



PPIs in primary care: continue, reduce or stop?

Confirm indication, optimise treatment and review whether it is still needed.

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1. Confirm indication

Check the original indication, gastroscopy findings and current dose. Treatment may be needed for symptom control, prevention of relapse, ulcer bleeding or other complications.

How long is treatment needed?

Situation	Common indications	Practical approach
Long-term treatment	LA grade C/D oesophagitis, peptic stricture, Barrett's oesophagus or PPI-responsive EoE	Long-term therapy may be indicated even when symptoms have resolved, to prevent complications. Follow the maintenance plan.
May continue	Reflux repeatedly returns after stopping, including non-erosive reflux	Use the lowest effective dose; intermittent treatment may suit milder disease.
Short course	Uncomplicated reflux or dyspepsia without alarm features	Optimise treatment for 4-6 weeks, then review. Reduce or stop if settled.
Treat then reassess	H. pylori eradication or uncomplicated peptic ulcer	Complete eradication and ulcer healing. Continue only if ulcer findings, NSAIDs or bleeding risk warrant it.
Gastroprotection	Previous ulcer bleeding with ongoing antithrombotics; two or more antithrombotics; NSAID/aspirin plus additional bleeding risks	Usually appropriate while risk persists. Consider age, ulcer history, other antithrombotics and oral steroids. A single anticoagulant or antiplatelet alone is not an automatic indication.

A normal gastroscopy does not exclude reflux

Many patients with reflux have no visible oesophagitis. If the diagnosis is uncertain, pH or impedance-pH monitoring can establish whether reflux is driving symptoms.

Active upper-GI bleeding or an impacted food bolus needs urgent hospital assessment.

Red flags and referral

Finding	Action
Bleeding or obstruction	Haematemesis, melaena, circulatory compromise or inability to swallow saliva: urgent hospital assessment.
Alarm symptoms	Progressive dysphagia, odynophagia, weight loss, iron deficiency anaemia, persistent vomiting or a mass: prompt investigation and gastroscopy consideration.
Higher cancer risk	New symptoms in an older adult, family history of upper-GI cancer or other gastric cancer risk: lower threshold for gastroscopy.
Persistent symptoms	Despite optimised PPI: consider gastroenterology assessment, gastroscopy or reflux monitoring.



2. Optimise treatment

Take the PPI 30-60 minutes before breakfast; add a pre-evening-meal dose if prescribed twice daily. Heartburn is more likely to respond than regurgitation, early satiety or post-meal fullness.

For uncomplicated reflux, use a step-up then step-down approach. Start once daily; if symptoms persist after checking timing, adherence and the diagnosis, use a defined twice-daily trial rather than repeatedly switching. Once controlled, reduce to the lowest effective dose or intermittent/on-demand treatment for non-erosive reflux. Severe erosive disease, a peptic stricture or Barrett's oesophagus usually needs maintenance treatment. Trials suggest that doubling the dose and switching PPI give similar average benefit, so repeated switching is rarely useful.

Dyspepsia without alarm features

1. Review medicines

NSAIDs (ibuprofen, naproxen, diclofenac), aspirin, iron, dabigatran, steroids and bisphosphonates may contribute. Check OTC use.

2. Consider *H. pylori*

Check prior testing and treatment. Consider stool antigen testing with ulcer history, increased infection risk or persistent dyspepsia. Confirm eradication after treatment.

3. Optimise PPI

Treat for 4-6 weeks where appropriate. Persistent symptoms may need gastroscopy or specialist advice.

H. pylori: medicine pauses before stool antigen testing

Medicine	Minimum interval before testing
PPI	Two weeks without treatment, when clinically safe.
Antibiotics or bismuth	At least four weeks after the last dose.

These medicines can cause false negatives. An antacid or alginate can help during the pause. Confirm eradication 4-8 weeks after treatment, allowing the same medicine intervals.

Dose comparison and formulation

Practical adult reflux dose bands, not identical acid suppression or milligram-for-milligram equivalents.

PPI	Usual daily dose	Higher-dose treatment
Omeprazole	20-40 mg once daily	20-40 mg twice daily
Pantoprazole	40 mg once daily	40 mg twice daily
Lansoprazole	30 mg once daily	30 mg twice daily

Omeprazole can be increased to 40 mg twice daily in selected severe or refractory reflux. Higher doses for hypersecretory conditions need specialist management. For swallowing difficulty, check suitable formulations with the pharmacist; do not crush enteric-coated granules.

Does switching PPIs help?

One switch can help after checking adherence and timing, or for minor adverse effects. PPIs are the same drug class; there is no good evidence for repeated switches after one has failed.

With clopidogrel, pantoprazole may be more appropriate than omeprazole because it inhibits CYP2C19 less. Check other interactions before switching.

If symptoms persist after optimisation

Consider non-acid reflux, reflux hypersensitivity, functional heartburn or dyspepsia. Discuss gastroscopy or pH/impedance-pH monitoring to distinguish these from inadequate acid suppression.



Expected response in reflux and dyspepsia

Condition studied	Typical response reported
Erosive oesophagitis	70-80% complete symptom relief at about four weeks.
Reflux without visible inflammation	50-60% complete relief at about four weeks; some study participants had non-acid symptoms.
Functional dyspepsia	31% had no/minimal symptoms with PPI versus 26% with placebo, over 2-8 weeks.

Different study populations and endpoints: symptom relief, not mucosal healing.

3. Put safety concerns in perspective

PPIs have an excellent overall safety profile. Observational links with dementia or osteoporosis do not prove causation. Recognised risks include enteric infection, rare acute interstitial nephritis and hypomagnesaemia.

Review long-term use periodically; six-monthly is a practical option. Consider magnesium, particularly with diuretics or digoxin. Check B12, renal function or other tests according to symptoms and risk factors, rather than a routine panel for everyone.

Fundic gland polyps

Small sporadic fundic gland polyps are benign and not associated with increased gastric cancer risk. Typical polyps do not require surveillance or stopping a useful PPI. Large or atypical polyps, dysplasia or suspected hereditary polyposis need separate assessment.

Useful figures when discussing safety

Evidence	Clinical perspective
COMPASS trial: about three years	Fractures: 2.3% with pantoprazole versus 2.4% with placebo. Enteric infection: 1.4% versus 1.0% (about 4 extra per 1,000). Participants had cardiovascular disease.
NZ acute interstitial nephritis study	Hospitalisation/death: about 12 versus 2 per 100,000 person-years in current versus past PPI users. Rare; higher rates in older people. Can occur early or later.
Long-term renal effects	A later COMPASS analysis found slightly faster eGFR decline. The clinical importance remains uncertain.

4. Review and consider step-down if appropriate

Continue, reduce or stop?

Continue

Maintenance or bleeding-prevention indication: continue the lowest dose that controls symptoms and prevents relapse or complications.

Reduce or stop

Settled symptoms and no ongoing indication: try once daily if taking twice daily, then consider stopping.

If symptoms return

Rebound symptoms may last a few days to a few weeks; an alginate or antacid may help. Persistent or recurrent symptoms: restart the lowest effective dose and consider investigation.

Full references and supporting guidance | PPI patient guide