. pylori* (s1m1VacA) eradication were stained with CM-$H_2$DCFDA and MitoTracker Red FM and examined by fluorescence microscopy. Scale bar = 50 μm.

(B) Flow cytometry of AGS cells at 15 and 24 hr after *H. pylori* (s1m1VacA) eradication. $H_2$DCF fluorescence intensity was determined by using analysis software. Data represent the mean ± SD of three independent assays; **p < 0.01.

genotype (Marshall et al., 1999; Yamaoka et al., 1998). In fact, m1 and m2 VacA strains are both observed in gastric cancer patients (Wang et al., 1998). From these reports, we hypothesized that there was a characteristic alteration in host cell associated with the inhibition of autophagy, which led to the accumulation of intracellular CagA. CD44v9-expressing gastric cancer cells are resistant to ROS, supported by increased intracellular GSH synthesis (Ishimoto et al., 2011). We hypothesized that accumulation of intracellular CagA resulted from inhibiting autophagy induction in CD44v9-expressing cells. To prove this hypothesis, we prepared MKN28 mutant cells by transfection of CD44 standard form (CD44s)- or CD44v9-expression vectors into CD44-negative MKN28 cells (Ishimoto et al., 2011). CD44s or CD44v9 expression in MKN28 cells was confirmed using flow cytometry (Figure S5A). Intracellular GSH levels in MKN28 cells expressing CD44s were significantly increased in comparison to MKN28 cells, whereas GSH levels in MKN28 cells expressing CD44v9 were increased in comparison to MKN28 cells expressing CD44s (Figure S5B). These results were consistent with previous observations that CD44v9 expression increases cellular GSH contents through the promotion of xCT-mediated cystine uptake, and CD44s expression increases cellular GSH levels through the maintenance of pentose phosphate pathway (PPP) flux and consequent NADPH production (Tamada et al., 2012). Intracellular GSH levels in MKN28 cells expressing CD44v9 were not decreased at 15 or 24 hr after the eradication of *H. pylori* ATCC700392 (s1m1VacA), in contrast to the reduction of GSH levels in MKN28 cells expressing CD44s (Figure 7A). Intracellular CagA levels were significantly increased in MKN28 cells expressing CD44v9, as compared with those in MKN28 cells expressing CD44s (Figure 7B). In addition, the increase of Akt and MDM2 phosphorylation and p53 degradation were not observed in MKN28 cells expressing CD44v9 (Figure 7B). As a result, LC3-I to LC3-II conversion was repressed (Figure 7B) and LysoTracker signals were markedly decreased in MKN28 cells expressing CD44v9 (Figure 7C). These results suggest that intracellular CagA accumulated in cells expressing CD44v9 through the inhibition of autophagy. We then examined the effect of sulfasalazine, a potent xCT inhibitor, on the stability of intracellular CagA in MKN28 cells expressing CD44v9. Intracellular CagA levels were decreased by the application of sulfasalazine in a dose-dependent fashion (Figure 7D). Moreover, Akt and MDM2 phosphorylation was significantly increased, and p53 downregulation was induced by treatment with sulfasalazine (Figure 7D), resulting in a significant increase in the conversion of LC3-I to LC3-II (Figure 7D).

To assess the effect of CD44v9-expression on the accumulation of intracellular CagA in human gastric adenocarcinoma, endoscopically resected early gastric cancer tissue from four patients (case 1: 62-year-old female, well-differentiated adenocarcinoma, *H. pylori*-positive; case 2: 68-year-old male, well-differentiated adenocarcinoma, *H. pylori*-positive; case 3: 72-year-old male, well-differentiated adenocarcinoma, *H. pylori*-positive; case 4: 78-year-old male, well-differentiated adenocarcinoma, *H. pylori*-positive), with written informed consent, was used. Remarkable intracellular CagA staining was detected with an anti-CagA antibody in the CD44v9-positive cells in each gastric adenocarcinoma (Figure 7E). It was confirmed using an anti-*H. pylori* antibody that these CagA-stained patterns were different from *H. pylori*-specific staining (not CagA) (data not shown), suggesting that only transported CagA, but not the *H. pylori* itself, was detected in CD44v9-expressing gastric cancer tissue. Endoscopically resected early gastric cancer tissue from an *H. pylori*-negative patient (80-year-old female, well-differentiated adenocarcinoma), with written informed consent, was used as a CagA-negative control. In this specimen, intracellular CagA staining was not detected in either CD44v9-positive or CD44v9-negative cells (Figure S5C). In addition, we detected the intracellular CagA-negative region in both CD44v9-positive and CD44v9-negative cells in endoscopically resected early gastric cancer tissue from a patient at 40 months after *H. pylori* eradication (72-year-old male, well-differentiated adenocarcinoma), with written informed consent (Figure S5D). In addition to performing a general pathological assessment, LC3B and CD44v9 were stained using fluorescent immunohistochemistry for a paraffin-embedded pathological tissue specimen. In cells expressing CD44v9, there were fewer LC3B-positive puncta than in CD44v9-negative cells, suggesting that autophagy was repressed within the CD44v9-positive cells (Figure 7F). These results indicate that the accumulation of intracellular CagA with autophagy inhibition was confirmed in CD44v9-expressing cancer stem-like cells of human gastric adenocarcinoma.

## DISCUSSION

The present study reveals that the accumulation of intracellular CagA in CD44v9-expressing cancer stem-like cells is caused by the repression of autophagy. The autophagic pathway associated with CagA degradation is induced as follows: m1VacA-induced GSH deficiency via binding to LRP1 and then enhances Akt phosphorylation at Ser473. Activation of Akt induces MDM2-mediated p53 degradation through the ubiquitin-proteasome system and then activates autophagy.

Figures S1I and S3D indicated that binding of m1VacA to LRP1 was required for the reduction of intracellular GSH levels and the induction of autophagy, causing CagA degradation. In contrast,

(C) AGS cells infected with *H. pylori* (s1m1VacA) for 5 hr were incubated in a medium containing antibiotic for the indicated times with 250 μM acetovanillone (NOX inhibitor), 20 μM MnTMPyP (MnSOD mimic), or 10 mM NAC. p53 expression and LC3-II formation were examined. Data represent the mean ± SD of three independent assays; *$p < 0.05$, **$p < 0.01$, compared to AGS cells at 0 hr after eradication (p53-expression, middle panel). None indicates without inhibitor.

(D) AGS cells infected with *H. pylori* (s1m1VacA) for 5 hr were incubated in a medium containing antibiotic for the indicated times with 250 μM acetovanillone (NOX inhibitor), 20 μM MnTMPyP (MnSOD mimic), or 10 mM NAC, and intracellular CagA levels were examined. Data represent the mean ± SD of three independent assays; **$p < 0.01$. None indicates without inhibitor.

(E) AGS cells infected with *H. pylori* (s1m1VacA) for 5 hr were incubated in a medium containing antibiotic for 15 and 24 hr, and intracellular GSH levels were measured. Data represent the mean ± SD of three independent assays; **$p < 0.01$.

(F) AGS cells or CagA-expressing WT-A10 cells were incubated with m1VacA for 24 hr, and intracellular GSH levels were measured. Data represent the mean ± SD of three independent assays; **$p < 0.01$. See also Figure S3.

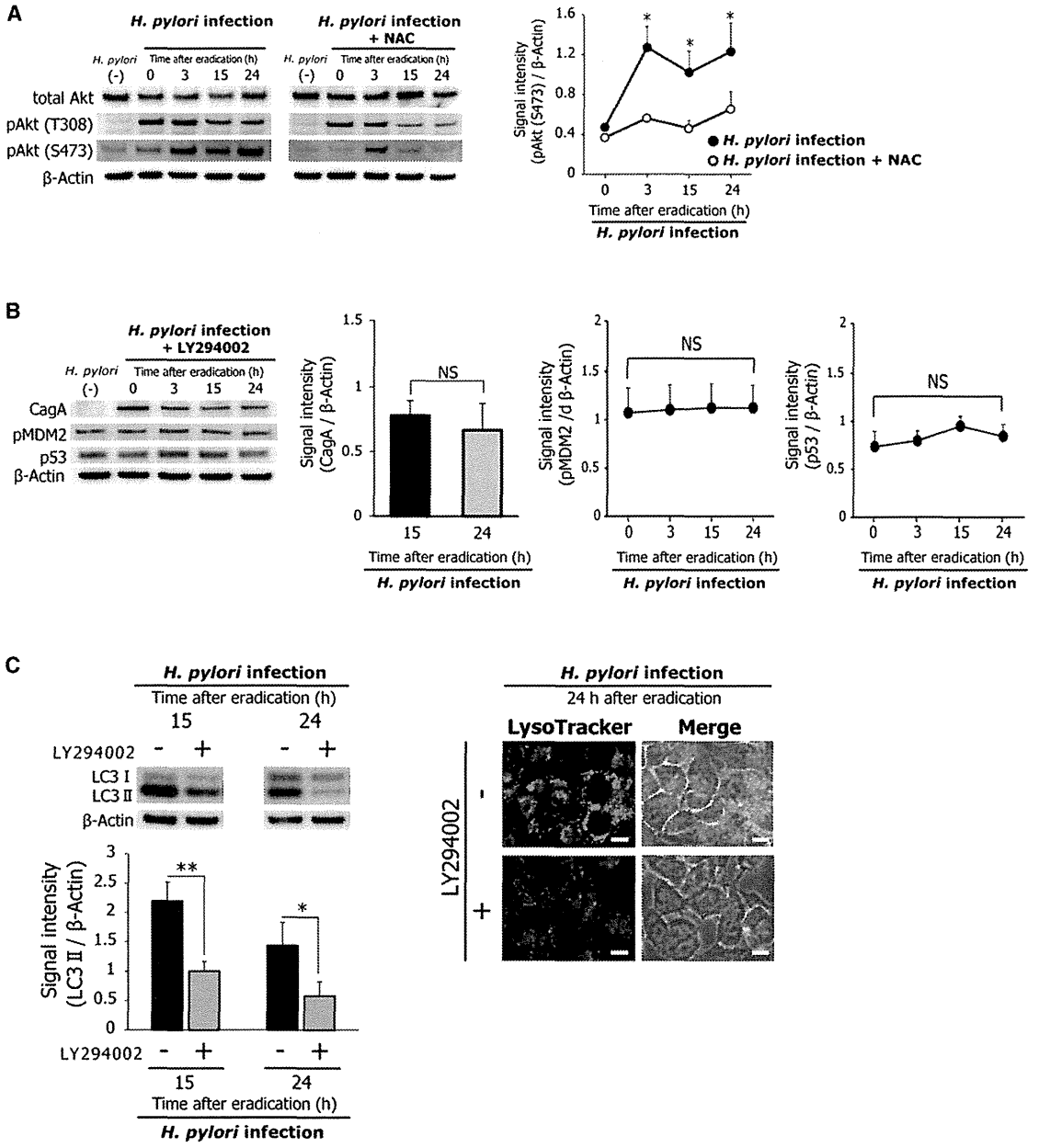


**Figure 6. Akt Phosphorylation in Response to Intracellular ROS Accumulation Contributes to Induction of Autophagy, Causing CagA Degradation**

(A) AGS cells infected with *H. pylori* for 5 hr were incubated in a medium containing antibiotic for the indicated times, with or without 10 mM NAC. Akt phosphorylation at Thr308 and Ser473 was examined. Data represent the mean ± SD of three independent assays; *$p < 0.05$, compared to AGS cells at 0 hr after eradication (right panel).

(B) AGS cells infected with *H. pylori* for 5 hr were incubated in a medium containing antibiotic for the indicated time with 10 μM LY294002 (Akt-phosphorylation inhibitor), and the levels of intracellular CagA, pMDM, and p53 were examined. Data represent the mean ± SD of three independent assays; NS, not significant.

(C) AGS cells infected with *H. pylori* for 5 hr were incubated in a medium containing antibiotic for the indicated times with 10 μM LY294002 (Akt-phosphorylation inhibitor), and LC3-II formation was examined. Data represent the mean ± SD of three independent assays; *$p < 0.05$, **$p < 0.01$. AGS cells at 24 hr after eradication with or without LY294002 were stained using LysoTracker Red DND-99 (right panel). Scale bar = 50 μm. See also Figure S4.

the binding to LRP1 of m2VacA was not detectable by immunoprecipitation assay (Figure S1I). It has been reported that the mid-region of VacA has an important role in the binding of VacA to host cells (Cover and Blanke, 2005). Therefore, these findings suggest that the reason m2VacA could not induce autophagy was the lack of binding ability to LRP1, unlike m1VacA.

Our observations indicate that m1VacA reduces intracellular CagA levels via the induction of autophagy (Figure 3). Intracellular CagA deregulates SHP-2 and PAR1, which promote cell

proliferation, thus causing loss of cell polarity (Saito et al., 2010). Therefore, an excess of intracellular CagA leads to cell damage that disturbs the attachment of bacteria to gastric epithelial cells. Recently, it was suggested that VacA can downregulate CagA-induced signal-transduction in gastric epithelial cells to some extent, thus minimizing the degree of cellular damage (Yokoyama et al., 2005). Therefore, this CagA degradation response to VacA is considered an important strategy for the long-term colonization of the gastric mucosa by *H. pylori*.

*H. pylori* ATCC700392-derived CagA contains the EPIYA-ABC motif, and CagA expressed in WT-A10 cells contains the EPIYA-ABCCC motif derived from *H. pylori* NCTC11637. Our data showed that both of these types of CagA were degraded by autophagy induced by m1VacA (Figures 1, 2, and 3). These results suggest that CagA degradation by autophagy is not affected by differences in the EPIYA motif.

A number of studies demonstrated a link between CagA and gastric cancer development (Blaser et al., 1995; Huang et al., 2003). However, intracellular CagA was only detected in the gastric mucosa of *H. pylori*-infected patients with atrophic gastritis, and not in the gastric mucosa of patients with intestinal metaplasia or cancer (Yamazaki et al., 2003). Therefore, CagA was thought to play a causative role at a relatively early phase of gastric carcinogenesis. Our findings indicate that intracellular CagA is degraded by autophagy induced by the accumulation of intracellular ROS. Thus, even if CagA is translocated into a host cell, it does not persist for a long period. The accumulation of intracellular CagA is restricted to cells in which autophagy is suppressed. We demonstrated that intracellular CagA specifically accumulates in CD44v9-expressing human gastric cancer cells in which CagA degradation by autophagy has been suppressed by their resistance to ROS (Figure 7E). Thus, we show a direct molecular link between CagA and gastric cancer stem-like cells and suggest that the role of CagA in gastric carcinogenesis is not restricted to the early phase.

Chronic inflammation triggers the expression of CD44s (Ishimoto et al., 2010), suggesting that chronic severe inflammation after long-term *H. pylori* colonization induces CD44 expression in normal gastric epithelial cells. CD44-expressing cells have increased intracellular GSH levels, as compared to CD44-negative cells, by maintaining PPP flux and the consequent production of NADPH (Tamada et al., 2012) (Figure S5B), suggesting that CD44-positive cells are slightly resistant to oxidative stress. Conversely, CD44v9-expressing cells are more resistant to oxidative stress, compared with CD44s-expressing cells, by enhancing intracellular GSH levels through the promotion of xCT-mediated cystine uptake (Ishimoto et al., 2011) (Figure S5B). Thus, CagA specifically accumulates in CD44v9-expressing cells by escaping from the autophagy induced by ROS (Figure 7). Additionally, the mRNA expression of *lgr5*, one of the markers of stem cells besides CD44, was not detectable in the CD44- or CD44v9-expressing MKN28 cells (data not shown). Takaishi et al. (2009) reported that the expression of other potential cell-surface markers did not show any correlation with CD44-expressing gastric cancer stem cells. From these findings, we conclude that the accumulation of intracellular CagA by inhibition of autophagy is a specific character of CD44v9-expressing gastric cancer stem-like cells because of their resistance of ROS, and it does not correlate with LGR5. A variety of CD44 isoforms are generated by alternative splicing of the pre-mRNA. CD44v9 is one of the CD44 isoforms and is expressed in gastric cancer stem cells (Mayer et al., 1993). In addition, *H. pylori* infection induced CD44v9 expression, suggesting that the development of cells that accumulate CagA can be caused by *H. pylori* infection (Fan et al., 1996). CD44v9 expression, which is regulated by epithelial splicing regulatory protein 1, plays a functional role in carcinogenesis, differentiation, and metastasis (Yae et al., 2012). In addition, CagA oncogenic signals were maintained in CD44v9-expressing cancer stem-like cells in the present study.

xCT, stabilized by CD44v9, plays an important role in maintaining intracellular redox balance (Patel et al., 2004). Sulfasalazine, a potent xCT inhibitor that has been used routinely for the treatment of inflammatory bowel disease and rheumatoid arthritis, suppresses metastasis of CD44v9-expressing lung cancer and inhibits hepatocellular carcinoma cell growth (Yae et al., 2012). In the present study, sulfasalazine also inhibited the accumulation of intracellular CagA in CD44v9-expressing cells by suppressing autophagy (Figure 7D), suggesting a prophylactic effect for sulfasalazine against CagA-dependent gastric cancer development, especially by targeting cancer stemness.

## EXPERIMENTAL PROCEDURES

### In Vitro *H. pylori* Infection Model

Cells were incubated with s1m1VacA *H. pylori*, VacA-negative *H. pylori*, s1m2VacA *H. pylori*, and s2m2VacA *H. pylori* for 5 hr (multiplicity of infection of 50), and the cells were incubated with RPMI1640 culture medium containing 400 μg/ml kanamycin to kill extracellular bacteria with or without each inhibitor (MG132, Lact, 3MA, Wort, LY294002, nutlin-3, or sulfasalazine) or each antioxidant (acetovanillone, MnTMPyP, or NAC) for the indicated incubation period (0, 3, 15, and 24 hr). The cells were then washed three times with PBS and harvested.

### Preparation of *H. pylori* Culture Supernatants

s1m1VacA, VacA-negative, s1m2VacA, and s2m2VacA *H. pylori*, normalized to an $OD_{600}$ of 0.3, were transferred to cell culture medium (RPMI1640 medium supplemented with 10% FBS) and cultured for a further 15 hr. The supernatants were collected by centrifugation, passed through 0.22 μm filter units to remove any bacteria, and diluted with fresh medium.

### Immunohistochemistry

Tissue was fixed in 4% paraformaldehyde, embedded in paraffin, and sectioned at a thickness of 4 μm. The sections were depleted of paraffin and then rehydrated in a graded series of ethanol solutions. For immunohistochemistry, the sections were washed in Tris-buffered saline with Tween-20 (TBS-T) and subjected to antigen retrieval by heating for 10 min at 105°C in Target Retrieval Solution (pH 9.0) (Dako, Tokyo). Nonspecific binding was blocked by Protein Block (Dako). The sections were incubated overnight at 4°C with primary antibody (see Supplemental Experimental Procedures). Immunoreactivity was detected using Alexa Fluor 568-conjugated goat anti-mouse IgG (Invitrogen, Carlsbad, CA), Alexa Fluor 568-conjugated goat anti-rabbit IgG (Invitrogen), and Alexa Fluor 488-conjugated goat anti-rat IgG (Invitrogen). The samples were examined using an FV10i fluorescence microscope (Olympus, Tokyo).

### Electron Immunocytochemistry

CagA-expressing WT-A10 cells stimulated with 100 nM rapamycin for 24 hr were fixed with 4% paraformaldehyde and 0.1% glutaraldehyde for 80 min. The specimens were then dehydrated in a graded ethanol series and processed with a postembedding immunocytochemical technique using reduced osmium and acrylate resin. Immunogold labeling was performed by incubation with an anti-CagA goat polyclonal antibody (bK-300, 1:1000, Santa Cruz Biotechnology), followed by the addition of secondary antibodies conjugated

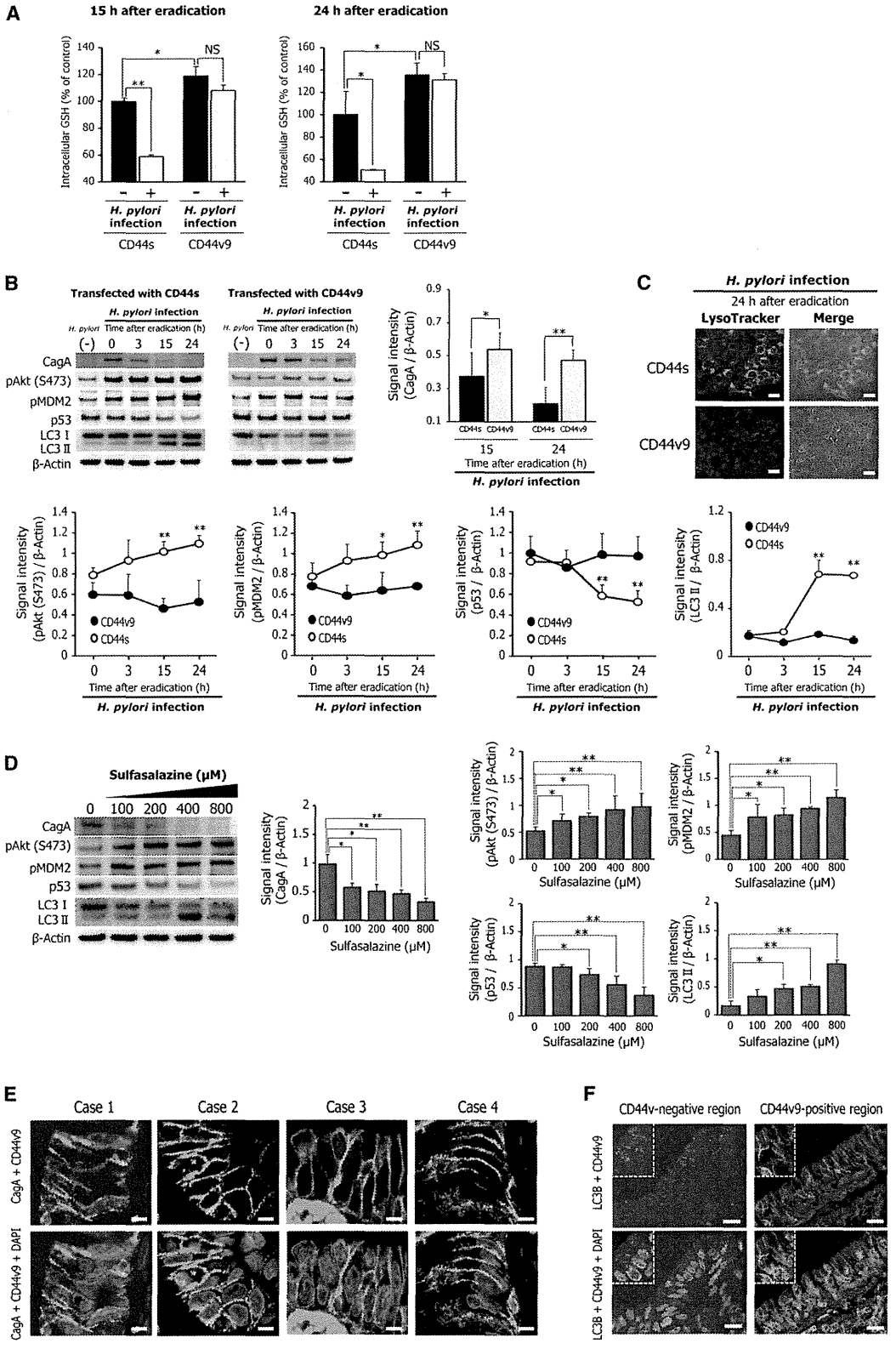


**Figure 7. Accumulation of Intracellular CagA Is Detected in CD44v9-Expressing Gastric Cancer Stem-like Cells**

(A) MKN28 cells were transfected with the pRC/CMV-CD44s or pRC/CMV-CD44v expression plasmid; cells infected with *H. pylori* (s1m1VacA) for 5 hr were incubated in a medium containing antibiotic for 15 and 24 hr, and intracellular GSH levels were examined. Data represent the mean ± SD of three independent assays; *p < 0.05, **p < 0.01; NS, not significant.

to 15 nm gold particles. The sections were poststained with uranyl acetate and modified Sato's lead solution and visualized using a JEM-1200EX electron microscope (JEOL, Tokyo).

### Cell Vacuolation Assay

CagA expression in WT-A10 cells was induced by treatment with m1VacA or m2VacA for 24 hr, and the extent of vacuolation was determined quantitatively by measuring the uptake of neutral red.

### Immunoprecipitation Assay

After s1m1VacA and s1m2VacA *H. pylori* infection for 5 hr, the cell lysates were incubated overnight with anti-LRP1 monoclonal antibody (Santa Cruz Biotechnology) at 4°C. This was followed by the addition of EZview Red Protein A Affinity Gel (Sigma) and overnight incubation. Proteins were detected using antibodies against VacA (Yahiro et al., 1999).

### Fluorescence Immunocytochemistry

To detect EGFP-LC3B signals, AGS cells transfected with the EGFP-LC3B plasmid were infected with *H. pylori* for 5 hr. The cells were incubated with RPMI1640 culture medium containing 400 μg/ml kanamycin—with or without an autophagy inhibitor (3MA and Wort)—for 24 hr, fixed with 4% paraformaldehyde, and incubated with the anti-CagA antibody (AUSTRAL Biologicals). Alexa Fluor 568-conjugated goat anti-mouse IgG (Invitrogen) was used as the secondary antibody. To detect the LysoTracker signals, after *H. pylori* infection for 5 hr, the AGS cells were incubated with RPMI1640 culture medium containing 400 μg/ml kanamycin for 24 hr, and then with LysoTracker Red DND-99 (Invitrogen) for 90 min, followed by fixation with 4% paraformaldehyde. The samples were examined using an FV10i fluorescence microscope (Olympus).

### Measurement of ROS

After *H. pylori* infection for 5 hr, AGS cells were incubated in RPMI1640 culture medium containing 400 μg/ml kanamycin for 15 or 24 hr. The cells were incubated with 10 μM CM-$H_2$DCFDA (Invitrogen) in Hanks balanced salt solution (HBSS) for 60 min at 37°C and washed three times with PBS. To label mitochondria, the cells were incubated with 10 μM MitoTracker Red FM (Invitrogen) in HBSS for 30 min. The samples were examined using an FV10i fluorescence microscope (Olympus). To quantify the intensity of DCF fluorescence, the cells were dissociated using 1 mM EDTA and subjected to flow cytometry using a Gallios Flow Cytometer (Beckman Coulter, Brea, CA) and analysis software (Summit V6.0.2.11185) (Beckman Coulter).

### GSH Assay

Intracellular GSH levels were determined using a GSH-Glo Glutathione Assay Kit (Promega, Madison, WI). The cells ($2 \times 10^3$ per well) were plated in 96-well plates. This assay is based on the conversion of a luciferin derivative to luciferin by glutathione S-transferase in the presence of GSH. The signal generated in a coupled reaction with firefly luciferase is proportional to the amount of GSH in the sample. The assay results were normalized using the GSH standard solution provided with the kit.

### Western Blotting

Total protein (10 μg/lane) was separated on a 4%–12% NuPAGE gradient gel (Invitrogen) and transferred to a PVDF membrane (Invitrogen), which was probed with each primary antibody, followed by reprobing with an anti-actin antibody (Sigma) as the loading control. Signal detection of the immunoreactive bands was facilitated by enhanced chemiluminescence using ECL plus (GE Healthcare, Piscataway, NJ). Signal quantification was performed using the ImageJ program (National Institutes of Health).

### Statistical Analysis

All values are expressed as means ± SD. The statistical significance of differences between two groups was evaluated using Student's t test. Analysis was performed using JSTAT statistical software (version 8.2). Statistical significance was accepted at $p < 0.05$, unless otherwise indicated.

### Tissue Specimens

Human gastric adenocarcinoma tissue specimens were obtained from a 62-year-old female (case 1), a 68-year-old male (case 2), a 72-year-old male (case 3), a 78-year-old male (case 4), an 80-year-old female (*H. pylori*-negative patient), and a 72-year-old male (patient at 40 months after *H. pylori* eradication) who underwent endoscopic submucosal dissection at Keio University Hospital after receiving written informed consent before the procedure. Pathological diagnosis was well-differentiated adenocarcinoma according to the Japanese Gastric Cancer Association classification of gastric carcinoma (14th edition). The study protocol was approved by the ethics committees of Keio University School of Medicine and registered with the UMIN Clinical Trials Registry (UMIN000001057; http://www.umin.ac.jp/ctr/). The study was performed in accordance with the principles of the Declaration of Helsinki.

## SUPPLEMENTAL INFORMATION

Supplemental Information includes five figures and Supplemental Experimental Procedures and can be found with this article online at http://dx.doi.org/10.1016/j.chom.2012.10.014.

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(B) MKN28 cells were transfected with the pRC/CMV-CD44s or pRC/CMV-CD44v expression plasmid; cells infected with *H. pylori* (s1m1VacA) for 5 hr were incubated in a medium containing antibiotic for the indicated times, and intracellular CagA levels were quantified. Data represent the mean ± SD of three independent assays; *$p < 0.05$, **$p < 0.01$. Akt and MDM2 phosphorylation, p53 expression, and LC3-II formation were quantified. Data represent the mean ± SD of three independent assays; *$p < 0.05$, **$p < 0.01$, compared to each cell at 0 hr after eradication.

(C) Representative staining for LysoTracker Red DND-99 is shown. MKN28 cells were transfected with the pRC/CMV-CD44s or pRC/CMV-CD44v expression plasmid; cells infected with *H. pylori* (s1m1VacA) for 5 hr were incubated in a medium containing antibiotic for the indicated times, and the cells were stained using LysoTracker Red DND-99. Scale bar = 50 μm.

(D) MKN28 cells were transfected with the pRC/CMV-CD44v expression plasmid; cells infected with *H. pylori* ATCC700392 (s1m1VacA) for 5 hr were incubated in a medium containing antibiotic with sulfasalazine for 24 hr; and intracellular CagA, pAkt (Ser473), pMDM2, p53, and LC3-II formation were examined. Data represent the mean ± SD of three independent assays; *$p < 0.05$, **$p < 0.01$.

(E) Immunostaining of CagA and CD44v9 in human gastric adenocarcinoma. Case 1, Case 2, Case 3, and Case 4 indicate each gastric adenocarcinoma tissue specimen from the four different patients. Red staining indicates intracellular CagA and green indicates CD44v9. Nuclei (blue) were stained with DAPI. Scale bar = 20 μm.

(F) Immunostaining of LC3 and CD44v9 in human gastric adenocarcinoma. The left panel indicates a CD44v9-negative region and the right panel indicates a CD44v9-positive region. Red staining indicates LC3B-positive puncta and green indicates CD44v9. Nuclei (blue) were stained with DAPI. Scale bar = 30 μm. See also Figure S5.

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# CDX1 confers intestinal phenotype on gastric epithelial cells via induction of stemness-associated reprogramming factors SALL4 and KLF5

Yumiko Fujii[a,b], Kyoko Yoshihashi[a], Hidekazu Suzuki[c], Shuichi Tsutsumi[d], Hiroyuki Mutoh[e], Shin Maeda[f], Yukinori Yamagata[g], Yasuyuki Seto[g], Hiroyuki Aburatani[d], and Masanori Hatakeyama[a,1]

[a]Division of Microbiology, Graduate School of Medicine, The University of Tokyo, Tokyo 113-0033, Japan; [b]Division of Chemistry, Graduate School of Science, Hokkaido University, Sapporo 060-0810, Japan; [c]Division of Gastroenterology and Hepatology, Department of Internal Medicine, Keio University School of Medicine, Tokyo 160-8582, Japan; [d]Genome Science Division, Research Center for Advanced Science and Technology, The University of Tokyo, Tokyo 153-8904, Japan; [e]Division of Gastroenterology, Department of Medicine, Jichi Medical University, Tochigi 329-0498, Japan; [f]Department of Gastroenterology, Yokohama City University Graduate School of Medicine, Yokohama 236-0004, Japan; and [g]Department of Gastrointestinal Surgery, Graduate School of Medicine, The University of Tokyo, Tokyo 113-8655, Japan

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**Intestinal metaplasia of the stomach, a mucosal change characterized by the conversion of gastric epithelium into an intestinal phenotype, is a precancerous lesion from which intestinal-type gastric adenocarcinoma arises. Chronic infection with *Helicobacter pylori* is a major cause of gastric intestinal metaplasia, and aberrant induction by *H. pylori* of the intestine-specific caudal-related homeobox (CDX) transcription factors, CDX1 and CDX2, plays a key role in this metaplastic change. As such, a critical issue arises as to how these factors govern the cell- and tissue-type switching. In this study, we explored genes directly activated by CDX1 in gastric epithelial cells and identified stemness-associated reprogramming factors *SALL4* and *KLF5*. Indeed, *SALL4* and *KLF5* were aberrantly expressed in the CDX1$^+$ intestinal metaplasia of the stomach in both humans and mice. In cultured gastric epithelial cells, sustained expression of CDX1 gave rise to the induction of early intestinal-stemness markers, followed by the expression of intestinal-differentiation markers. Furthermore, the induction of these markers was suppressed by inhibiting either SALL4 or KLF5 expression, indicating that CDX1-induced SALL4 and KLF5 converted gastric epithelial cells into tissue stem-like progenitor cells, which then transdifferentiated into intestinal epithelial cells. Our study places the stemness-related reprogramming factors as critical components of CDX1-directed transcriptional circuitries that promote intestinal metaplasia. Requirement of a transit through dedifferentiated stem/progenitor-like cells, which share properties in common with cancer stem cells, may underlie predisposition of intestinal metaplasia to neoplastic transformation.**

CagA | Wnt | β-catenin

Metaplasia is a histological change from one tissue type to another, which is associated with conversion of its respective cell types to the corresponding ones. Metaplastic changes can occur either in a physiological process or a pathological condition, the latter of which predisposes cells to undergo neoplastic transformation via a metaplasia–dysplasia–carcinoma sequence. Intestinal metaplasia, a pathological change of non-intestinal epithelium into an intestinal-like mucosa, is most frequently found in the stomach and esophagus (1, 2). *Helicobacter pylori*-induced chronic gastritis is a major cause of gastric intestinal metaplasia, from which intestinal-type adenocarcinoma arises (3). Likewise, replacement of the esophageal squamous epithelium by intestinal epithelium known as Barrett's esophagus substantially increases the risk of esophageal adenocarcinoma (2).

The *Drosophila* homeobox gene *caudal* plays a critical role in development of the posterior embryo (4). *Caudal* has three homologs in vertebrates (*CDX1*, *CDX2*, and *CDX4* in humans; *Cdx1*, *Cdx2*, and *Cdx4* in mice; and *CdxA*, *CdxB*, and *CdxC* in chickens) (5, 6). These genes encode Caudal-related homeobox transcription factors (hereafter denoted as CDX family proteins), which play unique roles in axial patterning and gut development by regulating specific genes through binding to an A/T-rich responsive element. The consensus binding sequence for these CDX family proteins is (A/C)TTTAT(A/G), in which TTTAT acts as a conserved core motif (4, 5). In mammals, CDX family members, especially CDX1 and CDX2, are critically involved in development and maintenance of the intestine (6). Indeed, both CDX1/Cdx1 and CDX2/Cdx2 are expressed in the epithelium of the large and small intestines but not in the epithelium of the stomach or esophagus. They are, however, aberrantly expressed in the intestinal metaplastic lesion of the stomach as well as in Barrett's esophagus (6). *CDX1* is transactivated by several distinct signaling mechanisms such as Wnt/β-catenin signal and retinoic acid signal (7). We previously reported that *H. pylori* CagA, which is delivered into gastric epithelial cells via bacterial type IV secretion, aberrantly stimulates β-catenin signaling and thereby induces Wnt target genes including *CDX1* (8). This observation suggested that CagA-mediated Wnt/β-catenin deregulation plays an important role in the ectopic expression of CDX1 in the stomach infected with *H. pylori*.

Transgenic expression of Cdx1 or Cdx2 in mouse stomach causes intestinal metaplasia (9, 10), indicating a causal and redundant role of ectopically expressed CDX1 and CDX2 in the metaplastic change. Because metaplasia is defined as a switching from one tissue to another, the process may be initiated through changes in cell differentiation status so as to acquire some sort of cell/tissue stemness or multipotency. However, little is known about CDX-governed transcriptional circuitries that give rise to intestinal metaplasia of the stomach. In this work, we investigated genes directly activated by CDX1 in gastric epithelial cells by combining expression microarray and chromatin immunoprecipitation (ChIP)-chip analyses and identified transcription factors, *SALL4* and *KLF5*, both of which are involved in lineage reprogramming and stemness acquisition. We show that CDX1-mediated induction of *SALL4* and *KLF5* plays an important role in transdifferentiation of gastric epithelial cells into an intestinal phenotype, which underlies intestinal metaplasia of the stomach.

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The authors declare no conflict of interest.

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Data deposition: The data reported in this paper have been deposited in the Gene Expression Omnibus (GEO) database, www.ncbi.nlm.nih.gov/geo (accession no. GSE35369).

See Commentary on page 20173.

[1]To whom correspondence should be addressed. E-mail: mhata@m.u-tokyo.ac.jp.

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## Results

**Genes Affected by Ectopic CDX1 Expression in Gastric Epithelial Cells.** To investigate genes targeted by ectopically expressed CDX1, we established several transfectant clones that inducibly express Flag-tagged CDX1 from MNK28 human gastric epithelial cells using a tetracycline-regulated Tet-Off system (Fig. 1*A* and *B* and Fig. S1*A*). Among these, MKN28-A2 cells, which showed the highest expression upon depletion of doxycycline (Dox), a water-soluble tetracycline analog, were subjected to expression microarray analysis and ChIP-chip analysis. First, we compared mRNA expression profiles of MKN28-A2 cells cultured in the presence (CDX1 induction −) or absence (CDX1 induction +) of Dox for 24 h through genome-wide expression microarray analysis and identified 958 genes that showed increases in transcript levels of more than twofold after CDX1 induction and 260 genes whose expression levels were decreased to less than half by CDX1 expression (Fig. 1*C*). Because the removal of Dox had little impact on the mRNA expression profile in parental MKN28 (*tet-off*) cells (Dataset S1), genes selected in Fig. 1*C* were due to specific induction of CDX1. We next carried out ChIP-chip analysis using a human promoter array. CDX1 mostly bound to the promoter regions that are localized substantially upstream of the transcription start sites (TSSs) of genes (Fig. S1*B*). The results of ChIP-chip analysis revealed 1,997 genes to which CDX1 binds at the regulatory regions (Fig. 1*C*). These identified genes contained known CDX1-target genes (Fig. S1*C*). By combining data obtained from expression microarray and ChIP-chip analyses, we selected 166 genes that should include genes specifically up-regulated by CDX1 (Fig. 1*C* and Dataset S2). Unlike a bacterial restriction endonuclease, which strictly recognizes a unique nucleotide sequence, a mammalian transcription factor binds to a range of related sequences (11). Indeed, in the CDX consensus (A/C)TTTAT(A/G), positions 1 and 7 are less stringent compared with the core motif TTTAT (positions 2–6) (5). Given this, we investigated sequences that were enriched in the upstream regions of CDX1-induced genes and found that TTTATT was overrepresented in these regions (Fig. S1*D*). This result reinforced the importance of the TTTAT core motif for specific DNA binding of CDX family proteins. The result also raised the possibility that, whereas CDX1 can variably interact with a number of sequences related to the CDX consensus (A/C) TTTAT(A/G), it preferentially binds to TTTATT. The slight difference between TTTATT and the CDX consensus may allow CDX1 to regulate genes in a manner that is quantitatively and/or qualitatively different from that by which genes are regulated by other CDX members.

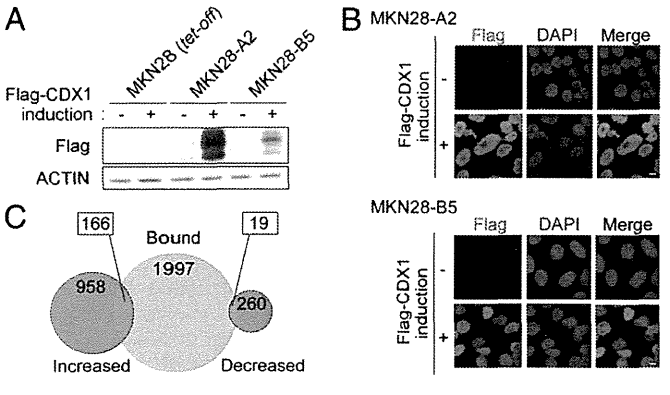


**Fig. 1.** Transcriptional targets of CDX1. (*A*) Lysates prepared from MKN28 (*tet-off*) cells and the transfectant clones, MKN28-A2 and MKN28-B5 cells, were subjected to immunoblotting with the respective antibodies. Flag-tagged CDX1 was induced by Dox depletion. (*B*) Anti-Flag immunostaining of MKN28-A2 and MKN28-B5 cells with or without Flag-CDX1 induction. Nuclei were visualized by DAPI. (Scale bars, 10 μm.) (*C*) Venn diagram showing the overlap between genes to which CDX1 bound and those of which mRNA levels were altered by CDX1 expression.

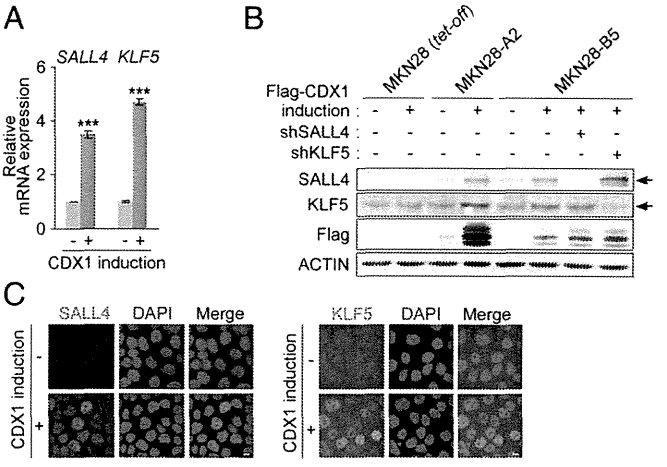


**Fig. 2.** Induction of SALL4 and KLF5 by CDX1. (*A*) *SALL4* and *KLF5* mRNA levels in MKN28-A2 cells with or without CDX1 induction for 24 h were determined by RT-qPCR. Error bars, ± SD; $n = 3$. (*B*) Cells transfected with an expression vector for a SALL4- or KLF5-specific short hairpin RNA (shRNA), pSUPER-shSALL4/1 or pSUPER-shKLF5/1, were induced to express Flag-CDX1 by Dox depletion for 24 h. Lysates prepared were immunoblotted with the respective antibodies. Arrows indicate the positions of SALL4 and KLF5. (*C*) MKN28-B5 cells were immunostained with the respective antibodies. Flag-CDX1 was induced for 48 h. (Scale bars, 10 μm.)

**Transactivation of Reprogramming Factors by Ectopic CDX1.** We hypothesized that CDX1 induces stemness-regulating reprogramming factors in gastric epithelial cells that revert cell-differentiation status so that the cells acquire intestinal stem/progenitor-like properties. With this idea, we investigated whether the identified CDX1-target genes included genes that could confer multipotency upon differentiated somatic cells and we found *Sal-like 4* (*SALL4* in humans and *Sall4* in mice), a gene encoding the SALL4/Sall4 transcription factor that is essential for maintaining stemness in embryonic stem (ES) cells (Dataset S2) (12, 13). Of note, *Sall4* is not expressed in the adult gastrointestinal tract under physiological conditions (14). The identified CDX1-target genes also included *Krüppel-like factor 5* (*KLF5* in humans and *Klf5* in mice), which encodes the KLF5/Klf5 transcription factor (Dataset S2). Klf5 is capable of replacing Klf4 in generating inducible pluripotent stem (iPS) cells, indicating its role in the acquisition of stemness (15). Whereas *Klf5* is predominantly expressed in the small intestine and colon, a small amount of the *Klf5* transcript is also detectable in the stomach (16). A reverse–transcription quantitative PCR (RT-qPCR) analysis revealed that both *SALL4* and *KLF5* mRNAs were induced in MKN28-A2 cells upon ectopic expression of CDX1 (Fig. 2*A*). Induction of endogenous SALL4 and KLF5 by CDX1 was also demonstrated through immunostaining or immunoblotting (Fig. 2 *B* and *C*). ChIP-chip analysis revealed that CDX1 binds to the sequence between −2083 and −737 of the *SALL4* promoter, which contains two CDX-binding TTTAT core motifs conserved between the human and mouse sequences (Fig. 3*A*, *Left* and Fig. S2). A luciferase reporter assay using a series of deletion mutants of the *SALL4* promoter showed that the sequence between −1305 and −938, which contains a single putative CDX-binding sequence, was involved in induction of *SALL4* by CDX1 (Fig. 3*B*, *Left*). A further deletion of the *SALL4* regulatory region from −938 to −642 slightly but significantly restored the reporter activity. This observation was reproduced in the nontransformed human gastric epithelial cell line GES-1 (Fig. S3), indicating the presence of a *cis*-acting repressor element between −938 and −642. The results of ChIP-chip analysis also showed that CDX1 binds to

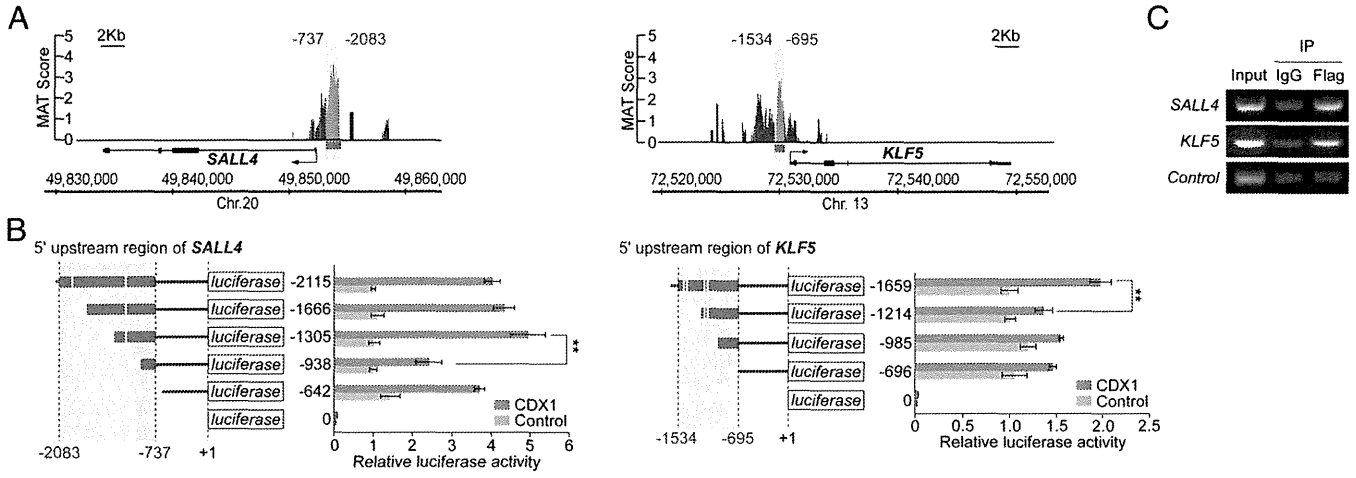


**Fig. 3.** Transactivation of *SALL4* and *KLF5* by CDX1. (*A*) ChIP-chip signals at the *SALL4* or *KLF5* loci. Red lines represent CDX1-binding regions. (*B*) MKN28 cells transfected with the indicated reporter plasmids together with a CDX1 or control vector were subjected to luciferase reporter assay. Schematic diagrams represent *SALL4* (*Left*) or *KLF5* (*Right*) upstream regions. Numbers indicate the distance from the TSS. Red lines indicate the CDX1-binding regions identified in *A* and yellow boxes represent putative CDX1-binding sites containing the TTTAT core motif. Error bars, ± SD; $n = 3$. (*C*) ChIP-PCR analysis for Flag-CDX1 occupancies of the *SALL4* and *KLF5* upstream regions in CDX1-induced MKN28-A2 cells.

the sequence between −1534 and −695 of the *KLF5* promoter (Fig. 3*A*, *Right* and Fig. S2), which contains four CDX1-binding core motifs conserved between the human and mouse sequences. To further elucidate the enhancer element that is used for CDX1-dependent transactivation of *KLF5*, a luciferase reporter assay was carried out using a series of deletion mutants for the *KLF5* promoter region. The results of the experiment revealed that CDX1 transactivates *KLF5* via the sequence between −1659 and −1214 that contains two putative CDX1-binding sites (Fig. 3*B*, *Right*). In both *SALL4* and *KLF5* cases, reduction in luciferase activity by deletion of the putative CDX1-binding sites was not robust. In eukaryotes, however, rarely does a single transcription factor govern transcription of the target gene. Instead, different combinations of ubiquitous and cell-type–specific transcription factors act together by binding to the respective binding sites, with each one having a differential functional contribution (17). Hence, despite its partial promoter stimulation, CDX1 may play a pivotal role in passing a certain threshold of the promoter activation that is required for ectopic expression of *SALL4* and *KLF5*. By ChIP experiment, specific binding of CDX1 to the upstream regulatory regions of *SALL4* and *KLF5* were confirmed (Fig. 3*C*). Based on these observations, we concluded that *SALL4* and *KLF5* are direct transcriptional targets of CDX1.

To generalize the above-described observations, we transiently transfected a Flag-tagged CDX1 vector into AGS and GES-1 human gastric epithelial cells. The results of luciferase reporter assays confirmed that CDX1 transactivates *SALL4* and *KLF5* in both cells (Fig. 4*A*). A ChIP experiment revealed that CDX1 bound to the upstream regions of *SALL4* and *KLF5* genes (Fig. 4*B*). Induction of SALL4 and KLF5 proteins by ectopic expression of CDX1 was also demonstrated in AGS and GES-1 cells (Fig. 4*C*).

To investigate the pathophysiological relevance for induction of these reprogramming factors in intestinal metaplasia, expression of *Sall4* and *Klf5* was investigated in the stomach of Cdx1-transgenic mice using RT-qPCR and found that both of the mRNAs were detectable in the intestinal metaplastic lesions of the mouse stomach (Fig. 4*D*). The expression of *SALL4* and *KLF5* was also examined in intestinal metaplasia of the human stomach by semiquantitative RT-PCR (Fig. 4*E*). In control RNAs obtained from gastric mucosa without intestinal metaplasia

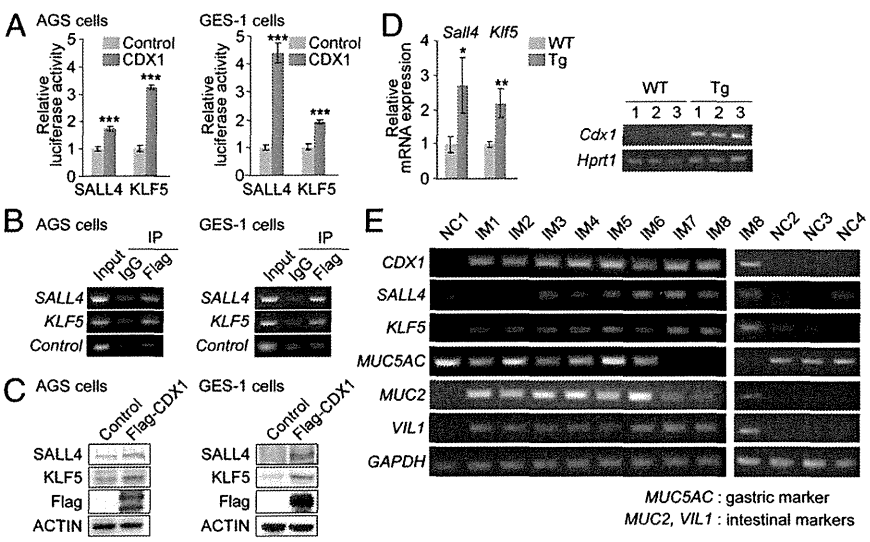


**Fig. 4.** Aberrant expression of *SALL4* and *KLF5* in intestinal metaplasia. (*A*) Cells transfected with pGL3-*SALL4*(−1305) or pGL3-*KLF5*(−1659) reporter plasmid together with a CDX1 or control vector were subjected to luciferase reporter assay. Error bars, ± SD; $n = 3$. (*B*) ChIP-PCR analysis for Flag-CDX1 occupancies of the *SALL4* and *KLF5* upstream regions in cells transiently transfected with a Flag-CDX1 vector. (*C*) Induction of SALL4 and KLF5 in cells transiently transfected with a Flag-CDX1 vector. (*D*) Levels of *SALL4* and *KLF5* mRNAs in the stomach of wild-type (WT) and Cdx1-transgenic (Tg) mice were determined by RT-qPCR. Error bars, ± SD; $n = 3$ (*Left*). Transgenic expression of *Cdx1* in the stomach of Cdx1-Tg mice was confirmed by RT-PCR (*Right*). (*E*) Expression of the indicated mRNAs in human stomachs with (IM1–IM8) or without (NC1–NC4) intestinal metaplasia was determined by semiquantitative RT-PCR.

[normal control (NC1-NC4)], *CDX1*, *SALL4*, or *KLF5* was hardly detectable. In contrast, in samples in which *CDX1* was expressed [intestinal metaplasia (IM1-IM8)], *KLF5* was also detectable and the level of *KLF5* expression was in proportion to the level of CDX1 expression. *SALL4* was also detected in samples IM3–IM8. However, it was only weakly expressed in samples IM1 and IM2, in which the expression levels of CDX1 were less than those in samples IM3–IM8. Induction of *SALL4* may therefore require a higher level of CDX1 expression than that required for *KLF5* induction. In samples IM1–IM6, both gastric mucin (*MUC5AC*) and intestinal mucin (*MUC2*) were detected, indicating that these samples contained both intestinal metaplastic lesions and normal gastric mucosa. In samples IM7 and IM8, the level of mucin expression, either intestinal or gastric type, was low, whereas that of *Villin1* (*VIL1*) was high. Although *VIL1* is known as an enterocyte marker, it is also expressed in gastrointestinal stem/progenitor cells (18). Accordingly, samples IM7 and IM8 may have been derived from lesions that persisted in a less-differentiated state rather than having undergone transdifferentiation. These observations provided in vivo evidence that *KLF5* and *SALL4* were aberrantly expressed in intestinal metaplasia of the stomach in both humans and mice.

**Induction of Intestinal Stem/Progenitor Markers by CDX1.** Through microarray analysis, the genes activated by CDX1 in gastric epithelial cells also included genes expressed in intestinal progenitor cells such as *GATA binding protein 6* (*GATA6*) and *follistatin* (*FST*). GATA6 is expressed in the intestinal crypt and involved in proliferation of immature cells (19). Likewise, FST, an antagonist of TGF-β superfamily proteins, is expressed in undifferentiated intestinal epithelial cells (20). RT-qPCR analysis exhibited one order-of-magnitude increase in the level of *GATA6* or *FST* upon ectopic CDX1 expression in gastric epithelial cells (Fig. 5*A*).

Recent studies have demonstrated that intestinal stem cells are characterized by the expression of intestinal-stemness markers (21). Microarray analysis demonstrated that one of the genes most robustly induced by ectopic CDX1 in gastric epithelial cells was *leucine-rich repeat containing G protein-coupled receptor 5* (*LGR5*), an intestinal-stemness marker (Table S1). Ectopic CDX1 also gave rise to the expression of other intestinal-stemness markers, such as *BMI1 polycomb ring finger oncogene* (*BMI1*) (Table S1). RT-qPCR analysis confirmed increased expression of *LGR5* and *BMI1* upon CDX1 expression in MKN28-A2 cells (Fig. 5*B*). Although highly reproducible and statistically significant, induction of *BMI1* mRNA by CDX1 was relatively weak. This was most probably due to the higher level of CDX1 required for activation of *BMI1* than that required for activation of *LGR5*. From these observations, we concluded that aberrantly expressed CDX1 endowed gastric epithelial cells with an intestinal stem/progenitor-like phenotype.

**Up-Regulation of Intestinal-Differentiation Markers by Sustained CDX1 Expression in Gastric Epithelial Cells.** Intestinal metaplasia comprises variably differentiated intestinal epithelial cell lineages such as absorptive enterocytes, goblet cells, enteroendocrine cells, and Paneth cells in nonintestinal epithelium (1, 2). Transgenic expression of Cdx1 has been reported to induce all of those epithelial cell lineages in the mouse stomach (9). Consistently, microarray analysis demonstrated that ectopic expression of CDX1 in gastric epithelial cells induces *sucrase-isomaltase* (*SI*) and *membrane metallo-endopeptidase* (*MME*), which are physiologically expressed in absorptive enterocytes of the small intestine. *Vasoactive intestinal peptide* (*VIP*), a gastrointestinal hormone secreted from enteroendocrine cells in the small intestine, was also induced upon CDX1 expression in gastric epithelial cells. RT-qPCR experiments confirmed up-regulation of these intestine-differentiation markers in gastric epithelial cells by CDX1 (Fig. 5*C*). The expression levels of these intestinal-differentiation markers increased progressively upon sustained

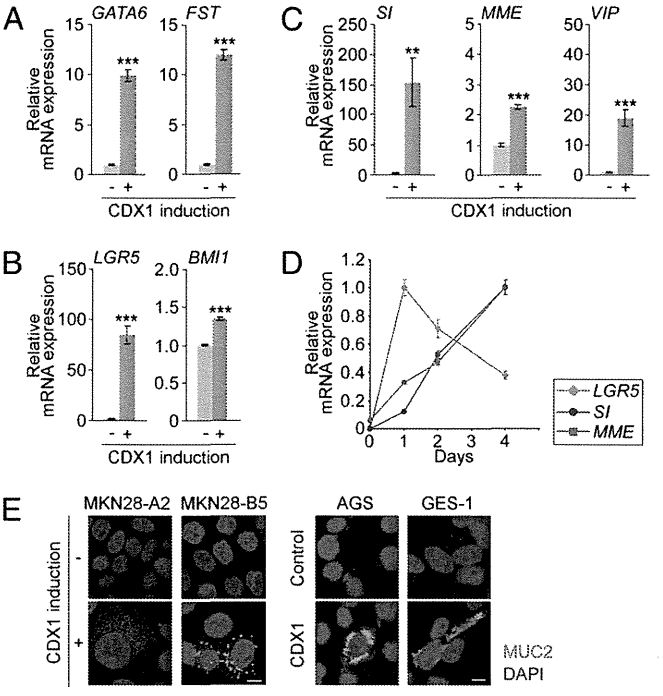


**Fig. 5.** Induction of intestinal markers by CDX1 in gastric epithelial cells. (*A–C*) Levels for intestinal-progenitor markers (*A*), intestinal-stemness markers (*B*), and intestinal-differentiation markers (*C*) in MKN28-A2 cells before and after induction of CDX1 for 24 h were determined by RT-qPCR. Error bars, ± SD; $n$ = 3. (*D*) Kinetic changes in the expression of the respective genes following induction of CDX1 in MKN28-A2 cells were determined by RT-qPCR. Error bars, ± SD; $n$ = 3. (*E*) Anti-MUC2 immunostaining of cells inducibly expressing Flag-CDX1 (*Left*) or transiently transfected with a Flag-CDX1 vector (*Right*) for 4 d. (Scale bars, 10 μm.)

CDX1 expression, whereas that of the intestinal-stemness marker reached a peak within 24 h after CDX1 induction (Fig. 5*D*). *MUC2*, a goblet cell marker, was not detected within 24 h after CDX1 induction. However, in all gastric epithelial cells examined (MKN28, AGS, and GES-1), a fraction of cells became $MUC2^+$ after prolonged exposure (~4 d) to CDX1 (Fig. 5*E*). The Paneth cell and the enteroendocrine cell markers were negative following sustained CDX1 expression in cultured gastric cells (Fig. S4). Thus, CDX1 on its own may support differentiation into absorptive enterocytes and goblet cells in a cell autonomous fashion. Development of other types of intestinal epithelial cells might require non–cell-autonomous signals in addition to CDX1. Also notably, most of these intestinal-differentiation markers were not likely to be directly transactivated by ectopic CDX1 in gastric epithelial cells (Dataset S2), suggesting that they were induced via de novo formation of CDX1-governed transcriptional circuitries that promote intestinal differentiation.

**Requirement of SALL4 and KLF5 in CDX1-Mediated Intestinal Transdifferentiation.** To investigate the role of SALL4 and/or KLF5 induction in the transdifferentiation of gastric epithelial cells by ectopic CDX1, we established two independent CDX1-inducible MKN28 cell lines, A2-KD/SK and B5-KD/SK, in which expression of both SALL4 and KLF5 was suppressed by stable expression of specific shRNA vectors (Fig. 6 *A* and *B*, *Left*). MKN28 cells expressing a luciferase-specific shRNA (A2-KD/C and B5-KD/C) were also established and were used as a control. Increased CDX1 expression or decreased SALL4/KLF5 expression had no relevance to the expression levels of transcription factors such as NF-κB p65/v-rel reticuloendotheliosis viral oncogene homolog A (RelA) and specificity protein 1 (Sp1), which may not be regulated by CDX1, SALL4, or KLF5 (Fig. S5).

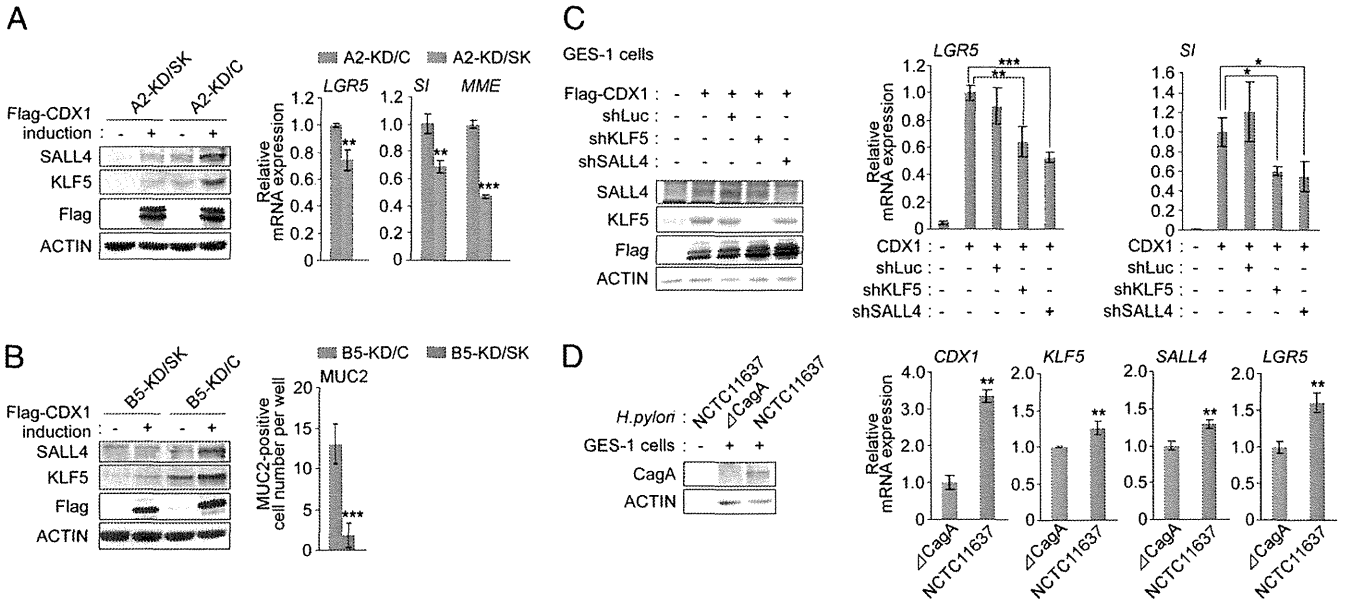


**Fig. 6.** Involvement of SALL4 and KLF5 in CDX1-mediated intestinal transdifferentiation. (*A* and *B*) MKN28-derived SALL4/KLF5 double-knockdown (A2-KD/SK or B5-KD/SK) or control-knockdown (A2-KD/C or B5-KD/C) cells were induced to express CDX1 by Dox depletion for 24 h. Cell lysates were subjected to immunoblotting with the respective antibodies (*Left*). The mRNA levels for intestinal markers were determined by RT-qPCR in CDX1-induced cells (*A*, *Right*). The number of MUC2$^+$ cells per well in the eight-well chamber slide was counted in CDX1-induced cells (*B*, *Right*). (*C*) GES-1 cells transiently transfected with a Flag-CDX1 vector together with pSUPER-shLuc, pSUPER-shKLF5/1, or pSUPER-shSALL4/1 were cultured for 24 h. Cell lysates were immunoblotted with the respective antibodies (*Left*). Levels of the *LGR5* and SI mRNAs were determined by RT-qPCR (*Right*). (*D*) GES-1 cells infected with *H. pylori* for 24 h were lysed with 0.1% saponin, which disrupts mammalian cells but not bacterial cells. The lysates were then immunoblotted with the respective antibodies (*Left*). RNAs isolated from GES-1 cells infected with *H. pylori* isogenic strains for 96 h were subjected to RT-qPCR analysis for the indicated mRNAs (*Right*). Error bars, ± SD; $n = 3$.

Induction of the intestinal-stemness marker, *LGR5*, by ectopic CDX1 was subdued under the condition of suppression of SALL4 and KLF5 (Fig. 6*A*, *Right*). Expression of intestinal-differentiation markers, *SI* and *MME*, by ectopic CDX1 was much less efficient when the expression of SALL4 and KLF5 was inhibited (Fig. 6*A*, *Right*). The number of MUC2$^+$ cells following prolonged exposure to CDX1 was dramatically decreased upon knockdown of SALL4 and KLF5 (Fig. 6*B*, *Right*). The degree of induction of intestinal-stemness marker and intestinal-differentiation marker by ectopic CDX1 was also reduced when expression of endogenous SALL4 or KLF5 was transiently inhibited in GES-1 cells (Fig. 6*C*). Thus, CDX1-mediated induction of SALL4 and KLF5 plays a critical role in the intestinal transdifferentiation of gastric epithelial cells by establishing an intestinal stem/progenitor-like state, from which various intestinal cell types arise.

We then infected GES-1 cells with a *cagA*$^+$ or a *cagA*$^-$ *H. pylori* isogenic strain (Fig. 6*D*, *Left*). At 96 h after *H. pylori* infection, RNAs were isolated from the cells and subjected to RT-qPCR analysis. The results of the experiment revealed that *H. pylori* infection induced *CDX1* in a *cagA*-dependent manner in GES-1 cells, followed by elevated levels of reprogramming factors, *SALL4* and *KLF5*, and an intestinal stem cell marker, *LGR5* (Fig. 6*D*, *Right*). These observations provided pathophysiological relevance for the ectopic expression of CDX1 in the induction of intestinal metaplasia in patients infected with *H. pylori cagA*$^+$ strains.

## Discussion

Chronic infection with *H. pylori* is a major cause of gastric intestinal metaplasia, a precancerous mucosal lesion from which intestinal-type adenocarcinoma arises. CagA, a major virulence factor of *H. pylori* that is delivered into gastric epithelial cells via type IV secretion, aberrantly activates the Wnt/β-catenin signal and ectopically induces Wnt target genes including *CDX1* (8). A causal relationship between ectopic CDX1 and intestinal metaplasia has been provided by the observation that transgenic expression of Cdx1 per se is sufficient to induce intestinal metaplasia in the mouse stomach (9). Persistence of metaplastic changes after removal of triggering agents such as *H. pylori* indicates that expression of a key inducer of metaplasia must have been maintained in the absence of triggering agents. CDX1 fits this idea in that it establishes an autoregulatory network to maintain its own expression (22). However, the mechanism by which ectopic CDX1 provokes metaplastic changes has remained poorly understood.

In intestinal epithelial cells, CDX1 acts as a differentiation-promoting factor (6). Assuming that metaplasia requires the conversion of differentiated cells into less-differentiated states, ectopically expressed CDX1 may also activate stemness-regulating reprogramming factors, which allow dedifferentiation of gastric epithelial cells so that they acquire multipotency characteristic of intestinal stem/progenitor-like cells. Consistently, Cdx1 has recently been reported to be a constituent of the transcriptional network that confers pluripotency on ES cells (23). We found that CDX1 directly induces SALL4, a zinc-finger transcription factor playing an important role in maintaining self-renewal and pluripotency (12). Especially, Sall4 positively regulates *octamer-binding protein 4 (Oct4)*, *c-Myc*, *SRY-box containing gene 2 (Sox2)*, and *Klf4*, the four defined transcription factors capable of generating iPS cells (13). CDX1 also transactivates *KLF5*, a gene encoding a member of the KLF family of transcription factors. Importance of KLFs in the acquisition of pluripotency has been highlighted by recent studies showing that depletion of Klf2, Klf4, and Klf5 in mouse ES cells abolishes self-renewal (24). Furthermore, Klf5 can replace Klf4 in generating iPS cells, indicating a redundant role between KLF4 and KLF5 in stemness induction/maintenance (15). In adult tissues, Sall4 and Klf5 are expressed in hepatic stem cells and hair follicle stem cells, respectively, to maintain tissue stemness (25, 26). Identification of the reprogramming factors SALL4 and KLF5 as direct transcriptional targets of CDX1 therefore provides a mechanistic basis underlying intestinal metaplasia of the stomach. On the one hand, CDX1 activates reprogramming transcription factors in

gastric epithelial cells and thereby rewires transcriptional circuitries so as to redirect gastric epithelial cells toward a less-differentiated intestinal stem/progenitor-like state. On the other hand, CDX1 creates transcriptional circuitries that direct transdifferentiation of dedifferentiated cells into intestinal epithelial cells. Cancer stem cells have recently been reported to possess properties that are shared in common with tissue stem/progenitor cells (27). The observation indicates that acquisition of stemness traits is linked to cell transformation and suggests that a transition through intestinal stem/progenitor-like states via dedifferentiation predisposes cells to undergo neoplastic changes. This may explain the clinical observation that intestinal metaplasia is a precancerous lesion of the stomach (3).

In intestinal epithelial cells, the two homologous CDX1 and CDX2 (Cdx1 and Cdx2 in mice) transactivate a number of intestine-specific genes (6). Like Cdx1, transgenic expression of Cdx2 in the mouse stomach also causes intestinal metaplasia (10), indicating a redundant role of Cdx1 and Cdx2 in the pathogenic change. Interestingly, genomic binding sites for CDX2 include 5′-flanking regions of *SALL4* and *KLF5* (28). It is therefore possible that CDX2 provokes intestinal transdifferentiation via direct activation of *SALL4* and *KLF5*, like CDX1. Also of note, Cdx2 is capable of inducing *Cdx1* mRNA in the mouse stomach (29). Hence, CDX2-mediated intestinal metaplasia might be at least partly due to CDX2-induced CDX1. Whereas CDX-induced intestinal metaplasia is thought to be a precancerous stomach lesion, the potential role of CDX1 or CDX2 in intestinal carcinogenesis remains unclear. Cdx1 and Cdx2 were originally described as an oncoprotein and tumor suppressor, respectively, in intestinal cells (30, 31). However, recent studies suggested that overexpression of Cdx1 has very limited contribution, if any, to the development of intestinal tumors (32, 33). Hence, CDX1 could promote oncogenesis only when it is ectopic expressed in non-intestinal epithelial cells.

The present work provided evidence that ectopic expression of CDX1 and subsequent induction of stemness-associated reprogramming factors SALL4 and KLF5 by CDX1 are key events underlying gastric intestinal metaplasia. As far as we know, this is a unique demonstration of the involvement of reprogramming factors in metaplastic changes. The finding also gives mechanistic insights into intestinal transdifferentiation; CDX1-directed rewiring of transcriptional circuitries through induction of reprogramming factors converts differentiated gastric epithelial cells to immature intestinal stem/progenitor-like cells, which can transdifferentiate into intestinal cells. Reactivation of such reprogramming factors may broadly contribute to the plasticity of the lineage commitment in both physiological and pathological conditions. Our work therefore provides deeper insights into organogenesis and oncogenesis that can be applied to help the progress of regenerative medicine as well as cancer prevention and treatment.

## Materials and Methods

The experiments using human materials were approved by the Research Ethics Committee of the Graduate School of Medicine, The University of Tokyo, and the Ethics Committee of Keio University School of Medicine. Informed consent was obtained from all patients. The experiments using animals were approved by the Committee of Experimental Animal Ethics of Jichi Medical University. Cdx1-transgenic mice have been described previously (9). Luciferase reporter assay, qPCR analysis, and cell-counting assay were evaluated using Student's *t* test. $P < 0.05$ was considered to be statistically significant. For all statistical comparisons in these assays, $P < 0.001$ was denoted as ***, $P < 0.01$ as **, and $P < 0.05$ as *. The Gene Expression Omnibus accession number for expression microarray and ChIP-chip analyses in this study is GSE35369. Details of materials and methods are described in *SI Materials and Methods*. Primers used in this study are shown in Table S2.

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# *Helicobacter pylori* infection in functional dyspepsia

*Hidekazu Suzuki and Paul Moayyedi*

**Abstract** | Functional dyspepsia is the most common reason for patients to experience chronic epigastric pain or discomfort. The causes of functional dyspepsia are multifactorial but *Helicobacter pylori* infection is one likely candidate. Infection with this bacterial pathogen clearly results in chronic mucosal inflammation in the stomach and duodenum, which, in turn, might lead to abnormalities in gastroduodenal motility and sensitivity. Chronic gastritis might also affect a variety of endocrine functions of the stomach including the production of the gastrointestinal hormones and neurotransmitters somatostatin, gastrin and ghrelin. Although these abnormalities might generate symptoms in some patients with functional dyspepsia, the clinical evidence needs to be critically evaluated before this hypothesis can be confirmed. A Cochrane review reported that eradication of *H. pylori* in these patients had a small but statistically significant long-term effect on symptom relief when compared with placebo, lasting at least 12 months after 1 week of eradication therapy. The efficacy of eradication therapy was seen in all symptom subtypes of functional dyspepsia, but was more marked in Asian than Western patients. This evidence has led to alterations in most of the major guidelines throughout the world, which now recommend *H. pylori* eradication in patients with functional dyspepsia if they test positive for this bacterium.

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## Introduction

Dyspepsia refers to a broad range of chronic gastroduodenal symptoms—including pain or discomfort centred in the upper abdomen, early satiety, fullness, bloating sensation in the upper abdomen and nausea—seen commonly in individuals throughout the world.[1] Patients with dyspepsia have a normal life expectancy,[2] but a markedly reduced quality of life[3] and often need to undergo multiple tests to establish the aetiology of their symptoms. Upper gastrointestinal endoscopy findings appear normal in approximately 75% of patients with dyspepsia,[4] and most of these individuals are diagnosed with functional dyspepsia. The treatment of functional dyspepsia remains a challenge, however, as the pathophysiology of the condition is poorly understood.

Multiple theories have been proposed to describe the underlying pathophysiology of functional dyspepsia symptoms, including dysmotility and/or hypersensitivity in the upper gastrointestinal tract.[5] In some cases, these abnormalities might have a postinfectious cause.[6,7] Although a variety of bacterial infections have been implicated in the pathogenesis of this disorder,[8] *H. pylori* is one of the most likely causes, as it is the most common chronic infection worldwide and primarily involves the gastric mucosa. Moreover, large population-based studies have shown that this bacterium is found more frequently in the gastric mucosa of patients with dyspepsia than in that of healthy individuals.[9] Trials conducted to evaluate the efficacy of *H. pylori* eradication treatment for functional dyspepsia have yielded conflicting results, but eradication of this bacterium is suggested to be effective in at least a subset of patients with this disorder.[10,11] This Review outlines the evidence that *H. pylori* is involved in the pathogenesis of functional dyspepsia.

Division of Gastroenterology and Hepatology, Department of Internal Medicine, Keio University School of Medicine, 35 Shinanomachi, Shinjuku-ku, Tokyo 160-8582, Japan (**H. Suzuki**). Farncombe Family Digestive Health Research Institute, Division of Gastroenterology, Department of Medicine, McMaster University, 1280 Main Street West, Hamilton, ON L8S 4K1, Canada (**P. Moayyedi**).

Correspondence to: H. Suzuki hsuzuki@a6.keio.jp

**Competing interests**
H. Suzuki declares associations with the following companies: Astellas, AstraZeneca, Eisai, Otsuka, Daiichi–Sankyo, Dainippon–Sumitomo, Takeda, Tsumura and Zeria. P. Moayyedi declares associations with the following companies: AstraZeneca, Abbott, Pendopharm, Shire and Takeda. See the article online for full details of these relationships.

## Pathogenesis

### Inflammation and microcirculation

*H. pylori* colonization evokes a considerable level of inflammation in the gastric mucosa.[12] Reactive oxygen species, which are released from polymorphonuclear neutrophils after activation by *H. pylori* colonization, are potential toxic factors involved in *H. pylori*-induced gastric mucosal injury.[13] Moreover, polymorphonuclear cell infiltration of the gastric mucosa leads to the development of the initial lesions of *H. pylori* infection, namely chronic active gastritis (Figure 1). The inflammation caused by infection with *H. pylori* leads to gastric microcirculatory disturbances including leukocyte rolling, adhesion and extravasation. Moreover, unstable microvascular flow dynamics (such as ischaemia–reperfusion) also promote leukocyte recruitment, generating a vicious cycle between inflammatory lesion formation and further ischaemia-associated

injury.[14] Gastric ischaemia–reperfusion injury induces delayed gastric emptying through the inactivation of interstitial cells of Cajal and neuronal nitric oxide synthase (nNOS)-positive nerves.[15] Under such a state of ischaemia–reperfusion, gastric mucosal ghrelin-positive X/A-like cells and the levels of plasma ghrelin and ghrelin production in the stomach decrease, resulting in anorexia in rats.[16] These alterations are predicted to trigger dyspeptic symptoms, such as postprandial fullness and early satiation, in humans.

### Acid secretion

Acid secretion, which is affected by infection with *H. pylori*, is also associated with dyspepsia.[17] Indeed, patients with functional dyspepsia and *H. pylori* infection had a fourfold increase in acid secretion after intravenous infusion of gastrin-releasing peptide (GRP)—a neuropeptide that induces responses that mimic the physiological responses to food ingestion.[18] By contrast, asymptomatic *H. pylori*-positive individuals had only a 2.5-fold increase in stimulated acid secretion. Acid secretion during *H. pylori* infection depends on the spread of gastric mucosal atrophy and the local inflammatory states, which are determined by host–bacterial interactions and environmental factors.[19] In a subset of *H. pylori*-infected patients with antral predominant gastritis without corpus atrophy, acid secretion might be enhanced compared with those with normal uninfected mucosa, and is a potential cause of dyspeptic symptoms, such as epigastric pain or burning.[20,21] Conversely, when atrophy extends to the corpus mucosa (fundic gland), diminished acid secretion caused by the direct damage to parietal cells in the corpus has been shown to be associated with gastric ulcers and gastric cancer; interestingly, this atrophy does provide protection from gastro-oesophageal reflux.[22]

## Gastric endocrinology

### Gastrin and somatostatin

*H. pylori* colonized in the antral mucosa have been hypothesized to lead to the injury of somatostatin-producing D cells, leading to a decrease in the secretion of somatostatin. As somatostatin is a negative regulator of gastrin secretion, the reduction in somatostatin levels would, in turn, lead to an increase in gastrin levels.[23–26] Support for this hypothesis comes from the observation that fasting and postprandial serum gastrin levels are increased in patients infected with *H. pylori*, with an equivalent decrease in gastric mucosal concentrations of somatostatin.[27,28] Interestingly, these abnormalities are corrected by *H. pylori* eradication therapy.[23,29] These findings suggest that the eradication of *H. pylori* in patients with symptomatic antral gastritis would be beneficial for symptom relief.

### Ghrelin

Given the gastric location of ghrelin production, it is perhaps not surprising that an insult to the gastric mucosa affects circulating ghrelin levels in humans, which has a subsequent affect on appetite. Indeed, infection with *H. pylori* is associated with chronic gastritis, gastric atrophy and ulceration as well as reduced appetite and a reduced BMI. *H. pylori* also damages the ghrelin-producing gastric X/A-like cells[30] and decreases ghrelin secretion.[31–33] Ghrelin is predominantly produced by the gastric enteroendocrine cell compartment and is octanoylated by ghrelin *o*-acyltransferase (GOAT) before secretion into the bloodstream. This octanoylation is essential for many of the biological properties of ghrelin including appetite stimulation and anti-inflammatory properties, as only the acylated form of ghrelin binds to the ghrelin receptor, the growth hormone secretagogue receptor.[34] Ghrelin is involved in hunger sensations, acid secretion[35] and gastrointestinal motility; the alteration of ghrelin production in the stomach by *H. pylori* could contribute to upper gastrointestinal symptoms in patients with functional dyspepsia. This idea is supported by the observation that ghrelin levels fluctuate in some patients with functional dyspepsia,[36] although whether this fluctuation is the cause or a consequence of upper gastrointestinal symptoms remains to be elucidated. Both enhanced acid and ghrelin secretion can be reversed to some extent by eradication therapy,[37–39] and restoration of these physiological changes might explain the beneficial effect of eradication therapy on dyspeptic symptoms in patients with *H. pylori* infection. In *H. pylori*-positive patients with chronic atrophic gastritis, the plasma level of total and active ghrelin is

**Key points**

- *Helicobacter pylori* infection is a major cause of gastritis and is associated with a variety of motility, endocrine and acid-secretory abnormalities that could drive the symptoms of functional dyspepsia
- In a meta-analysis of randomized controlled trials, *H. pylori* eradication had a small but statistically significant effect in controlling the symptoms of functional dyspepsia
- *H. pylori* eradication improves symptoms in patients with epigastric-pain-predominant and postprandial-distress-predominant functional dyspepsia
- The majority of guidelines recommend *H. pylori* eradication in at least a subset of patients with functional dyspepsia

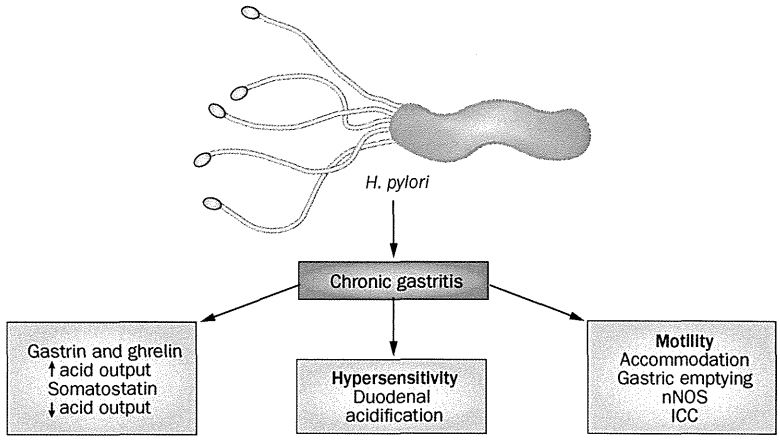


**Figure 1** | Symptoms of chronic gastritis caused by *Helicobacter pylori* infection. Duodenal acidification leads to duodenal hypersensitivity. Deregulation of accommodation and gastric emptying is thought to be caused by inactivation of nNOS and ICC. Acid output is predicted to be promoted by gastrin and ghrelin, and suppressed by somatostatin. Abbreviations: ICC, interstitial cells of Cajal; nNOS, neuronal nitric oxide synthase.

significantly lower than in uninfected individuals.[37–39] However, after eradication of this pathogen, results are mixed;[39,40] some researchers report restoration of ghrelin levels,[41,42] whereas others report no significant changes in ghrelin levels after eradication.[32,43]

As ghrelin—especially the active acylated form of ghrelin—has an appetite-promoting action through neuropeptide Y (NPY) in the hypothalamus, the change in ghrelin dynamics could affect the gastroduodenal symptoms of early satiety and appetite loss. Indeed, activation of ghrelin receptors leads to increased levels of NPY and agouti-related peptide.[44] Such enhancement of the NPY pathway would promote appetite and so could be beneficial for the treatment of early satiety or anorexic symptoms.

### MicroRNAs

Gastroduodenal motility might be linked to *H. pylori* infection in a subset of infected individuals, such as those with delayed gastric emptying.[45,46] However, a correlation between gastric emptying and eradication therapy has not been observed in all studies.[47] In 2011, we found that gastric emptying was significantly accelerated in mice with chronic *H. pylori* infection, as well as those infected with another *Helicobacter* species, *H. felis*.[48] The muscular layer of the stomach of the *H. pylori*-infected mice was considerably thickened; moreover, infected mice had hyperplasia of myocytes in the stomach and downregulation of the muscle-specific microRNAs *miR-1*, *miR-133a* and *miR-133b*. However, the expression of histone deacetylase 4 and serum response factor (reported to be target genes of *miR-1* and *miR-133* and known to enhance muscular hyperproliferation) were increased. Chronic *H. pylori* infection with downregulated expression of muscle-specific miRNAs might cause hyperplasia of the muscular layer of the stomach and dysfunction of gastric emptying, especially accelerated gastric emptying, possibly through disturbed gastric accommodation. These findings provide a novel insight into the molecular pathogenesis of gastric dysmotility, specifically associated with *H. pylori* infection.[48]

In idiopathic gastroparesis, administration of ghrelin enhances gastric emptying and improves meal-related symptoms.[49] Therefore, analogues of ghrelin are expected to represent a new class of prokinetic agents that could be useful in gastric dysmotility.[50] TZP-101, a synthetic, selective ghrelin agonist, is now being tested in clinical trials.[51]

### Mast cells

Mast cells are considered as another cause of dyspeptic symptoms. However, mast cells are found in patients with *H. pylori*-negative dyspepsia but not in *H. pylori*-positive patients, suggesting a different mechanism underlying the development of symptoms in patients with *H. pylori*-negative dyspepsia.[52]

## Detection of *H. pylori*-positive gastritis

Nodular gastritis, a unique type of gastritis caused by *H. pylori* infection, is detectable by routine endoscopy.[53,54] Patients with this type of gastritis often have dyspeptic symptoms, which remit after *H. pylori* eradication, with the disappearance of goose-flesh gastritis.[53,54] In addition, enlarged fold gastritis with hypochlorhydria is reversed by the eradication of *H. pylori*,[55] although no specific dyspeptic symptoms have been reported. Macroscopic or endoscopic changes (including gastric mucosal atrophy and intestinal metaplasia) are frequently observed in patients from North Eastern Asia, such as Japan and Korea, where highly virulent *H. pylori* strains, such as those that express the vacuolating cytotoxin (for example, m1VacA-positive strains), are predominant.[56] Endoscopy has revealed that *H. pylori* infection causes definite structural changes, possibly fulfilling the definition for organic disease.[57–59] Since 2005, reports from both Japan and Western countries have shown that high-resolution endoscopy equipped with magnification apparatus can be used to identify *H. pylori* infection status with high accuracy.[60,61] Therefore, if clinicians are well-trained, the presence of *H. pylori* infection could be diagnosed endoscopically by checking the absence of the regular arrangement of collecting venules. On the other hand, the diagnosis of *H. pylori* infection could be performed without endoscopy by using urea breath test, stool antigen test, serological testing or urine test.[12,62]

## Eradication in functional dyspepsia

In an era of evidence-based medicine, the key question is whether any evidence from randomized controlled trials (RCTs) supports the proposal that eradication of *H. pylori* leads to resolution of functional dyspepsia symptoms. Initial RCT evidence was conflicting,[63,64] as were the main systematic reviews that addressed this question.[65,66] As data have emerged,[67] however, it has become clear that *H. pylori* eradication has a small but statistically significant effect on functional dyspepsia symptoms. This conclusion was confirmed by a large South American RCT[68] and by the latest Cochrane review on *H. pylori* eradication, which is in the process of being updated.[69,70] In the published Cochrane review, 21 trials involving 4,331 patients with functional dyspepsia who had undergone *H. pylori* eradication therapy or received placebo were analysed.[70] All trials used either improvement in overall dyspepsia symptoms or complete absence of symptoms as an outcome. When more than one outcome was given in the paper, the most stringent outcome was chosen for the meta-analysis (that is, the outcome that was closest to describing complete absence of dyspepsia symptoms). No statistically significant variation was observed between RCT results, and most studies evaluated participants at 12 months. Overall, the number needed to treat to cure one case of dyspepsia that would not be cured by placebo was 14 (95% CI 10–20).[70] This estimate does not include studies identified in a further systematic review[71] that also found a significant effect of *H. pylori* eradication on functional dyspepsia, although six of the seven studies only evaluated patients at 1 month.

Overall, the effect of *H. pylori* eradication on functional dyspepsia is modest and it could be argued

**Table 1** | Summary of guidelines that evaluate use of *H. pylori* eradication in functional dyspepsia

| Country | Focus of guideline | *H. pylori* eradication in functional dyspepsia | Recommendation | Level of evidence | Comments | Study |
|---|---|---|---|---|---|---|
| Denmark | *H. pylori* | Yes | Strong | Highest | "Effect modest at best" | Bytzer *et al.* (2011)[89] |
| Korea | Functional dyspepsia | Yes | N/A | N/A | "*H. pylori* eradication can be one of the therapeutic options in functional dyspepsia" | Jee *et al.* (2011)[90] |
| Germany | *H. pylori* | Yes | Strong | Highest | N/A | Fischbach (2009)[91] |
| Asia | Functional dyspepsia | Yes | Strong | Highest | "Eradicate *H. pylori* if socioeconomic conditions allow" | Miwa *et al.* (2012)[94] |
| Asia | *H. pylori* | Yes | Strong | Highest | N/A | Fock *et al.* (2009)[93] |
| Japan | *H. pylori* | Yes | Strong | Highest | "Eradication therapy is strongly recommended for patients with *H. pylori*-positive functional dyspepsia. However, further investigation will be required to determine the actual value of eradication therapy for Japanese patients" | Asaka *et al.* (2010)[95] |
| Europe | *H. pylori* | Yes | Strong | Highest | "*H. pylori* eradication produces long-term relief of dyspepsia in one of 12 patients with *H. pylori* and functional dyspepsia; this is better than any other treatment" | Malfertheiner *et al.* (2012)[96] |
| USA | *H. pylori* | Controversial | N/A | N/A | "A subset of patients with functional dyspepsia derives benefit from *H. pylori* eradication" | Chey *et al.* (2007)[92] |

Abbreviation: N/A, not applicable.

that acid suppression[72,73] or prokinetic therapy[73] have a greater effect on functional dyspepsia symptoms. However, the sizes of the effect reported in these studies are driven by lower quality studies than those for eradication treatment.[74] Moreover, in the case of prokinetic therapy, there is evidence of publication bias or other small study effects[73] that could have led to an overestimation of the treatment effect. Furthermore, an economic analysis suggested that *H. pylori* eradication is the most cost-effective treatment approach for infected patients with functional dyspepsia,[66] as long-term effects are seen with just 1 week of therapy. By contrast, alternative medical therapies need to be taken long-term as the majority of patients with functional dyspepsia continue to have symptoms over a number of years.[75] Long-term acid suppressive therapy might also be related to serious adverse events, such as risk of hip fracture, pneumonia and enteric infection, although this area is still controversial.[76] New eradication protocols[77,78] have been developed with increased eradication rates, which might increase the efficacy of *H. pylori* eradication therapy in individuals with functional dyspepsia.

Some trials in the Cochrane systematic review[70] supported eradication therapy, although most found no benefit. One possibility is that these different conclusions are a result of variations in trial design; indeed, this hypothesis is likely to be the case for some of the Chinese studies,[71] which had unclear methods of randomization and only a 1-month follow-up period. Another possibility is that positive studies had different approaches to patient selection, treated control patients differently or used different *H. pylori* eradication therapies. However, when these possibilities were explored in subgroup analyses, they did not seem to be the explanation.[70] Indeed, no statistically significant heterogeneity was found between studies and so it is most likely that any variation in individual trial results was simply owing to chance. The beneficial effect of *H. pylori* eradication in functional dyspepsia is modest and all trials were underpowered to detect this difference. It would therefore be expected that most trials would show no benefit but a few, by chance, would find a statistically significant effect and indeed this trend was observed in the meta-analysis.[70]

## Symptom subgroups in functional dyspepsia

Patients with functional dyspepsia have various upper gastrointestinal symptoms that have been grouped together in different ways.[79] Current concepts have focused on epigastric pain predominant and postprandial distress related symptoms.[80] Acid suppressive therapy can improve symptoms in patients with reflux-predominant symptoms and epigastric-pain-predominant symptoms, but is ineffective in patients with dysmotility-type symptoms.[72] It is currently unclear whether *H. pylori* eradication therapy has a different efficacy depending on the symptom subgroup of functional dyspepsia. Three RCTs,[68,81,82] involving a total of 468 patients with functional dyspepsia categorized into either epigastric pain or dysmotility subgroups, have investigated the effect of *H. pylori* eradication. Overall, *H. pylori* eradication seemed to be effective in both epigastric-pain-predominant dyspepsia and dysmotility-type dyspepsia, with no heterogeneity in effect between the subgroups. This trend is supported by three other trials[83–85] that evaluated the effect of *H. pylori* eradication in 470 patients with epigastric pain; *H. pylori* eradication was significantly more efficacious than placebo at relieving this symptom. This symptom relief was also

seen in the 200 patients in these three studies who had bloating but not in the 252 patients with early satiety. A potential explanation for these observations is related to ghrelin levels. As ghrelin enhances gastric emptying, a decrease in ghrelin levels could delay gastric emptying, resulting in postprandial fullness, whereas an increase in ghrelin levels could lead to early gastric emptying, early duodenal acidification,[86] hypersensitivity and epigastric pain.[87]

Overall, *H. pylori* eradication therapy has an effect on a wide variety of upper gastrointestinal symptoms, which suggests that although the effect is modest it does seem to apply to the general functional dyspepsia population rather than specific patient subgroups. This observation is in contrast to acid suppressive therapies or prokinetic therapies, which are only effective for certain functional dyspepsia symptoms.[88]

## Eradication in Asia

The prevalence of *H. pylori* infection and gastric cancer is extremely high in the East, especially in East Asia including Japan, Korea and the northern part of China. Symptom relief from eradication of *H. pylori* in functional dyspepsia might, therefore, be different, as a much larger proportion of the population in these regions is infected with *H. pylori* than in the West. Furthermore, genetic profiles, socioeconomic conditions and dietary habits are different in Asian populations than in European and American populations. A comparison of data from Chinese,[71] South American[68] and Western[69,70] studies revealed that *H. pylori* eradication therapy has a statistically significant effect on functional dyspepsia symptoms in all populations; overall, however, the effect of *H. pylori* eradication seems to be more pronounced in Asian populations, which could relate to the factors specific to Asian populations as described above. However, much greater variation in trial results was observed in Asian populations and most of this was unexplained. Moreover, the majority of the Asian studies only evaluated patients for 1 month compared to 1 year in non-Asian studies. Therefore, other differences in these studies might explain the greater effects rather than just the population that was studied.

## Guidelines

Two types of guidelines have addressed *H. pylori* eradication in functional dyspepsia: guidelines aimed at managing *H. pylori* infection and those related to functional dyspepsia. We have searched for both types of guidelines published over the past 5 years and identified eight papers from Asian, European and US societies[89–96] (Table 1). Most guidelines were from the perspective of *H. pylori* management and the majority also formally evaluated the quality of the evidence and gave a strength of recommendation (Table 1). All guidelines recommended *H. pylori* eradication in some patients with functional dyspepsia and all of those that graded the evidence suggested that the data were of the highest quality (Table 1). These recommendations reflect the high number of RCTs that have evaluated *H. pylori* eradication in functional dyspepsia and the consistency of the effect seen in the meta-analyses described above. The weakest recommendation was seen in the oldest guideline to be included in our search, namely the American College of Gastroenterology guideline.[92] It will be interesting to see what the update of this guideline will show and whether it will soon agree with the guidelines that have been published since. On the other hand, many guidelines also noted that the effect was modest and the data are also consistent in this regard. Guidelines strongly recommended *H. pylori* eradication despite the small benefit as no therapy has been shown to be particularly effective in functional dyspepsia,[94] and some guidelines noted that the effect is long-term and eradication has other benefits such as the prevention of peptic ulcer disease,[97] including bleeding ulcers[98] and the possible reduction in the risk of gastric cancer.[99]

## Conclusions

High quality evidence indicates that *H. pylori* infection is the cause of dyspeptic symptoms in a small proportion of the infected population with functional dyspepsia. Patients with dyspepsia undergoing endoscopy should have a test for this infection and if positive should be offered treatment. The pathophysiology underlying symptom generation in *H. pylori*-positive individuals is clearly different from those who are uninfected. *H. pylori*-positive and *H. pylori*-negative cohorts should therefore be independently assessed in clinical trials investigating the efficacy of medication.

**Review criteria**

A search for original articles published between 1966 and September 2012 was conducted using MEDLINE. The search terms used were "pylori" combined with "dyspepsia". The reference lists of identified articles were also searched for further relevant papers.


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