NHS
Norfolk and Suffolk
Integrated Care Board

Proton Pump Inhibitor (PPI) Deprescribing Advice for Prescribers

In most cases PPIs are licensed to be prescribed for a limited period and then the dose reduced or stopped once the benefit has been realised. This reduces the potential for harm to the patient which increases with courses longer than 12 months in duration.

Fear of the previous symptoms returning is a significant barrier to deprescribing in some individuals. A shared decision-making approach can help the clinician identify the patient's concerns and agree a strategy to reduce harm whilst maintaining confidence in the service.

Prescribing for deprescribing

- When starting a PPI, explain why the patient is taking the medicine, how long you expect them to be using the medicine and how and when you intend to stop it.
- Avoid using terms such as "lifelong". "For the foreseeable future" is more realistic and helps with deprescribing conversations.
- Provide the patient with a written record of the indication and the planned end point. Agree this plan with the patient.

How to deprescribe – practical points

1. Reduce to low dose for 2 to 4 weeks and reassess.
2. Switch to on demand use of PPI or stop. Ensure that the patient has a supply of PPI if on demand use is planned.
3. During/after taper – cover with an acute prescription for an alginate after meals and at bedtime. A short course of cimetidine or famotidine at night may be helpful if rebound.
4. **Reinforce rebound acid hypersecretion** (1 in 10 patients affected, transient for 2 to 4 weeks), safety net and review plan. This is the primary reason for dose reduction and deprescribing plans failing.

Engaging patients and carers in the consultation – conversation points

People change over time and re-assessing long term medication is good practice.

- Your medicine was designed to be used for a certain period/for a certain condition.
- Every medicine has the potential to cause harm.
- You have derived the benefits that you are going to get from this medication.
- We now need to look at reducing your risks from the medicine.
- You may no longer need the medicine and can self-manage any symptoms that arise.

Rationale for considering option of discontinuation

Making sure medicines are still the best fit for individual patients

- Lifestyle changes may have reduced the need for the medicine – smoking cessation, weight loss, reduced stress
- Medicines which contributed to symptoms may have stopped or may no longer be necessary – calcium channel blockers, non-steroidal anti-inflammatory drugs, anticoagulants, antiplatelets, antidepressants

What matters most?

Quality of life and risk aversion varies between individuals

- Everyone has their own risk appetite
- Fear of symptoms returning may indicate a slower taper would be more acceptable
- Some patients may be bothered by taking many medications and prioritise lowering pill burden
- A patient may have other things that they prioritise

Evidence

- For patients with mild to moderate GORD or upper GI symptoms who have no ongoing symptoms, lowering the dose of a PPI does not lead to a significantly greater relapse compared with continuing at standard dose.
- There is a lack of evidence of serious harm from deprescribing.
- On demand and H2RA therapy increase the risk of relapse more so than reducing the dose does.
- Many patients could take PPIs for short periods but remain on them for years.
- For some people, the dose of PPI can be reduced, or the PPI can be stopped and taken only if symptoms return.
- Long term (more than 1 year) risks with PPIs include: increased risk of Clostridiodes infection, increased fracture risk, hyponatraemia and reduced absorption of vitamin B12 and magnesium with signals emerging for worsening of chronic kidney disease and increased rate of cognitive decline in patients with mild cognitive decline or dementia.
- In frail elderly patients there is an increased risk of falls and fractures. Advice is to use the lowest effective dose and provide rescue alginate on prescription when reducing and stopping the PPI.

References

Curtin D, Gallagher P, O'Mahony D. (2020) Deprescribing in older people approaching end-of-life: development and validation of STOPPFrail version 2. *Age and Ageing,* 50, 465–471. DOI: http://doi.org/10.1093/ageing/afaa159

Ferrell B, Pottie K, Thompson W, Boghossian T, Pizzola L, Rashid FJ, Royas-Fernandez C, Walsh K, Welch V, Moayyedi P. (2017) Deprescribing proton pump inhibitors: Evidence-based clinical practice guideline. *Canadian Family Physician,* 63, 354-364. Available from: http://www.cfp.ca/content/63/5/354.full.pdf (Accessed 17 November 2025)

NHS Greater Glasgow and Clyde. (December 2023) Polypharmacy Review in Adults Living with Moderate to Severe Frailty Version 1. Available from: https://www.rightdecisions.scot.nhs.uk/media/bpjbqneg/343428_1_0-polypharmacy-review-in-frailty-poster_s.pdf (Accessed 17 November 2025)