MANAGING PROTON PUMP INHIBITOR USE IN OLDER ADULTS

This tool is designed to help primary care providers assess and discuss with their patients 65 years of age or older, the potential benefits and risks of proton pump inhibitors (PPIs). This tool contains steps to support primary care providers in safely discontinuing, starting or continuing to prescribe PPIs for their older patients.

SECTION A: POTENTIAL RISKS AND BENEFITS OF PPIs

Many common indications for PPI use require short-term treatment. However, chronic use of PPIs has become problematic and rampant.1 PPIs are often viewed as safe and well-tolerated medications, and while the incidence of risks might be small, older adults are more susceptible due to comorbid conditions. When PPIs are inappropriately prescribed or used for too long, they can contribute to polypharmacy-related adverse reactions, medication errors, drug interactions, emergency department visits and hospitalizations.1

<table>
<thead>
<tr>
<th>Potential Risks from Long-Term (≥ 1 YEAR) USE</th>
<th>Potential Benefits from Short-Term Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased risk of hip fracture1</td>
<td>• Uninvestigated gastroesophageal reflux disease (GERD): heartburn remission</td>
</tr>
<tr>
<td>• NNH at 1 year = 4167 for women and 6667 for men2</td>
<td>• PPI 72% vs. placebo 25%, NNT at 1-12 weeks = 2*</td>
</tr>
<tr>
<td>• Clostridium difficile infection2</td>
<td>• Prevention of NSAID-associated peptic ulcer</td>
</tr>
<tr>
<td>• NNH at 1 year = 10003</td>
<td>• PPI 14% vs. placebo 36%, NNT at &gt;3 weeks = 4</td>
</tr>
<tr>
<td>• Acute interstitial nephritis1</td>
<td>• Reflux (erosive) esophagitis</td>
</tr>
<tr>
<td>• NNH at 1-6 months = 556</td>
<td>• Acute Healing</td>
</tr>
<tr>
<td>• Low levels of the mineral magnesium in the blood2</td>
<td>• PPI 83% vs. placebo 28%, NNT at 8 weeks = 2*</td>
</tr>
<tr>
<td>• Vitamin B12 deficiency*</td>
<td>• Maintenance of healed esophagus</td>
</tr>
<tr>
<td>• NNH at 1 year = 4*</td>
<td>• PPI 78% vs. placebo 21%, NNT at 8 weeks = 2*</td>
</tr>
</tbody>
</table>

1Due to the observational nature of the evidence, harms observed may be over-represented due to potential confounding
2Quality of evidence unclear
3Moderate quality of evidence

DISCUSS WITH A PATIENT THEIR USE OF PPIs WHEN A PATIENT:

☐ Is ≥ 65 years of age
☐ Comes in for a prescription renewal or refill
☐ Has had a recent hospitalization
☐ Has had a recent medication reconciliation
☐ Is admitted to long-term care
☐ Complains of side effects (headache, nausea, diarrhea and rash, etc.)
☐ Is on medications that do not match their active medical concerns

TIPS FOR REVIEWING PPI USE WITH PATIENTS

☐ Set EMR reminders or patient record flags to review a patient’s PPI use during their next appointment.
☐ Encourage patients to talk about their PPI use at their next appointment: 1) hand out patient material to patient ages > 65 or over; 2) put waiting room patient posters up; or, 3) provide screening questions while patients wait for their appointments. This type of patient material is available from the Canadian Deprescribing Network.7

Determine whether a PPI is appropriate or problematic1

Short-term uses:
• Mild to moderate esophagitis or GERD
• Peptic ulcer disease (from NSAID; H. pylori)
• Upper GI symptoms without endoscopy
• Uncomplicated H. pylori
• ICU stress ulcer prophylaxis

Is patient asymptomatic or has treatment duration been met/exceeded?

☐ Yes
☐ No

See Section B: Discontinuing PPIs

See Section C: Starting and continuing PPIs and revisit the conversation once the patient is asymptomatic or has completed the treatment duration

See Section D: Alternatives to PPIs

Address the patient’s PPI use
"What was the initial reason that you started the PPI and does that reason still exist?"
"If you no longer have symptoms, we can consider stopping the PPI."

March 2021

References
SECTION B: Discontinuing PPIs

Tapering steps
If taking a PPI is no longer appropriate for a patient, then use the following steps to help the patient taper off of the medication or taper to a lower dose.8

### 1. BEFORE STARTING A TAPER

Ensure that lifestyle changes and alternative therapies are implemented to reduce the risk of relapse symptoms during or following the taper (see Section D: Alternatives to PPIs).

### 2. PLAN THE TAPER

There is no evidence that one tapering approach is better than another. The tapering plan should be based on patient preference and what plan seems most tolerable.

- **Engage patients** in developing a clear plan for tapering
- Find out when the patient’s symptoms are most severe and customize their tapering plan
- **Establish the method of tapering**
  - Identify whether the Ontario Drug Benefit (ODB) covers the doses you plan to use during tapering (see PPIs available in Ontario) and if not, consider alternate-day dosing or switching to another PPI [that is covered]
  - Potential tapering methods:
    - Reduce the dose from twice daily to once daily
    - Reduce the dose from daily to every second or third day
    - Stop the PPI and replace it with H2 blockers
    - Reduce the dose to PRN
    - Include a note in the prescription to inform the pharmacist of the tapering plan
    - Consult the pharmacist if pill splitting is necessary to accommodate tapering doses and to discuss packaging options for older adults (e.g. dosette or blister pack)

### 3. INITIATE THE TAPER AND MONITOR

- **Initiate the taper**
- **Ask the patient to call in 2-4 weeks to report any relapse symptoms**
  - Ask the patient if they are experiencing:
    - Heartburn
    - Reflux (used synonymously with heartburn)
    - Sore throat (i.e. difficulty swallowing)
    - New onset of coughing
    - Abdominal pain
  - Alternatively, if the patient is non-verbal, use a visual analogue scale (VAS) to identify pain or discomfort due to symptom relapse and look for signs of:9
    - Weight or appetite loss
    - Behavioural changes (e.g. agitation)

- **If the patient experiences withdrawal and/or rebound acid reflux, suggest using non-pharmacological and non-PPI pharmacological alternatives to lessen symptoms** (see Section D: Alternatives to PPIs)
  - If the patient does not tolerate the taper and the taper interferes with their normal activities, determine if the patient should return to a previous PPI dose
  - If the patient is still experiencing a recurrence of symptoms, test for *H. pylori* and contact a GI specialist for further consultation

Talking points
Emphasize the need to reduce polypharmacy
“I want you taking only the medications that you need. Let’s see if we can take you off unnecessary medications to help you feel better.”

Frame discontinuing PPIs as a trial
“Let’s try taking you off the PPIs to see how you feel? If any symptoms come back, you can tell me. We can always restart the dose that you need to feel comfortable.”

Reassure a patient that a PPI will be tapered instead of stopped completely
"Most patients are successful in tapering off of their PPIs. Sometimes, patients slowly decrease the dose to help their body adjust, but often, patients don’t notice a recurrence of their symptoms."
SECTION C: Starting and continuing PPIs

For patients starting or continuing on a PPI, use the following information to ensure that the PPI is prescribed safely, considering individual patient factors.

### IMPORTANT INFORMATION TO COLLECT BEFORE STARTING A PPI

- **Pre-existing conditions that require a GI referral:**
  - Dysphagia
  - Odynophagia
  - GI bleeding/anemia
  - Recurrent vomiting
  - Weight loss
- **Dietary patterns and triggers** (i.e. caffeine, alcohol, foods high in acid, nicotine)
- **All prescribed and over-the-counter medications** that the patient is currently taking, including supplements, vitamins and naturopathic treatments (see [Medications that interact with PPIs](#))
- **History of previous non-pharmacological (i.e. lifestyle changes) and pharmacological alternatives tried** (see Section D: Alternatives to PPIs)
  - An adequate trial of non-pharmacological and pharmacological alternatives is approximately 6-8 weeks
- **History of adverse events**

### TIPS FOR SAFE PPI PRESCRIBING

- Ideally, limit a prescription to 2-8 weeks (high-risk patients might need more than 8 weeks; see the section below to identify high-risk conditions)
- Discuss a tapering plan before prescribing a PPI (see Talking points)
- Consult with your local GI specialist before concomitantly administering antisecretory agents because of the marked reduction in acid inhibitory effects.
  - Examples include, histamine-2 receptor antagonists (H2RAs), analogues of prostaglandin E (e.g. misoprostol) and somatostatin analogues (e.g. octreotide)
- Set EMR reminders or patient record flags to prompt you to revisit PPI use at the patient's next visit and ask your patient to book a follow-up appointment within 4-8 weeks

### CONTINUING PPIs

- First, it is important to determine if the chronic use of a PPI is warranted. Consider if the original indication for the PPI or ongoing risk factors for GI disease are present.

  - **The following are high-risk conditions that may require long-term PPI use:**
    - Barrett’s esophagitis
    - Chronic oral corticosteroids or chronic NSAID use
    - Grade C or D esophagitis
    - Documented history of bleeding GI ulcers
    - Dual antiplatelet therapy (with a prior upper GI bleed or one other risk factor)
  - Set annual EMR reminders or patient record flags to re-assess PPI use in patients with high-risk conditions

- Seek advice from a GI specialist for high-risk patients to assess ongoing risk factors

---

**Talking points**

**Provide instructions on when to take a PPI**

“Take your PPI 30-60 minutes before you eat your breakfast in the morning, with a glass of water (not coffee), or before your last meal of the day.”

**Discuss a tapering plan before prescribing a PPI**

“We will start you on the PPI and then we will slowly decrease your dose once you start feeling better.”
### SECTION C: Starting and continuing PPIs (continued)

#### MEDICATIONS THAT INTERACT WITH PPIs

<table>
<thead>
<tr>
<th>Medications</th>
<th>Decreases absorption/levels of PPI</th>
<th>PPI decreases efficacy/absorption</th>
<th>PPI increases drug exposure (half-life or area under the curve [AUC])/toxicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampicillin&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td>![bullet] applies to omeprazole only</td>
</tr>
<tr>
<td>Calcium supplements&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Carbamazepine&lt;sup&gt;17&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Cimetidine&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet] applies to omeprazole only</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Clomipramine&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet] applies to omeprazole only</td>
<td></td>
</tr>
<tr>
<td>Clopidogrel&lt;sup&gt;40,41&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet] applies to omeprazole and esomeprazole only</td>
<td></td>
</tr>
<tr>
<td>Diazepam&lt;sup&gt;17&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Digoxin&lt;sup&gt;17&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Ginkgo&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet] applies to omeprazole only</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>HIV protease inhibitors&lt;sup&gt;12&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Iron&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Itraconazole&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Ketoconazole&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Methotrexate&lt;sup&gt;12&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Phenytoin&lt;sup&gt;12&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet] applies to omeprazole only</td>
<td></td>
</tr>
<tr>
<td>Rifampin&lt;sup&gt;16&lt;/sup&gt;</td>
<td>![bullet] applies to omeprazole only</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Theophylline&lt;sup&gt;12,16&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet]</td>
<td></td>
</tr>
<tr>
<td>Warfarin&lt;sup&gt;17&lt;/sup&gt;</td>
<td>![bullet]</td>
<td>![bullet] applies to omeprazole only</td>
<td></td>
</tr>
</tbody>
</table>

**Legend:** $=<$15, $$=$15-30, $$$=$30-45, $$$$$=$45-60, $$$$$=$60-75,
**= Standard dose PPI taken BID only indicated in the treatment of peptic ulcer caused by H. pylori; PPI should generally be stopped once eradication therapy is complete unless risk factors warrant continuing PPI

**= If the patient is on this PPI and needs to taper to smaller doses: stay at the higher dose but switch to alternating days OR contact the patient or their family/caregiver to see if they approve the cost of smaller doses

+= available over the counter: Esomeprazole 20 mg (Nexium 24HR capsules) and Omeprazole 20 mg (Omepr Acid Reducer capsules, Heartburn Control capsules and Riva brand omeprazole)

a= Symptomatic non-erosive gastroesophageal reflux disease, b= Healing of erosive esophagitis, c= Non-erosive reflux disease, d= Reflux esophagitis, ^=Can be sprinkled on food

Note: reference to brand names does not imply endorsement of any of these products

---

### PPIS AVAILABLE IN ONTARIO

<table>
<thead>
<tr>
<th>PPI Type</th>
<th>Standard daily dose (healing)*</th>
<th>Low daily dose (maintenance)</th>
<th>ODB coverage</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexlansoprazole* (Dexilant®) Capsule</td>
<td>30 mg or 60 mg</td>
<td>30 mg</td>
<td>No**</td>
<td>$$$$$$</td>
</tr>
<tr>
<td>Esomeprazole*+ (Nexium®) Tablet</td>
<td>20 mg or 40 mg</td>
<td>20 mg</td>
<td>Yes</td>
<td>$$$$</td>
</tr>
<tr>
<td>Lansoprazole* (Prevacid®) Capsule</td>
<td>30 mg</td>
<td>15 mg</td>
<td>Yes</td>
<td>$</td>
</tr>
<tr>
<td>Omeprazole*+ (Losec®) Capsule</td>
<td>20 mg</td>
<td>10 mg</td>
<td>Yes</td>
<td>$</td>
</tr>
<tr>
<td>Pantoprazole* (Tecta®, Pantoloc®) Tablet</td>
<td>40 mg</td>
<td>20 mg</td>
<td>Yes</td>
<td>$</td>
</tr>
<tr>
<td>Rabeprazole* (Pariet®) Tablet</td>
<td>20 mg</td>
<td>10 mg</td>
<td>Yes</td>
<td>$</td>
</tr>
</tbody>
</table>

* Standard daily dose PPI taken BID only indicated in the treatment of peptic ulcer caused by H. pylori; PPI should generally be stopped once eradication therapy is complete unless risk factors warrant continuing PPI

**= If the patient is on this PPI and needs to taper to smaller doses: stay at the higher dose but switch to alternating days OR contact the patient or their family/caregiver to see if they approve the cost of smaller doses

+= available over the counter: Esomeprazole 20 mg (Nexium 24HR capsules) and Omeprazole 20 mg (Omepr Acid Reducer capsules, Heartburn Control capsules and Riva brand omeprazole)

---

March 2021 cep.health/PPIs
**SECTION D: Alternatives to PPIs**

**Alternatives to managing GERD or esophagitis**

**i. Non-pharmacological**
Older adult patients can manage their GERD or esophagitis by incorporating the following lifestyle changes into their daily routines.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid lying down for 2-3 hours after you eat$^{18,21}$</td>
<td>●</td>
</tr>
<tr>
<td>Avoid wearing tight clothing$^{18}$</td>
<td>●</td>
</tr>
<tr>
<td>Elevate the head of the bed (try placing a firm pillow between the mattress and the bed frame), particularly if nocturnal or laryngeal reflux symptoms are present$^{18}$</td>
<td>● ● ●</td>
</tr>
<tr>
<td>Modify diet:</td>
<td>● ● ●</td>
</tr>
<tr>
<td> Increase fibre intake to decrease heartburn$^{19}$</td>
<td></td>
</tr>
<tr>
<td> Avoid chocolate, alcohol, caffeine, acidic citrus juices, large fatty meals, spicy food and peppermint$^{18}$</td>
<td></td>
</tr>
<tr>
<td> Choose smaller quantities and eat slowly$^{20}$</td>
<td></td>
</tr>
<tr>
<td>Reduce bodyweight if BMI &gt;30 kg/m$^2$ or reverse recent weight gain$^{18}$</td>
<td>● ● ●</td>
</tr>
<tr>
<td>Smoking cessation$^{18}$</td>
<td>●</td>
</tr>
</tbody>
</table>

Level of evidence: ● ● ● ● = meta-analysis or systematic review of randomized controlled trials, ● ● = individual randomized controlled trial, ● = systematic review of cohort studies, = individual cohort study or expert opinion

"Heartburn is common. This is why we have effective over-the-counter medicine to help, which are often safer options."

"You may experience rebound symptoms, but they often go away with time and lifestyle changes. You can trial over-the-counter medication when you have rebound symptoms."

"Avoid chocolate, alcohol, caffeine, acidic citrus juices, large fatty meals, spicy food and peppermint. All of these foods can give you heartburn. Try increasing your intake of fruits, vegetables, protein and complex carbohydrates."$^{22}$
### SECTION D: Alternatives to PPIs (continued)

#### ii. Pharmacological
Medications with ODB\textsuperscript{14} coverage can be prescribed to patients if they are concerned about the cost of obtaining them over-the-counter. When possible and appropriate, eliminate drugs that impair esophageal motility and lower esophageal sphincter tone (e.g. anticholinergic agents, beta-adrenergic agonists, calcium channel blockers, theophylline and tricyclic antidepressants).\textsuperscript{18,31}

#### iii. Other alternatives
The following alternatives do not have the same efficacy as the non-pharmacological and pharmacological alternatives, but can alleviate minor symptoms of heartburn, reflux or stomach pain.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Level of evidence</th>
<th>Dose</th>
<th>Notes</th>
<th>Side effects</th>
<th>ODB coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antacids</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aluminum hydroxide/magnesium hydroxide</td>
<td>· · · ·</td>
<td>30 mL (regular strength) PRN after meals\textsuperscript{18}</td>
<td>Avoid antacids containing magnesium or aluminum in renal dysfunction\textsuperscript{18}</td>
<td>Constipation, diarrhea\textsuperscript{18}</td>
<td>No</td>
</tr>
<tr>
<td>combinations (Diovol®)\textsuperscript{18,29}</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alginates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aluminum hydroxide (Gaviscon® liquid)\textsuperscript{18,29}</td>
<td>· · · ·</td>
<td>10–20 mL PRN after meals\textsuperscript{18}</td>
<td>Alginates and some antacids contain significant amounts of sodium\textsuperscript{18}</td>
<td>Nausea, vomiting, belching, flatulence\textsuperscript{18}</td>
<td>No</td>
</tr>
<tr>
<td>Magnesium carbonate (Gaviscon® tablets)\textsuperscript{18,29}</td>
<td>· · · ·</td>
<td>2–4 tablets chewed PRN after meals followed by a drink of water\textsuperscript{18}</td>
<td></td>
<td>Nausea, vomiting, belching, flatulence\textsuperscript{18}</td>
<td>No</td>
</tr>
<tr>
<td><strong>Histamine H2-receptor antagonists</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cimetidine (Tagamet®)\textsuperscript{18,34}</td>
<td>· · · ·</td>
<td>400 mg twice daily\textsuperscript{16}</td>
<td></td>
<td>Diarrhea, constipation, headache, fatigue, confusion (most likely in older adults and those with poor renal function), cardiac effects, rash</td>
<td>Yes - generic only</td>
</tr>
<tr>
<td>Famotidine (Pepcid AC®, Pepcid AC Maximum Strength®)\textsuperscript{18,13}</td>
<td>· · · ·</td>
<td>20 mg twice daily\textsuperscript{16}</td>
<td>Available without a prescription\textsuperscript{18} Antacids may be given concomitantly if needed\textsuperscript{18}</td>
<td>Diarrhea, constipation, headache, fatigue, confusion (most likely in older adults and those with poor renal function), cardiac effects, rash</td>
<td>Yes - generic only</td>
</tr>
<tr>
<td>Nizatidine (Axid®)\textsuperscript{18,32}</td>
<td>· · · ·</td>
<td>150 mg twice daily\textsuperscript{16}</td>
<td></td>
<td></td>
<td>Yes - only brand name available</td>
</tr>
<tr>
<td>Ranitidine* (Zantac, Zantac Maximum Strength®)\textsuperscript{16,35}</td>
<td>· · · ·</td>
<td>150 mg twice daily\textsuperscript{16}</td>
<td>Available without a prescription\textsuperscript{18}</td>
<td></td>
<td>Yes - generic only</td>
</tr>
</tbody>
</table>

Level of evidence: · · · · = meta-analysis or systematic review of randomized controlled trials, · · · = individual randomized controlled trial, · · = systematic review of cohort studies, · = individual cohort study or expert opinion. Legend: *= Currently unavailable in Canada due to the 2019 recall and contamination. Consult Health Canada and the FDA for updates.

### Treatment Side effects/adverse events

- **Bismuth subsalicylate (Pepto Bismol®)**: Salicylate toxicity, black tongue, black stool, bismuth-induced encephalopathy\textsuperscript{28}
- **Calcium carbonate and magnesium hydroxide (Rolaids®)**: Hypercalcemia, hypermagnesemia, milk-alkali syndrome, nephrolithiasis, abdominal pain, constipation, dehydration, diarrhea, hypercalcemia, hypercalciuria, hypomagnesemia, nausea, vomiting\textsuperscript{26}
- **Calcium carbonate (Tums®)**: Constipation and nausea are the most common side effects, and other possible side effects include hypercalcemia, hypercalciuria, renal calcification and renal stones There may be an increased risk of MI with high supplement doses\textsuperscript{37}
- **Magnesium hydroxide (Milk of Magnesia®)**: Hypermagnesemia in renal dysfunction\textsuperscript{24}

Note: reference to brand names does not imply endorsement of any of these products.
For statistical and bibliographic purposes, please notify the Centre for Effective Practice (info@cep.health) of any use of this Tool, in whole or in part; or give or make any representation, warranty or endorsement of any external sources referenced in this Tool (whether their respective agents, appointees, directors, officers, employees, contractors, members or volunteers: (i) are providing medical, diagnostic or treatment services through this Tool; (ii) to the extent permitted by applicable law, accept any responsibility for the use or misuse of this Tool by any individual including, but not limited to, primary care providers or entity, including for any loss, damage or injury (including death arising from or in connection with the use of this Tool, in whole or in part; or (iii) give any representation, warranty or endorsement of any external sources referenced in this Tool (whether specifically named or not) that are owned or operated by their parties, including any information or advice contained therein.

This Tool was developed as part of the Knowledge Translation in Primary Care Initiative, led by the Centre for Effective Practice in collaboration with the Ontario College of Family Physicians and the Nurse Practitioners’ Association of Ontario. Clinical leadership for the development of the Tool was provided by Dr. Felicia Presenza CCFP and was subject to review and external review by health care providers and other relevant stakeholders.

This Tool was developed for licensed health care professionals in Ontario as a guide only and does not constitute medical or other professional advice. Health care professionals are required to exercise their own clinical judgement in using this Tool. Neither the Centre for Effective Practice (“CEP”), Ontario College of Family Physicians, Nurse Practitioners’ Association of Ontario, Government of Ontario, nor any of their respective agents, appointees, directors, officers, employees, contractors or volunteers are responsible for any medical, diagnostic or treatment services through this Tool; (ii) to the extent permitted by applicable law, accept any responsibility for the use or misuse of this Tool by any individual including, but not limited to, primary care providers or entity, including for any loss, damage or injury (including death arising from or in connection with the use of this Tool, in whole or in part; or (iii) give any representation, warranty or endorsement of any external sources referenced in this Tool (whether specifically named or not) that are owned or operated by their parties, including any information or advice contained therein.

The Managing Proton Pump Inhibitors (PPIs) in Older Adults Tool is a product of the Centre for Effective Practice. Permission to use, copy, and distribute this material is for all non-commercial and research purposes is granted, provided the above disclaimer is included. For statistical and bibliographic purposes, please notify the Centre for Effective Practice (info@cep.health) of any use of this Tool, in whole or in part; or give or make any representation, warranty or endorsement of any external sources referenced in this Tool (whether specifically named or not) that are owned or operated by their parties, including any information or advice contained therein.