Clinical e-Audit – PPIs: too much of a good thing?

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This commentary is based on the aggregate results of the first 808 GP participants, who submitted data for 8650 patients in the Clinical e-Audit on PPIs.

Results

Confirmed the presence of an ongoing indication for proton pump inhibitor (PPI) therapy

PPIs are an effective treatment for gastro-oesophageal reflux disease (GORD) and being generally well-tolerated, they are commonly used. However, they do have potential adverse effects and may interact with some medicines.1,2

In Phase 1 of this audit (the initial data collection), 95% of patients using a PPI had a confirmed indication for using the medicine. This increased to 100% in Phase 2 (the follow-up review of patients). Because of the high prevalence of PPI use (both prescribed and over-the-counter), this 5% change represents a significant number of patients – in this cohort, over 400 patients were using a PPI without a confirmed indication before they were reviewed.

In patients treated for uncomplicated GORD, up to one in three can stop PPI therapy after an initial course and remain symptom-free for a prolonged period.3

Provided lifestyle counselling

In Phase 1 of the audit, 82% of patients had had lifestyle counselling provided and this increased to 98% in Phase 2 of the audit. While only a few lifestyle measures (eg, weight loss and elevation of the head-end of the bed) have evidence for effectiveness in reducing GORD symptoms4 anecdotally, patients report symptom improvement with a variety of common-sense measures (eg, avoiding trigger foods, not bending/lying down after eating and so on). Discussions with patients can help determine what measures might help, and patients can be informed to try these measures but not persist if they don’t alleviate symptoms. Reducing symptoms not only improves patient wellbeing but also reduces pill-burden and the risk of adverse effects and drug interactions.

Referred for endoscopy specialist review when indicated

The rate of referral when indicated increased from 78% to 88% overall during the audit.

Gastro-oesophageal symptoms are common and GORD is a common diagnosis, but alarm symptoms or signs (eg, weight loss,3,5,6 vomiting,6 odynophagia,3,5,6 dysphagia,3,5,6 melaena,5,6 haematemesis,3,5,6 upper abdominal mass6) should be sought to identify more sinister conditions early.3,5,7 If the diagnosis is unclear, the symptoms start after the patient is aged 55 years or the symptoms are refractory to treatment, referral is also indicated.3,6,7
Use of regular daily dosing of PPI in patients in whom long-term PPPs is indicated

There is a role for daily PPI use in selected patients. Indications for long-term daily PPI use include high grade oesophagitis, Zollinger–Ellison syndrome, peptic oesophageal strictures, scleroderma oesophagus, prophylaxis of drug-induced gastric irritation or ulceration in high risk patients, and troublesome or frequent (more than once per week) symptoms that cannot be managed with symptom-driven on-demand or intermittent treatment. In Phase 1 of this audit, 89% of patients identified as warranting long-term daily PPI therapy were receiving this treatment. Whether this reflects these patients being specifically selected for long-term therapy is not clear, but on review among patients needing daily treatment many more (96%) were using the indicated treatment.

Continual regular use of a PPI for > 8 weeks in patients with adequate symptom control in conditions where ongoing use should be reviewed.

This indicator of best clinical practice showed the largest improvement. This reflects the large number of patients using a PPI who are candidates for step down treatment; in this audit 78% of patients were identified as candidates for reducing PPI treatment. While around two out of three patients who stop therapy will need to use PPIs again, in many cases this can be on an as-needed basis rather than regularly, again reducing pill-burden and associated risks.

A systemic review of six studies of discontinuing PPIs in appropriate patients using various methods (eg, step-down, taper, discontinue) found discontinuation without deteriorating symptom control in 14% to 64% of patients in all studies. The researchers concluded that tapering seemed most effective.

In the review phase of the audit the number of patients still using a PPI continually with adequate symptom control dropped from 78 to 33%. Despite tapering, some patients appear to require regular PPIs to maintain symptom control. This should be done at the lowest possible dose, and using the standard dose on alternate days is also worth trialling.

Use of medicine(s) that may cause or exacerbate gastric ulceration or irritation [not recommended]

In Phase 1 of the audit just over half of the patients using a PPI were using a medicine that could cause or exacerbate ulceration or gastric irritation. Of course, sometimes a PPI is specifically prescribed for the purpose of counteracting gastric or oesophageal effects of a needed medication. However, after review in Phase 2 only a quarter of patients using a PPI were using a medicine that could cause gastric ulceration or irritation, which is a reminder to review medicines periodically and regularly.
References


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