Derbyshire Medicines Management UPDATE

www.derbyshiremedicinesmanagement.nhs.uk

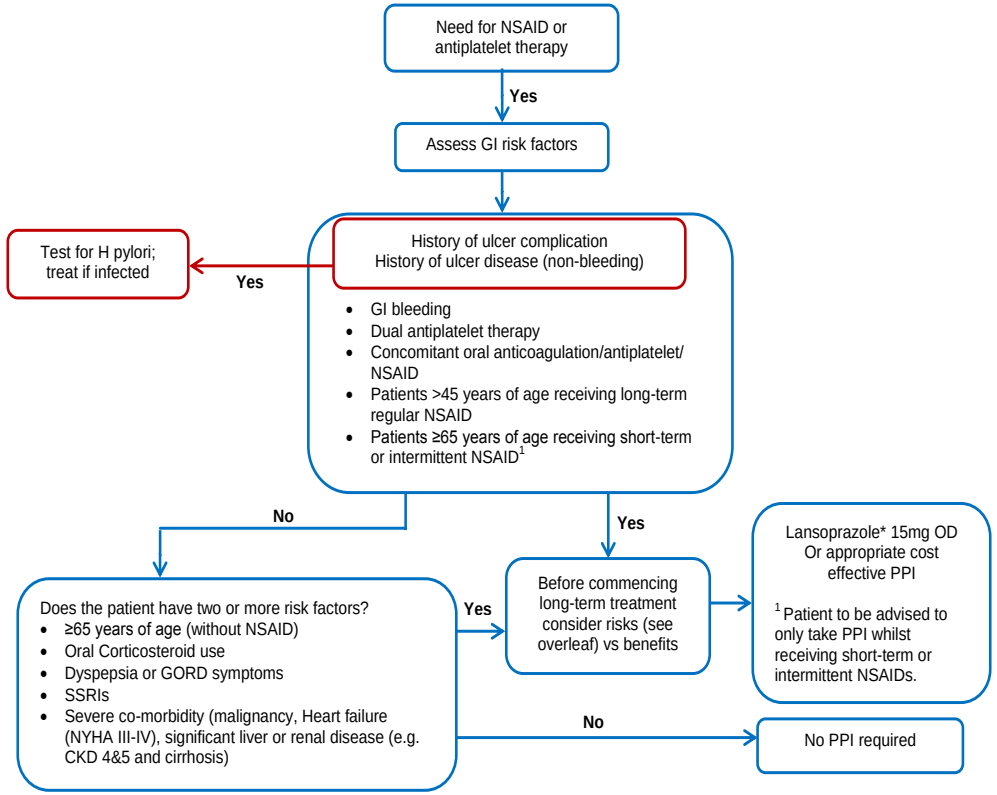
Guidance on appropriate prescribing of Proton Pump Inhibitors (PPIs)

Date Updated: December 2017

GUIDANCE FOR USE IN ADULTS

- For uninvestigated dyspepsia, use clinical judgement to offer either *H.pylori* testing or full dose PPI for one month.
- For functional dyspepsia, "test and treat", use PPI or H_2RA for 4 weeks if symptoms persist, use PPI at lowest dose/prn basis to control symptoms
- For GORD (post endoscopy), for severe dose use full dose of PPI for 8 weeks, double if no response, continue full dose PPI. For less severe grade step down to maintenance dose once symptoms resolve.
- For DU, stop NSAIDs, "test and treat", eradicated if positive (8 weeks of full dose to heal ulcer if NSAID induced first), reducing to low dose prn maintenance. If negative HP test, full dose PPI or H_2RA for 4-8 weeks, reducing to low dose prn maintenance dose.
- For GU, stop NSAIDs, "test and treat", eradicated if positive (8 weeks of full dose to heal ulcer if NSAID induced first, re-scope and test, refer if ulcer not healed. If test negative full dose PPI or H_2RA for 4-8 weeks, re-scope and refer if ulcer not healed. If ulcer healed then low dose treatment prn, periodic review
- All patients on PPIs should have an annual review. Patients on long term PPIs for GORD should be encouraged to step down to the lowest effective dose, treat "prn" or stop treatment.

ADVISORY GUIDANCE ON WHEN TO SO-PRESCRIBE A PPI WITH AN NSAID OR ANTIPLATELET



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WHAT ARE THE RISKS WHEN PRESCRIBING PPIs?

"***Concerns for patient safety should guide initial prescribing and perhaps more importantly, chronic use of even the most apparently benign drug"***

- More evidence on safety has been reported with wider prescribing, including:
  - Risk of Clostridium difficile infection (CDI) associated with PPIs – daily use increases even more with concurrent antibiotic use
  - Risk of hip fractures

  Other risks *associated* with PPI
  - Pneumonia (conflicting evidence)
  - Rebound hypersecretion when PPIs are stopped
  - AKI and Tubulo-Interstitial nephritis has been reported
  - Subacute Cutaneous Lupus Eryhtmatosus (OR 2.9)
  - Risk of hypomagnesaemia and vitamin B_{12} deficiency
  - Conflicting evidence on the risk of dementia associated with PPi use
- Long term, regular use should be reviewed as this has a limited role except in severe disease or for co-prescribing.

ROLE OF PPIs IN GORD IN CHILDREN

Only a small portion of children need managing as GORD. Reflux is a common and normal asymptomatic occurrence seen in infants.

If a PPI is indicated (see guidance), "specials" suspensions are usually more expensive, have short half-lives and have questionable stability compared to licensed medications.

Doses can be rounded to the nearest ¼ tablet (omeprazole MUPs). The tablet can be mixed in water, fruit juice, apple juice or yoghurt on a spoon. The division must be done before mixing the tablet as the granules do not form a uniform mixture. MUPS should not be dispersed in water to draw off a portion. Avoid oral syringes as granules will be deposited.

References:

Drug Safety Update volume 9 issue 2 September 2015: 4

http://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/Formulary_by_BNF_chapter_prescribing_guidelines/BNF_chapter_1/PPI_Guidance.pdf

http://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/Formulary_by_BNF_chapter_prescribing_guidelines/BNF_chapter_1/GORD_in_children_and_young_people.pdf

DTB 2017 55: 117-120 "Prescribing PPIs". Available at http://dtb.bmj.com/content/55/10/117 [Accessed 20 November 2017]

WHAT DOES THE FORMULARY SAY?

For gastroprotection, lansoprazole is the 1st line choice

Consider prescribing "PRN" for intermittent symptoms.

The dose of PPI should be reduced to maintenance dose where possible

If patient is taking clopidogrel, lansoprazole, pantoprazole or H_2RA preferred choices

The use of lansoprazole orodispersible should be restricted to patients with genuine swallowing difficulties or PEG tubes, Omeprazole MUPS are only recommended for their licensed use in children.

ROLE OF *H. PYLORI* TESTING

Stool antigen test is used across the Derbyshire CCGs. State whether diagnosis or eradication confirmation required.

If the person has received first-line Helicobacter pylori eradication therapy, do not routinely offer H. pylori re-testing. Assess the patient if treatment failure with eradication therapy. Consider compliance to treatment, wash-out period of PPIs and FH.
Arrange any necessary follow up tests at least 4 weeks after initial treatment (ideally 8 weeks)

Two weeks cessation of acid suppression prior to endoscopy. Self-care with alginates if required.

OTHER KEY MESSAGES

- NICE recommends lifestyle review: weight, diet, smoking, avoid known precipitants (e.g. smoking, alcohol, caffeine, chocolate, fatty foods), raise head of bed, eat main meal well before bedtime.
- Offer Patient Information Leaflets
- Consider whether drugs may be precipitating the condition
- Offer an annual review to patients requiring long-term treatment of dyspepsia symptoms.
- Encourage patients to step down or stop treatment
- A return to self-treatment with an antacid and/or alginate may be appropriate
- Explain PPIs are a course and not necessarily long term treatment