THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

PROTON-PUMP INHIBITORS

Deprescribing in older people: A clinical practice guideline

dRx™

PROTON-PUMP INHIBITORS (PPIS)

- Esomeprazole*
- Lansoprazole
- Omeprazole*
- Pantoprazole*
- Rabeprazole*

*Common Pharmaceutical Benefits Scheme medicine

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	Given the potential adverse effects associated with prolonged use (i.e. infections, nutritional deficiencies, fractures), we suggest deprescribing be offered to older people taking PPIs: 1. Originally for a short-term indication of: • Up to 8 weeks for gastroesophageal reflux disease (GORD); • Up to 12 weeks for peptic ulcer disease; • Up to 2 weeks for uncomplicated H. pylori eradication (as part of the eradication regimen); or • During an intensive care unit admission for stress ulcer prophylaxis. 2. Without a clear or known indication.
GPS	Deprescribing decisions should be made in consultation with the person and their GP and/or specialist providers to ensure it aligns with their preferences, goals, and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	In people with complicated gastrointestinal pathologies (e.g. Barrett's oesophagus, severe erosive disease) or those with a high risk of gastrointestinal complications using PPI for gastroprotection, we suggest continuing PPI therapy on the lowest effective dose according to the clinical indication, individual tolerance, and responses, provided this aligns with the individual's goals and preferences, following informed consent.
CBR	If deprescribing is unsuccessful despite multiple attempts, taking into account the possibility of rebound acid hypersecretion (occurred typically within four to eight weeks after PPI discontinuation), we suggest maintaining the person on the lowest effective dose, but reassessing the need for long-term therapy periodically.

CBR, consensus-based recommendation; GPS, good practice statement

HOW TO DEPRESCRIBE

CBR We suggest individualising the tapering schedule and adjusting it according to the individual's response.

In general, we suggest reducing the dose by 50% every two weeks (noting that enteric-coated formulations should not be broken*), ensuring individuals remain symptom-free before initiating each tapering.

Once half the lowest standard dose formulation is reached, we suggest switching to alternate-day dosing or discontinuing PPI therapy completely and switching to on-demand or intermittent use of PPIs, antacids, alginates, or H2 receptor antagonists (H2RAs) at the lowest effective dose.

We suggest a slower tapering for people taking a high dose (e.g. 20 mg omeprazole twice daily) prior to deprescribing to minimise rebound acid hypersecretion.

If symptoms recur during tapering, we suggest restarting PPIs at the previously tolerated dose until symptoms resolve **or** using an antacid, alginate, or H2RAs as a "rescue therapy" for occasional symptoms, delaying further dose reductions by an agreed interval for stabilisation, and planning for a more gradual taper.

**Marketed PPI dose forms that may be simpler to titrate include dispersible enteric tablets (omeprazole and esomeprazole), orally disintegrating tablets (lansoprazole), oral liquids (omeprazole) and granules (pantoprazole).*

CBR For people on combination therapy of PPI and either an antacid or H2RA, we suggest deprescribing one at a time, prioritising antacids and then H2RAs as these are typically associated with a lower risk of harm when discontinued compared to PPIs and can be used as "rescue therapy" for occasional symptoms while tapering PPIs.

Tapering of H2RAs can generally follow the same approach as PPI tapering (i.e. halving the dose every two weeks); however, we suggest individualising the tapering schedule and adjusting it according to the individual's response. Antacids and alginates typically do not require tapering unless used regularly and following patient preference.

The dose for concomitant acid suppressants may also need to be adjusted temporarily to compensate for the lower dose of the other agent.

GPS Healthcare providers should offer education on diet and lifestyle modifications (or referral to other relevant healthcare providers) and clearly differentiate between symptom recurrence or exacerbation due to lifestyle factors and adverse drug withdrawal events (ungraded good practice statement).

CBR, consensus-based recommendation; GPS, good practice statement

MONITORING

CBR We suggest closely monitoring for disease exacerbations (e.g. symptom recurrence) or dverse drug withdrawal events (e.g. rebound acid hypersecretion), every two weeks following each dose adjustment until at least eight weeks after the medicine has fully ceased, if practical.

After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

If monitoring visits are impractical, we suggest advising people to report symptom recurrence (e.g. acid-related gastrointestinal symptoms) and/or any appearance of new symptoms as needed.

GPS In individuals with recurrent symptoms after deprescribing, healthcare providers should test for *H. pylori* infection and proceed with eradication if the infection is present (ungraded good practice statement).

CBR, consensus-based recommendation; GPS, good practice statement

Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

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