NPS MEDICINEWISE

GORD
STEPPING DOWN PPIs

Practice Review: PBS data July 2018

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Dr Sam Sample
123 Sample Street
SAMPLETOWN ABC 1234

Your PBS data are provided confidentially to you only and are intended for personal reflection on your practice. **Data are not used for any regulatory purposes.**

Additional **MedicineInsight** general practice cohort data are included to complement your PBS data.

31 July 2018

Dear Dr Sample,

NPS MedicineWise supports clinicians in professional development and continuing quality improvement, with a focus on quality use of medicines (QUM) and medical tests. The enclosed data focus on your prescribing of proton pump inhibitors (PPIs).

Applying QUM principles
Identifying when a medicine is necessary, determining the most appropriate medicine for the patient, and using it safely and effectively for the required duration are some of the recommended QUM principles.[1] Adopting a systematic approach to identifying and stopping medicines that are no longer needed reduces polypharmacy and improves patient outcomes.[2]

PPIs: too much of a good thing?
Although many of the indications for PPIs (including GORD) do not usually require long-term daily treatment, PPIs continue to be one of the most widely prescribed classes of medicines in Australia. Four out of the five PPIs were ranked among the top 30 medicines by prescription volume in 2016—17, with two PPI medicines appearing in the top five.[3]

Up to two-thirds of patients with reflux can discontinue PPIs without deteriorating symptom control[4]
Tapering the dose or using on-demand treatment (ie, when required), alongside lifestyle modifications, can reduce symptoms due to rebound acid hypersecretion.[5] Almost a third of patients with GORD can expect to remain symptom free for a prolonged period after stopping an initial 4—8 weeks of PPI treatment.[5]

Reflect on your prescribing
The enclosed PBS data provide you with an opportunity to reflect on your practice and your prescribing patterns for PPIs. To complement your individual PBS data, additional information from the **MedicineInsight** general practice database is included. This information provides further insights into national prescribing patterns for PPIs to help you interpret your data in the context of your own clinical practice. See **nps.org.au/medicine-insight**

Learn more
Our national program *Starting, stepping down and stopping medicines* provides a range of clinical tools and patient resources as well as CPD activities for GPs:

- Educational visit – Starting, stepping down and stopping medicines
- Case study – Reviewing treatment for gastro-oesophageal reflux disease
- Clinical e-Audit – PPIs in GORD: a stepped approach

Yours sincerely,

Sharene Jackson
Executive Manager, Program & Product Development

See **nps.org.au/pbs-ppis** for more information on how to interpret your data in this Practice Review.

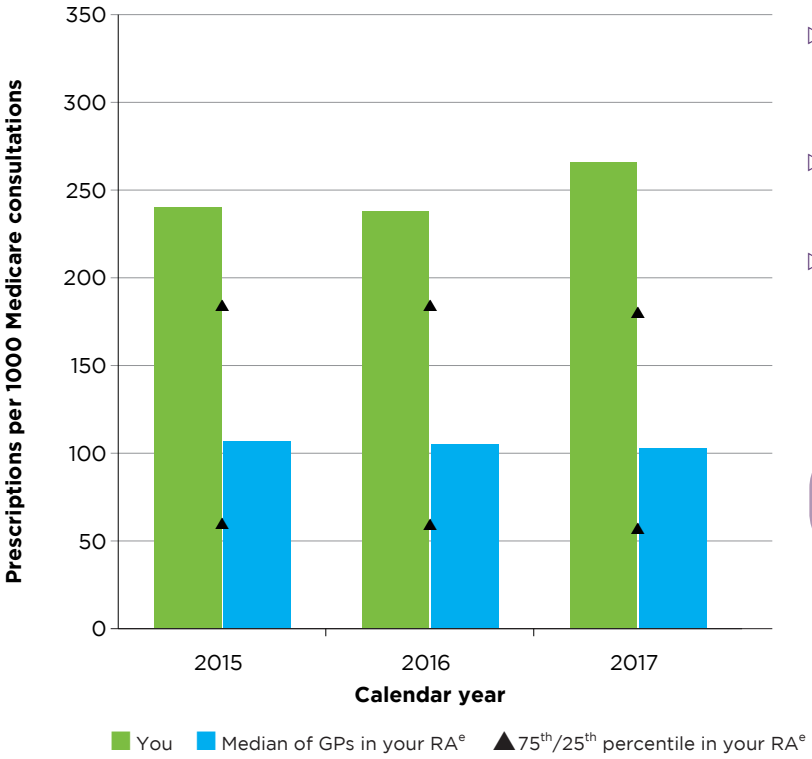
Level 7/418a Elizabeth Street
Surry Hills NSW 2010
PO Box 1147
Strawberry Hills NSW 2012

P: 02 8217 8700
F: 02 9211 7578
E: info@nps.org.au
nps.org.au

Your confidential prescribing data

NPS MedicineWise provides this information for your reflection only. The data are from the Department of Human Services (DHS) and include all PBS prescriptions for PPIs that you prescribed and were dispensed. The indication for prescribing cannot be determined from PBS data. Consider the data in relation to your patients and their indications for treatment.

How has your prescribing of PPIs changed over time?



Points for reflection

- PPIs are indicated for GORD when symptoms are frequent (2 or more days per week[6]) or severe enough to impact the patient's quality of life.[5]
- A standard dose PPI should initially be used for 4—8 weeks when prescribed for GORD, and the ongoing need reassessed after this time.[5]
- Changing or stopping medicines that may worsen GORD symptoms (over-the-counter and prescription medicines such as NSAIDs), and modifying lifestyle factors can help with GORD symptom control.[5]

MedicineInsight data[b] show that of all patients using a PPI with a recorded relevant indication, 82% of patients are using it for GORD.[c]

What is the cost of your PPI prescribing?

	Total number of PPI prescriptions	Total cost of PPIs ($)	Percentage of total PBS cost (%)	Total cost of high-strength PPIs[d] ($)	Total cost of standard-strength PPIs[d] ($)
You	1,407	9,153	4	2,288	6,634
All GPs in your RA[e]	12,613,917	126,618,605	4	40,141,003	83,117,553

Note. Total number of PPI prescriptions includes those for under co-payment medicines, which incur no PBS cost. Data reflects prescriptions dispensed in 2017.

Points for reflection

- High doses of PPIs (ie, esomeprazole 40 mg once daily or double the standard strength of other PPIs) are only indicated for GORD when symptoms are inadequately controlled after a 4—8 week trial of a standard-dose PPI.[5] Check adherence, and consider other diagnoses and referral for endoscopy if required.
- Using a standard-strength PPI[d] twice daily is more effective than a high-strength[d] (ie, esomeprazole 40 mg) once daily.[5]

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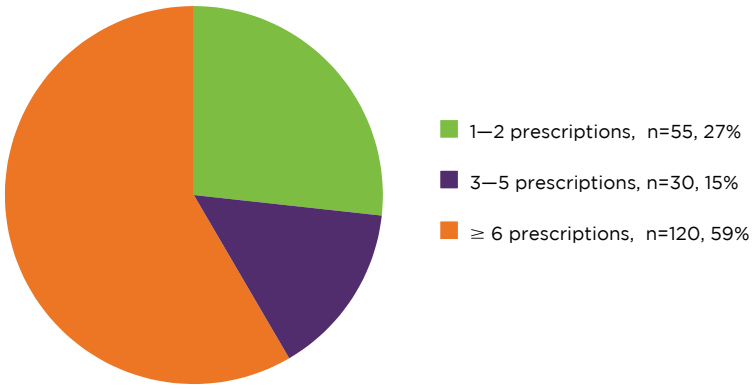
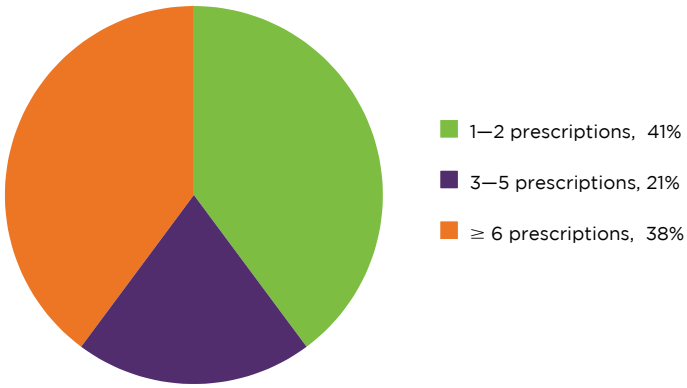
MedicineInsight is Australia's leading large-scale general practice dataset. Developed and managed by NPS MedicineWise with funding from the Australian Government Department of Health, MedicineInsight supports quality improvement in Australian primary care. Insights can be provided at practitioner, practice and regional level enabling monitoring of practice improvement over time, intra- and inter-practice comparisons, as well as identification of patients for intervention and follow-up.

How many prescriptions do you supply to your patients?

Your patients



Total patients in your RA[e]

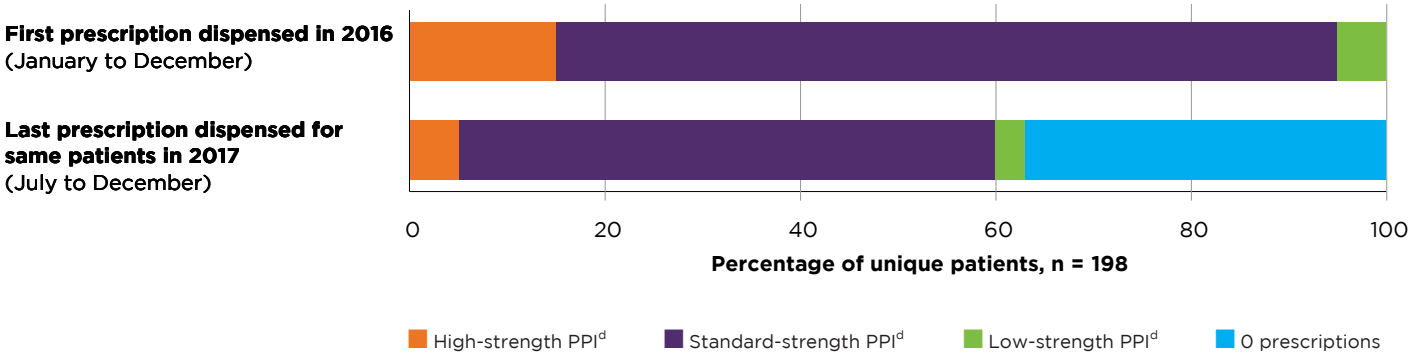


Points for reflection

- In calendar year 2017, **30** of your patients started PPI treatment.
- Long-term regular PPI use in GORD is only indicated in certain cases (eg, patients with complicated disease,[7] or who have frequent troublesome symptoms or inadequately controlled symptoms with stepped down treatment[8]).
- Regularly review patients using PPIs long-term with the view to maintain patients on the lowest effective dose, or stop treatment if possible.[5]
- While PPIs are generally considered safe and are well-tolerated by most patients, a range of rare but serious adverse effects have been reported with long-term use (eg, nutritional deficiencies, gastrointestinal infections and bone fractures).[9]
- RACGP, through Choosing Wisely Australia, recommends avoiding the use of PPIs long term for patients with uncomplicated disease without regular attempts at stepping down dose or stopping.[10] See **choosingwisely.org.au/recommendations/racgp**

Note. Due to rounding, percentages may not total 100%.
n = number of patients in 2017.

What is your approach to stepping down?



Note. Due to patients receiving multiple strength PPI medicines, percentages may not total 100%. n = total number of patients.

Points for reflection

- Set expectations of management and plan for stepping down or stopping treatment when symptoms are well controlled.[5]
- Individualise the approach to stepping down PPI treatment and support patients by providing clear instructions on how to self-manage symptoms.
- Transient rebound acid hypersecretion may occur up to 4 weeks after stopping treatment.[11] These symptoms may be managed by using antacids and H_2 receptor antagonists.[5]

MedicineInsight data[b] show that of all patients starting PPI treatment for GORD within the last 12 months, 25% started with a high strength, compared to 68% starting with a standard strength.

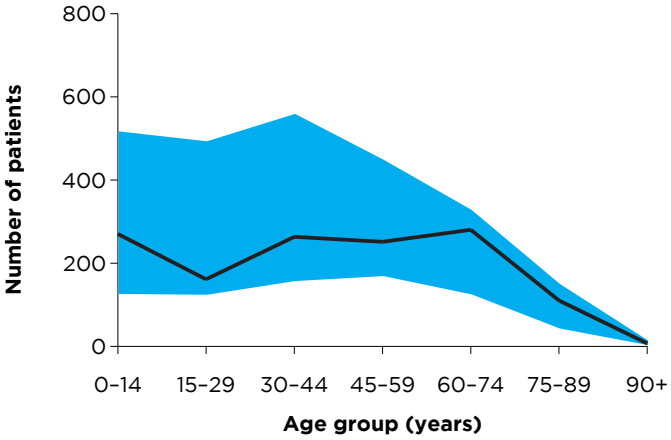
Practice profile

This practice profile is provided to help you interpret your prescribing data.

Your RA[e] peer group is Major City

Age profile of your patients

(1 January 2017 to 31 December 2017)



The black line represents the age profile of your patients. The shaded area lies between the 25th and 75th percentile for GPs in your RA.[e]

Your Medicare patients and concession card holders

(1 April 2017 to 30 June 2017)

Patients	You	Median of GPs in your RA[e]
Total Medicare	735	625
Concession card holders Includes those reaching Safety Net	199	169

Data from a 3-month period that represent patient mix have been provided. Department of Veterans' Affairs health card holders are not included.

Notes

a. Data shown are an aggregate of all your provider locations.
b. Aggregate MedicineInsight data on 1 May 2018.
c. PPI use and reference to relevant indication must be within the last 24 months.
d. High-strength: esomeprazole 40 mg; standard-strength: esomeprazole 20 mg, lansoprazole 30 mg, omeprazole 20 mg, pantoprazole 40 mg, rabeprazole 20 mg; low-strength: lansoprazole 15 mg, omeprazole 10 mg, pantoprazole 20 mg, rabeprazole 10 mg.
e. The comparator group 'RA' includes all general practitioners currently located in a similar geographical location.

References

References available online at **nps.org.au/pbs-ppis**

Contact

For queries about your data or any of this information, contact NPS MedicineWise:

02 8217 8700 **info@nps.org.au**

Updating your details

This mailout is sent to your preferred mailing address, as held at the Department of Human Services (DHS). To update your preferred mailing address:

Log in to your Health Professional Online Services (HPOS) account **https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/hpos**

Send your full name, provider number and new preferred mailing address to **provider.registration@humanservices.gov.au** from a personal email address that clearly identifies you, or is the email address stored on the Medicare Provider Directory.

Confidentiality

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