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Arabian International Conference on Science, Technology and Innovation (AICSTI 2026)

THE ROLE OF RISK FACTORS AND NUTRITION IN CHRONIC GASTRIC INFLAMMATION (CHRONIC GASTRITIS)

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Relevance. Chronic gastritis is one of the most prevalent gastrointestinal disorders, affecting a substantial proportion of the population. As the disease may remain asymptomatic for many years and can increase the risk of gastric mucosal atrophy, intestinal metaplasia, and gastric cancer, timely diagnosis and appropriate treatment are of considerable importance.

Objective. To analyse the aetiology, pathogenesis, diagnostic approaches, and treatment strategies for chronic gastritis based on contemporary scientific literature.

Main Body. The most important cause of chronic gastritis is Helicobacter pylori infection. Other contributing factors include autoimmune processes, prolonged use of non-steroidal anti-inflammatory drugs (NSAIDs), duodenogastric bile reflux, alcohol consumption, smoking, and unhealthy dietary habits. The Sydney System is used to classify gastritis according to its distribution (antral, corpus, or pangastritis) and morphological characteristics.

Clinical manifestations include epigastric pain or discomfort, nausea, abdominal bloating, and a sensation of postprandial fullness. Diagnosis is based on oesophagogastroduodenoscopy, mucosal biopsy and histological examination, as well as tests for detecting H. pylori, including the urea breath test, stool antigen test, and rapid urease test. The OLGA (Operative Link on Gastritis Assessment) and OLGIM (Operative Link on Gastric Intestinal Metaplasia Assessment) staging systems are used to evaluate the extent and severity of gastric atrophy and intestinal metaplasia.

Risk Factors. Several factors predispose individuals to chronic gastritis. These include H. pylori infection, particularly when acquired during childhood, intrafamilial transmission, and poor socioeconomic and living conditions; advancing age; uncontrolled use of NSAIDs and other medications that damage the gastric mucosa; smoking and excessive alcohol consumption; frequent intake of salty, spicy, smoked, and excessively hot foods; irregular eating habits; chronic stress; autoimmune diseases, such as autoimmune thyroiditis and type 1 diabetes mellitus; familial predisposition; and duodenogastric reflux. The coexistence of several risk factors may increase the likelihood of gastric atrophy and gastric cancer.

Treatment. The cornerstone of treatment is H. pylori eradication therapy, which involves a combination of proton pump inhibitors and antibiotics selected in accordance with current clinical recommendations and local antimicrobial resistance patterns. Dietary modification, avoidance of harmful habits, and elimination or management of contributing factors are also important components of treatment. Patients with atrophic gastritis require ongoing clinical follow-up and regular endoscopic surveillance, depending on their individual risk profile.

Dietary Management. Dietary modification is an integral component of the overall management of chronic gastritis. Patients are generally advised to consume small, frequent meals four to five times daily, follow a regular meal schedule, eat slowly, and chew food thoroughly. The final meal should preferably be consumed two to three hours before bedtime.

Boiled, steamed, or stewed foods served at a moderate temperature are generally recommended. Suitable options include oatmeal, buckwheat and rice porridge, lean meat and fish, eggs, low-fat dairy products, vegetables, ripe fruits, and bread that is not freshly baked. Fried, fatty, spicy, pickled, smoked, and canned foods, carbonated and alcoholic beverages, strong tea and coffee, and fast food

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should be limited according to individual tolerance. Limiting salt intake to no more than 5 g per day is also advisable.

During symptomatic exacerbations, and in selected patients with increased gastric acid secretion, a modified bland diet corresponding to Pevzner's Diet No. 1 may be recommended. For patients with atrophic gastritis and reduced gastric secretory function, dietary approaches corresponding to Diet No. 2, which includes foods that moderately stimulate gastric secretion, have traditionally been used. However, dietary recommendations should be individualised according to symptoms, nutritional status, and current clinical guidance. In autoimmune and atrophic gastritis, vitamin B12 and iron levels should be monitored to detect and manage potential deficiencies.

Conclusion and Recommendations. Patients should be advised to stop smoking, avoid alcohol, refrain from taking NSAIDs without medical supervision, reduce stress, maintain adequate sleep, engage in moderate physical activity, and avoid lying down immediately after meals. The success of H. pylori eradication should be confirmed by an appropriate test of cure, performed at least four weeks after completion of antibiotic therapy, with proton pump inhibitors withheld for approximately two weeks before testing when clinically appropriate. Adherence to personal hygiene practices may help reduce the risk of transmission within households.

Patients with gastric atrophy or intestinal metaplasia who are at high risk, particularly those classified as OLGA/OLGIM stages III–IV, generally require regular endoscopic surveillance, often at three-year intervals, depending on individual risk factors and applicable clinical guidelines. Patients should seek prompt medical assessment if alarm symptoms develop, including unexplained weight loss, persistent vomiting, black stools, or persistent abdominal pain.

In conclusion, early diagnosis of chronic gastritis, timely eradication of H. pylori, appropriate nutritional management, and preventive measures can reduce the risk of complications, including gastric cancer, particularly among patients with recognised high-risk conditions.

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