



PPIs: when to take them and when to cut back

A PPI can make a real difference to heartburn, help an ulcer heal or protect you from bleeding. We can discuss why you need it, the expected benefits and a balanced view of the potential risks. Where helpful, gastroscopy or reflux pH monitoring can guide a treatment plan that suits you.

Sources checked 24 October 2026 | Sources and further reading

Three things to know

1. Some people need ongoing treatment, even when they feel well.
2. Most people tolerate PPIs. They have an excellent safety profile, including when longer-term treatment is needed.
3. Temporary rebound acid after stopping does not mean dependence.

Why have I been prescribed a PPI?

PPIs are used for reflux and inflammation of the food pipe, stomach or duodenal ulcers, and as part of H. pylori treatment. They also protect the stomach in some people taking medicines that increase bleeding risk. In eosinophilic oesophagitis (EoE), they can help control inflammation even without heartburn.

PPIs can also help with dyspepsia: pain or burning in the upper tummy, feeling full too quickly or uncomfortable fullness after eating. They are more likely to help when acid contributes to the symptoms.

They reduce how much acid the stomach makes. They do not repair a hiatus hernia or stop every episode of fluid coming back up.

Three types of PPI are routinely available in New Zealand: omeprazole (Losec), pantoprazole (Panzop Relief) and lansoprazole (Lanzol Relief). Other brands or formulations may be supplied; check the active ingredient on your packet.

How should I take it?

For reflux, PPIs usually work best 30 to 60 minutes before a meal, often breakfast. If prescribed twice daily, take the second dose before the evening meal. Follow the instructions for your particular medicine. Regular use during the prescribed course gives the best acid suppression. PPIs reduce new acid production; they do not remove or neutralise acid already in the stomach. Antacids neutralise existing acid, which is why they can relieve symptoms more quickly.

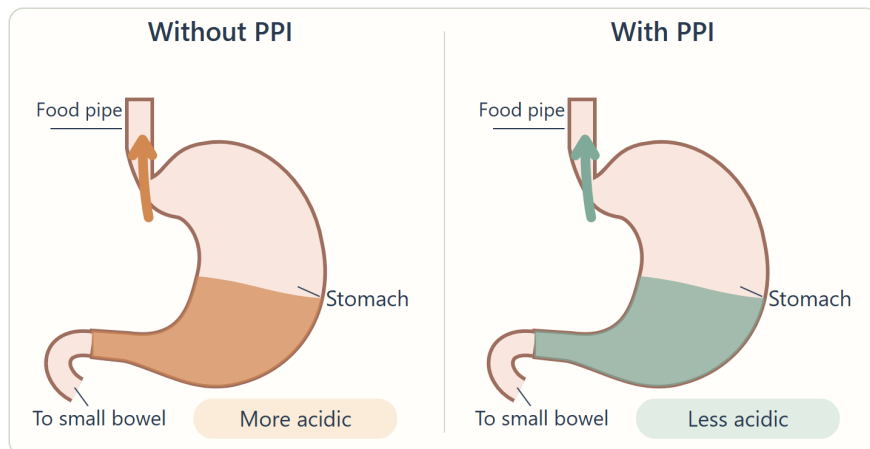
Do not crush or chew coated granules or tablets. Ask your pharmacist about a suitable formulation if swallowing is difficult. Tell them about your other medicines, especially clopidogrel, which can interact with omeprazole. They can check which PPI is suitable.

What if I am having an H. pylori test or gastroscopy?

PPIs can affect some test results. An H. pylori stool or breath test usually needs a two-week PPI pause, when safe. Gastroscopy instructions depend on the reason for the examination. Our team will tell you whether a pause is needed.



Reflux, PPIs and antacids



Less acid means less irritation from reflux

Reflux happens when stomach contents pass back up into the food pipe (oesophagus). A PPI makes the contents less acidic, helping relieve symptoms and heal or prevent acid damage. Some fluid may still come back up.

A PPI changes the acidity. It does not repair structural causes of reflux, such as a hiatus hernia.

The stomach makes acid	A PPI reduces new acid	An antacid acts on acid already there
Inside the stomach Acid-producing cell Cells in the stomach lining use tiny pumps to release acid into the stomach. Acid helps digestion. Acid is being produced.	Inside the stomach Acid-producing cell A PPI reaches the acid-producing cells through the bloodstream and blocks active acid pumps. Less new acid enters the stomach. It does not neutralise acid already there. Builds up its effect over several days of regular use.	Inside the stomach Acid-producing cell An antacid reacts with acid inside the stomach to make it less acidic. It works quickly, but does not switch off the acid pumps, so the effect is shorter-lived. Quick relief; new acid can still be produced.

Simplified diagrams. The cell views show one acid-producing cell. An alginate works differently: it forms a floating barrier to help reduce reflux. Some products combine an alginate with an antacid.

Who may need treatment long term?

A short course, for example four to six weeks, may be enough for uncomplicated reflux. Ongoing treatment is often appropriate after severe reflux oesophagitis or a reflux-related narrowing, with Barrett's oesophagus, when a PPI is controlling EoE, or when protection from an ulcer bleed is still needed.

Feeling better can mean the treatment is working. If you have one of these conditions, discuss a change with me or your GP first. We can still review the dose and use the lowest dose that provides the treatment you need.



Are PPIs safe? What about the things I have read?

PPIs have an excellent overall safety profile, including for long-term use when there is a good reason to continue. Most people tolerate them. Headache, nausea, tummy discomfort or loose stools can occur; tell your GP or pharmacist if these persist.

Some studies behind worrying headlines compare people who differ in age, health and other medicines. Those differences may explain the findings, rather than the PPI itself. Better-quality studies are reassuring. The table puts the less certain links and the recognised side effects into perspective.

Common concern	What the evidence means for you
Dependence	PPIs are not addictive. Temporary rebound acid can make stopping uncomfortable, and the original reflux can also return.
Dementia or heart attacks	There is insufficient evidence to conclude that PPIs cause dementia or heart attacks.
Stomach cancer	There is insufficient evidence to conclude that PPIs cause stomach cancer. Underlying stomach disease and H. pylori can affect the results of studies.
Osteoporosis and fractures	An extra fracture risk has not been established in trials. In a large three-year trial, fractures occurred in about 23 of every 1,000 people taking pantoprazole and 24 of every 1,000 taking placebo: no increase was shown. Your age and usual osteoporosis risk factors remain more useful guides.
Kidney problems	Rare kidney inflammation is a recognised reaction. A NZ study found about 12 cases requiring hospital care per 100,000 current PPI users per year, compared with about 2 among past users. It can occur at any stage, including early in treatment, and was more frequent in older adults. Possible small long-term effects on kidney function remain less certain; we consider these when reviewing existing kidney disease.
Low magnesium or vitamin B12	Low magnesium can occur, and vitamin B12 may fall with prolonged use. A six-monthly review is a reasonable opportunity to decide whether blood tests are needed. Six-monthly testing may suit some people with risk factors or previous low levels; it is not necessary for everyone.
Gut infections	In the same three-year trial, gut infections occurred in about 14 of every 1,000 people taking pantoprazole versus 10 taking placebo: about 4 extra cases per 1,000 people. Discuss this with your doctor if it concerns you. Persistent or severe diarrhoea needs assessment. Where do these risk figures come from? The three-year figures come from a trial in adults with heart or blood-vessel disease. They describe that study group, not your personal risk. The kidney-inflammation figures come from a separate NZ study.

Do I need regular blood tests or supplements?

Not everyone needs routine blood tests or supplements just because they take a PPI. For long-term treatment, a review about every six months is reasonable. We may check magnesium, especially with a diuretic or digoxin, and vitamin B12 or kidney function when your health, symptoms or previous results suggest a need. If monitoring is appropriate, we can agree an interval, such as six months. Iron tests and bone checks depend on your other risk factors.



What if PPIs aren't working?

We can review why. I start with how you take the medicine, which symptoms remain and whether they are likely to come from acid. Sometimes adjusting the treatment helps; sometimes a different diagnosis or investigation is more useful.

How often do symptoms improve?

Condition studied	Typical response reported
Reflux with oesophagitis	About 70–80% had complete symptom relief with a PPI, usually assessed after four weeks.
Reflux symptoms without visible inflammation	About 50–60% had complete symptom relief, usually assessed after four weeks. Some people in these studies had symptoms unrelated to acid.
Functional dyspepsia	In a Cochrane review, 31% taking a PPI reported no or minimal symptoms, compared with 26% taking placebo. Most trials lasted two to eight weeks. The average benefit is modest.

Possible reasons why reflux persists despite PPI

I check the common, practical explanations first. The order of further tests depends on your symptoms and previous results.

Possible reason	What we can do
Timing, missed doses or a dose that needs adjusting	Check regular use, the prescribed dose and taking it before meals. We can agree a dose change or a trial of a different PPI if appropriate.
Symptoms that are not mainly caused by acid	Fullness, bloating, functional heartburn or an unusually sensitive food pipe may need a different treatment. More acid suppression may not help.
Fluid keeps coming back up	PPIs reduce acidity but do not stop every reflux episode. Review meal habits, a possible hiatus hernia and whether reflux has been confirmed.
Another condition	Depending on the symptoms, consider <i>H. pylori</i> , an ulcer, eosinophilic oesophagitis or a stomach-emptying problem. Gastroscopy or other tests may help.
Acid is not sufficiently suppressed despite correct treatment	This is less common after treatment is optimised. A pH or pH-impedance study can measure acid exposure and check whether reflux episodes match symptoms.

What are PCABs?

Potassium-competitive acid blockers (PCABs) are another type of acid-suppressing medicine. They block the stomach's acid pump in a different way from PPIs and can provide faster, sustained acid control. They are not currently available for routine prescribing in New Zealand (checked October 2026).

Examples used overseas

Examples are listed below; this is not a complete list of countries. Availability and approved uses vary.

Vonoprazan (Takecab, Voquezna): Japan and the United States. Tegoprazan (K-CAB, Ki-CAB): South Korea, China and Mexico.

Fexuprazan (Fexuclue): South Korea and the Philippines. Keverprazan (Beiwen): China.



Can I reduce or stop it?

If symptoms have settled, we can review whether you still need daily treatment. Check the original diagnosis, any healing that needs to be maintained and whether you still need protection from bleeding.

The example below is for someone already taking high-dose omeprazole whose prescriber has agreed that reduction is appropriate. Start at your current dose; do not increase it to follow the diagram. We can agree the pace, often allowing two to four weeks at each lower dose, and slow down if needed.

An example of reducing high-dose omeprazole

01 If already prescribed 40 mg twice daily First confirm that reducing is appropriate.	02 Reduce the dose 20 mg twice daily Review symptoms before the next step.	03 Once a day 20 mg once daily Continue reducing if comfortable.	04 Trial without it Stop Use short-term relief if needed.
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This is an individual step-down example, not a starting dose. Other PPIs use different doses. Some people benefit from an extra 10 mg daily step before stopping.

If symptoms return or persist, you may need to restart a PPI at the lowest regular dose needed to control them. Review troublesome symptoms with me or your GP rather than repeatedly stopping and restarting without advice.

What can I do about rebound heartburn?

After regular PPI use, the stomach can temporarily make more acid when treatment stops. Symptoms can last days to a few weeks. This does not automatically mean you need lifelong treatment.

An alginate or antacid can provide short-term relief. Ask your pharmacist which product suits your other medicines and health conditions. Smaller evening meals, leaving two to three hours before lying down, and raising the head of the bed for night-time reflux may help.

If symptoms are severe, persist beyond a few weeks or keep coming back, contact me or your GP. You may need to return to a PPI, using the lowest regular dose that controls symptoms. We can also check whether further investigation would help.

When should I seek help?

Arrange prompt review for new difficulty swallowing, unexplained weight loss, repeated vomiting or symptoms that persist despite treatment.

Vomiting blood, black tarry poo or food stuck so that you cannot swallow saliva need urgent assessment. Call 111 for severe chest pain, especially with sweating, breathlessness or faintness. Do not assume new chest pain is reflux.

Related guides

Reflux and oesophagitis

Eosinophilic oesophagitis (EoE)

Barrett's oesophagus

H. pylori testing and treatment