Proton Pump Inhibitor De-prescribing Guidance

Amendment History

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<td>2.0</td>
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<td>Comments – Amendment to Flow chart and addition of Rationale page</td>
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REVIEWERS – Next review January 2020
This document had been reviewed by:

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APPROVALS
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APPLICABLE LEGISLATION

N/A

GLOSSARY OF TERMS

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**Proton Pump Inhibitor Deprescribing Guidance**

**Aim of guidance:**
To review the use of Proton Pump Inhibitors (PPIs) prescribed by checking for appropriate licensed indication, dose and duration. To discontinue PPIs which are no longer indicated by gradual tapering of the dose.

**Rationale**
- PPIs are commonly prescribed in primary care and the prevalence of their long-term use is rising.\(^1\)
- A reduction in cost has led to more liberal use of PPIs for a wide variety of upper gastrointestinal symptoms with a substantial proportion (up to 70%\(^1\)) of patients now prescribed PPIs having no true indication for treatment.\(^2\)
- Although PPIs are generally considered safe; numerous adverse effects, particularly associated with long-term use have been reported.
- Evidence suggests that the use of PPIs may be associated with rebound hypersecretion, Clostridium difficile infection, community- and hospital-acquired pneumonia, osteoporotic fractures, tubulointerstitial nephritis, cancer and hypomagnesaemia (especially in those who will take a PPI concomitantly with digoxin or drugs that may cause hypomagnesaemia (e.g. diuretics)).\(^2\)
- In order to limit the occurrence of adverse effects, off label and inappropriate repeat prescriptions for PPIs should be reviewed at least annually.\(^3\)
  - Prescribing should be undertaken in line with licensed indications and duration
- If used longer-term (over 1 year), PPIs should be limited to certain indications and used in the lowest effective dose. Indications for use PPIs are licensed and prescribed for a range of indications including:\(^1,2\)
  - Uninvestigated and non-ulcer (or functional) dyspepsia
  - GORD
  - Peptic ulcers
  - Eradication of Helicobacter pylori (in combination with antibiotics)
  - Control of excessive acid secretion in patients with Zollinger-Ellison syndrome
  - Prevention and treatment of non steroidal anti-inflammatory drug (NSAID) associated ulcers.

In addition, other indications for PPIs, encompassing unlicensed uses, are common in hospital settings and include the reduction of re-bleeding episodes after treatment of severe peptic ulcer bleeding, prophylaxis of acid aspiration during general anaesthesia and stress ulcer prophylaxis.

**Key Messages**\(^2\):
Prescribers should attempt to manage dyspepsia whilst minimising PPI overuse via the following:
1. Stop medicines which may exacerbate dyspepsia where possible: non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids, calcium antagonists, theophyllines, bisphosphonates, iron preparations, slow-release potassium, nitrates and anticholinergic drugs.

2. Provide patients with appropriate lifestyle advice: lose weight, stop smoking, reduce alcohol and caffeine intake, and avoid food/drink that worsens dyspeptic symptoms.

3. Test and treat for Helicobacter pylori where appropriate.

4. Step up: use “as required” or use regular alginate (See formulary) first and consider prescribing PPIs for short courses where needed, and step down: use lowest dose of PPI possible or consider “as required” PPI therapy.

5. When discontinuing PPIs which have been used for longer than 8 weeks, reduce dose gradually and use concomitant alginate cover for at least two weeks to prevent rebound hypersecretion. 4

6. Prescribe low acquisition cost PPIs in preference to high acquisition cost PPIs: there is no evidence that any one PPI is more effective than another. (See formulary)

7. Ensure clear documentation in patient records: indication for treatment, lifestyle and self-management advice, management plan and review date, reason for high dose/high acquisition cost PPI.

Date of Production: November 2015

Authors: Danielle Stacey Specialist Antimicrobial Pharmacist

Minesh Parbat Prescribing Advisor

References


5. NICE CG184 Gastro-oesophageal reflux disease and dyspepsia in adults 2014
Appendix 1. Review of proton pump inhibitors (PPI)\(^5\)

**Why is patient taking PPI?**

**INDICATION UNKNOWN**

**Patient currently taking a Proton-Pump Inhibitor**
- (ESOMEPRAZOLE, LANSOPRAZOLE, OMEPRAZOLE, PANTOPRAZOLE, RABEPRAZOLE)

**LONG TERM INDICATIONS**
- Prevention of NSAID-associated ulcers in patients at high risk of bleeding (e.g. Age>65, hepatic disease, diabetes, IHD, previous peptic ulcer)
- Severe Gastro-oesophageal reflux disease (GORD)
- Barrett’s oesophagus
- Zollinger-Ellison syndrome
- History of complicated ulcer (causing bleeding or...

**OTHER GASTROPROTECTION**
- Antiplatelet/Anticoagulant use unless high risk of bleeding (e.g. Age>65, hepatic disease, diabetes, IHD, previous peptic ulcer).
- Glucocorticoid use with no additional risk factor for GI bleed

**SHORT TERM INDICATIONS**
- Peptic ulcer 4-8 weeks
- Duodenal ulcer 8-12 weeks
- H.pylori infection 4 weeks

**Review PPI**

**Stop PPI**
- Cover for rebound hypersecretion for two weeks

**Decrease to lower dose OR Stop and treat PRN (cover for rebound hypersecretion for two weeks)**

**Review in 4-8 weeks**
- Symptoms for dyspepsia, weight loss, loss of appetite

**Lifestyle advice** — avoid meals 2 hours before bed, elevate head in bed, explore dietary triggers
- Consider review of medication which exacerbates symptoms

**Recurrent symptoms:**
- Consider/investigate H,pylori as cause of symptoms.
- Consider 4-6 week course of PPI/H\(_2\) antagonist followed by intermittent use to control symptoms

**Continue PPI at minimum effective dose**
- In patients using PPIs to prevent NSAID-associated ulcer, only continue PPI whilst taking NSAID