

## **PCT Board Prescribing Report (August 2010)**

### **Drugs for Dyspepsia – Prescribing Guidance and Discussion Points**

1. Has your PCT reviewed local clinical guidelines and protocols for the management of dyspepsia against the NICE guideline?
2. Does your PCT provide prescribing guidance which is consistent with the NICE guideline on dyspepsia? Does this include:
  - recommending an annual review for patients to offer advice on stepping down proton pump inhibitor (PPI) treatment to the lowest effective dose?
  - recommending discussing the possibility of using 'on demand' treatment with patients to manage their symptoms
3. In line with one of the NHS Institute for Innovation and Improvement Better Care, Better Value 'Indicators', does your PCT audit the percentage of items written for omeprazole and lansoprazole (excluding Zoton FasTab® and Losec MUPS®) as a percentage of the total volume of prescribing of PPIs?

Dyspepsia is defined by the NICE Clinical Guideline for the management of dyspepsia (August 2004) as any symptom of the upper gastrointestinal (GI) tract, present for 4 weeks or more, including upper abdominal pain or discomfort, heartburn, acid reflux, nausea or vomiting. Dyspepsia occurs in 40% of the population, leads to GP consultation in 5% and referral for endoscopy in 1% each year. In patients with symptoms severe enough to merit endoscopy 40% will have non-ulcer dyspepsia (NUD), 40% will have gastro-oesophageal reflux disease (GORD) and 13% will have some form of ulcer detected. Gastric and oesophageal cancers are seen in less than 3% of patients who have endoscopy and many of these cases are found during investigation for other symptoms, rather than following primary care referral for dyspepsia.

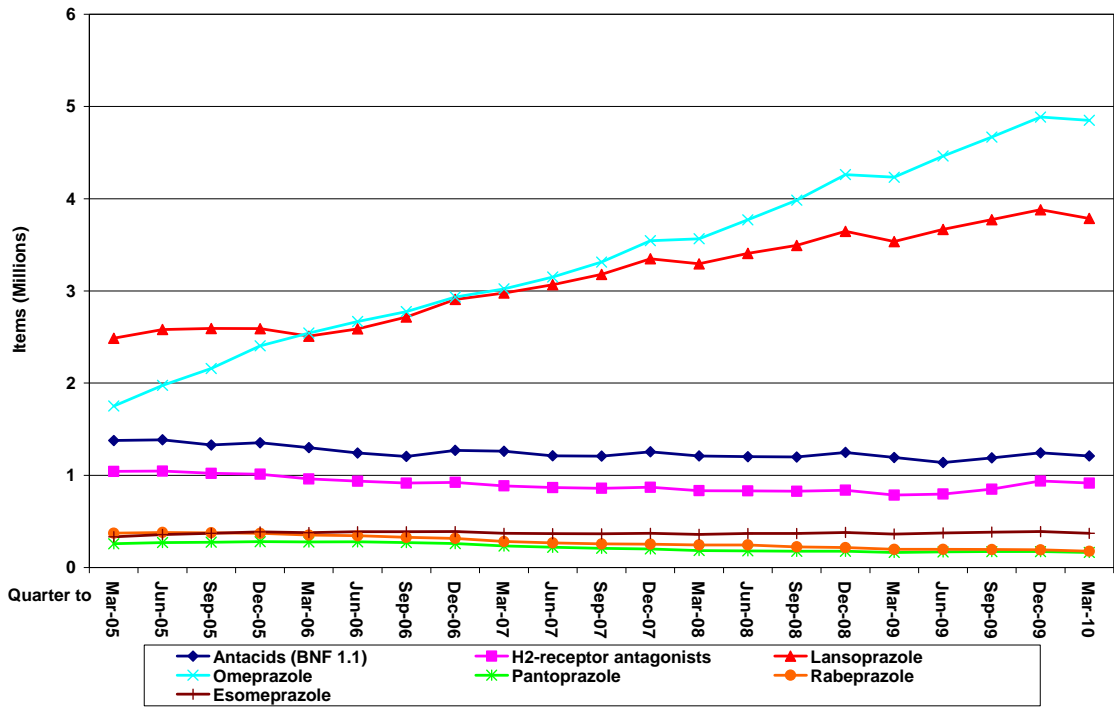


Figure 1: Trends in Prescribing of Drugs for Dyspepsia in General Practice in England

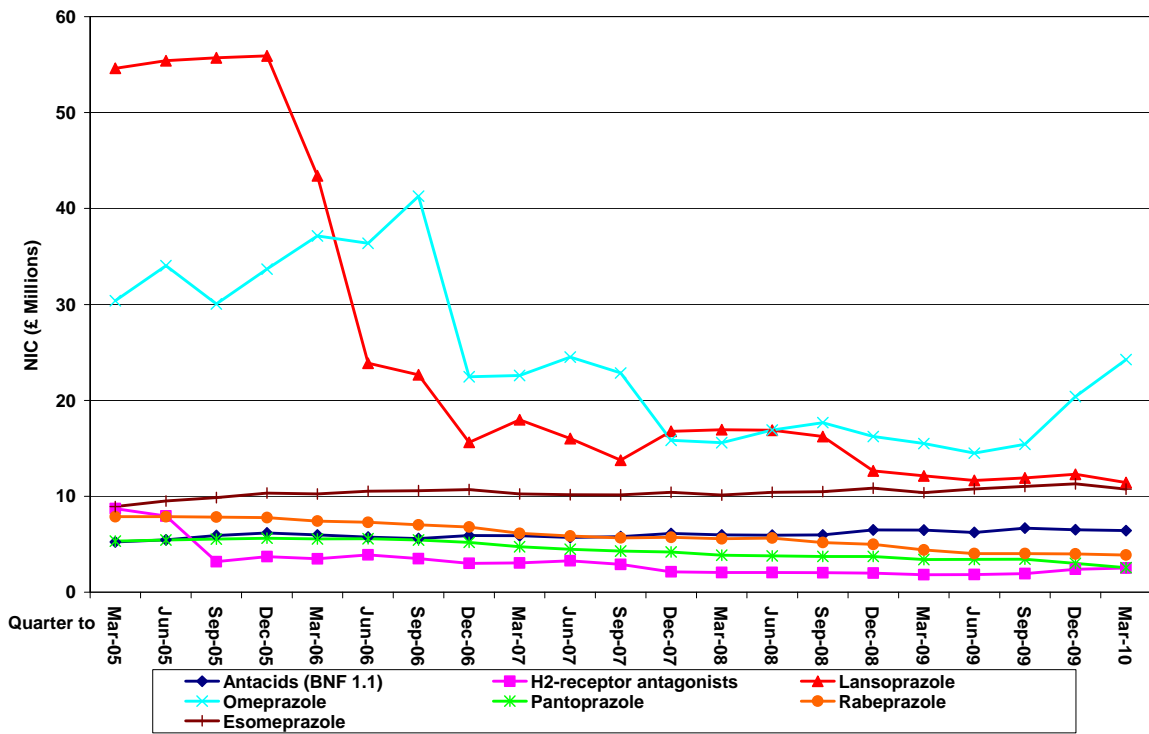
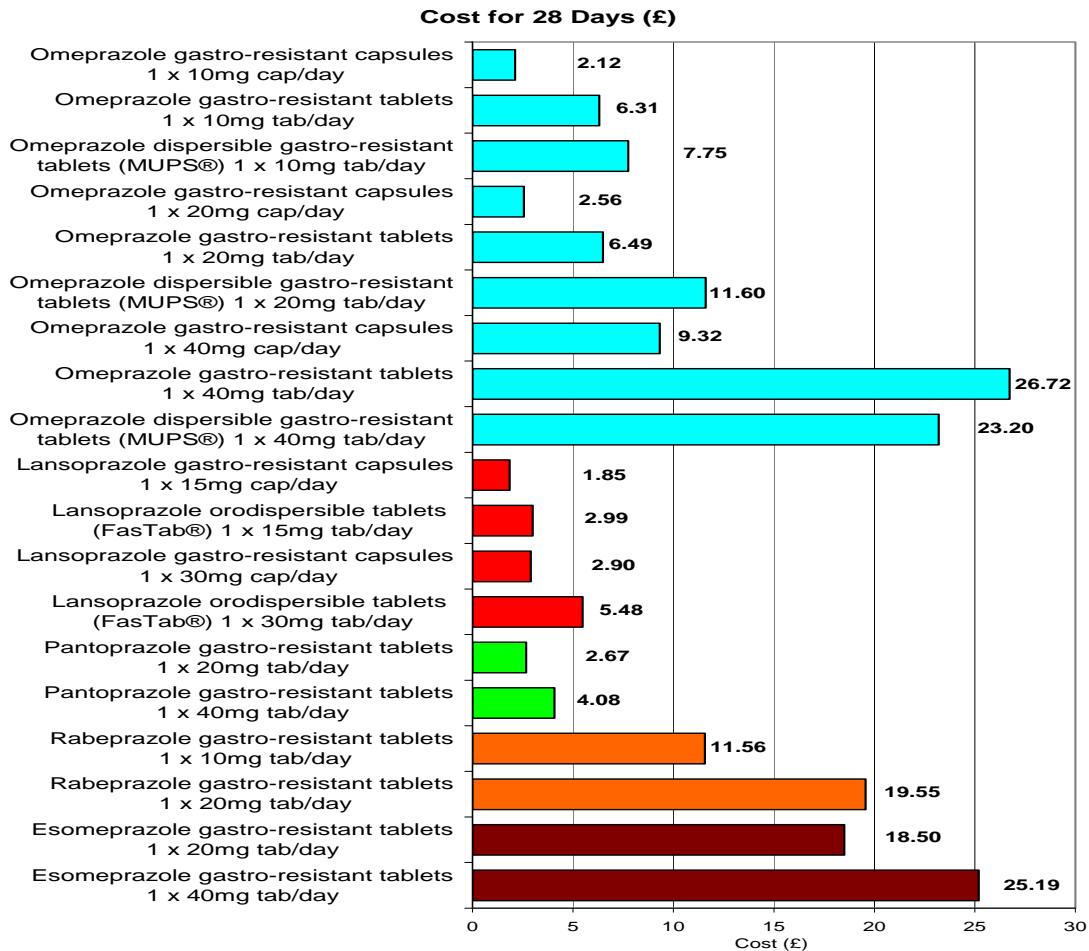


Figure 2: Trends in Spending on Drugs for Dyspepsia in General Practice in England

Over the last 5 years the prescribing of drugs used for dyspepsia has increased from 7.6 million items per quarter to 11.5 million items per quarter (figure 1) whilst costs have nearly halved from £122 million to £62 million per quarter (figure 2). The prescribing of PPIs has increased by 79% over this time period and PPIs now (quarter to March 2010) account for 81% of items (9.3 million) and 86% of the cost (£52.9 million) of drugs used for dyspepsia. Omeprazole is the most commonly prescribed PPI, 4.9 million items costing £24.2million, followed by lansoprazole with 3.8 million items and a cost of £11.4 million (quarter to March 2010).

There are five PPIs currently approved for use within the UK for the management of dyspepsia with some formulations markedly more expensive than alternatives, as illustrated in figure 3 which compares 28 days treatment of a once-daily dose of different forms and strengths of the PPIs. This table shows that, for example omeprazole 20mg gastro-resistant tablets are currently more than twice the cost of the gastro-resistant capsules, and the dispersible gastro-resistant tablets are over four times the cost of the capsules.

There is no evidence that one PPI is more effective than another when compared at appropriate, equivalent doses and newer PPIs offer no advantage in clinical efficacy over established PPIs. Increasing low cost PPI prescribing is one of the Better Care, Better Value indicators. This indicator measures the percentage of prescriptions written for omeprazole and lansoprazole (excluding Zoton FasTab® and Losec MUPS®) as a percentage of the total volume of PPI prescribing. If PCTs with below 92% use (achieved by the top quartile of trusts) of lower cost PPIs increased this to over 92%, £22 million would be saved in a year (based on quarter 1 2009/10).



Prices based on Drug Tariff August 2010 and the NHS dictionary of medicines and devices.

Figure 3: Comparison of the cost of Proton Pump Inhibitors

The NICE guideline identifies the priorities for implementation which include:

- Referral for endoscopy
- Interventions for uninvestigated dyspepsia, GORD, peptic ulcer disease and non-ulcer dyspepsia
- Reviewing patient care
- *Helicobacter pylori* testing and eradication

NICE recommends the initial management of patients with dyspepsia to include lifestyle advice and treatment from a community pharmacist. Studies show a weak link between obesity and GORD but no clear association between other lifestyle factors and dyspepsia. However lifestyle advice is still important because healthy eating, weight reduction and smoking cessation offer general health benefits.

One common element of care within the NICE guidelines if symptoms return is to offer PPI therapy stepped down to the lowest dose required to control symptoms and to discuss the possibility of using 'on demand' treatment with patients to manage their symptoms.

Health professionals should carefully review PPI prescribing to ensure it is in line with NICE guidance and PPIs should not be routinely continued after discharge from secondary care nor prescribed long term or in high doses without careful thought. Evidence from a group of US studies has highlighted two potential harms associated with PPI use: increased risk of *Clostridium difficile* infections and a possible increased risk of hip, wrist and spine fractures.

There has been a lot of recently published data on a possible interaction between PPIs and clopidogrel with a consequent possible loss of antiplatelet protection. The MHRA have reviewed all the available evidence and recommend that concomitant use of clopidogrel and omeprazole or esomeprazole should be avoided unless essential. The PPI of choice in combination with clopidogrel is therefore lansoprazole.

### **Sources of further information**

1. Information on prescribing for the PCT is available using ePACT.net and the Prescribing Toolkit.
2. NICE. Dyspepsia: Managing dyspepsia in adults in primary care. August 2004 (updated June 2005)
3. MeReC Bulletin Volume 16 Number 3 (March 2006)
4. NHS Better Care, Better Value Indicators. [www.productivity.nhs.uk](http://www.productivity.nhs.uk)
5. Drug Safety Update, MHRA. Volume 3, Issue 9, April 2010
6. MeReC Rapid Review, Increased risk of C difficile infections and of fractures: two more good reasons to review PPI prescribing, 3 June 2010.