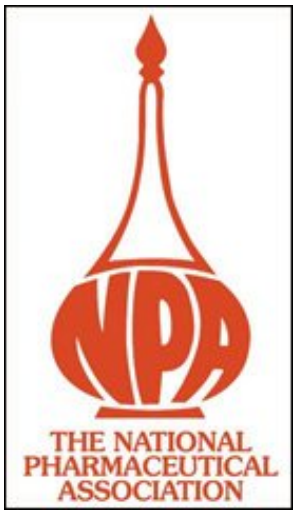

Response to ARM 7 (Request to Reclassify Omeprazole 10mg Gastro-resistant tablets from POM to P) from the NPA.

Response of the National Pharmaceutical Association to ARM 7

Thank you for giving the National Pharmaceutical Association (NPA) the opportunity to comment on Consultation letter ARM 7.

Indications

The history of applications to the FDA has shown that there are concerns about the appropriateness of over-the-counter indications for omeprazole. After many applications the FDA approved the non-prescription sale of omeprazole but only for the prevention of frequent heartburn with a label statement that it was intended for use in those who suffer heartburn two or more days per week.

The application is for the relief of reflux-like symptoms (e.g. heartburn in sufferers aged 18 and over). Omeprazole has a slow onset of action (acid suppression only 50% of maximum after 24 hours) and so is ineffective in the immediate relief of reflux-like symptoms. Considering the long action of omeprazole it would seem to be more suitable for the indication specified by the FDA than that applied for by the applicant.

Dosage

NICE guidelines[i] on the use of proton pump inhibitors in the treatment of dyspepsia recommend a step up or step down approach. The step up approach means patients should normally start on a low dose antacid, gradually trying stronger products until their symptoms are controlled. NICE states that patients with mild symptoms of dyspepsia would not normally be treated with PPIs on a long-term basis. Merec[ii] advises that the single agent approach where all dyspeptic symptoms are treated with a PPI regardless of severity is inappropriate. PRODIGY[iii] guidance on proven GORD also recommends a step up or step down approach. The order of therapy in the step up approach lists antacids or alginates, H2 receptor antagonists or prokinetic agents before the use of a PPI. The step down approach recommends commencing with a PPI and reducing to a less potent agent, therefore limiting the course length of the PPI.

The use of omeprazole as a first line single agent is therefore not supported by any of these nationally recognised guidelines and is inappropriate. In addition the dosage information is potentially confusing for patients and does not explain the step down approach adequately.

It would seem contradictory for pharmacists to recommend to GPs that they use H_2 antagonists and antacids as first line treatments for dyspepsia if they, themselves, sold omeprazole as a first line treatment for self-treatment.

Rationale for the Reclassification

The FDA considered omeprazole on three occasions in the US before approval was finally granted. The FDA found inconsistent results from the studies it looked at in its attempt to evaluate the efficacy of omeprazole. However all the studies failed to demonstrate benefit for occasional episodic use, the indication applied for by the UK applicant. The FDA was concerned that consumers would be confused because of the lack of benefit in acute heartburn and so approval was not granted. Another application was submitted with the indication "24 hour prevention of symptoms for up to 10 days". This was also refused. The third application was for an indication of prevention of frequent heartburn, with a label statement that it was intended for use in those who suffer heartburn two or more days a week. This application was approved.

The applicant has not specified any such indication. The use of omeprazole as a single first line agent for reflux-like symptoms is not in line with any existing guidelines and is not consistent with its pharmacological action. There is no evidence to support the use of omeprazole as a treatment for acute occasional heartburn. The NPA believes patients will be confused by the dosage schedule for omeprazole and will expect immediate relief from symptoms, which will not occur.

The mention of the PRODIGY[iii] guidance in the consultation document is misleading as the list of drugs mentioned is in the context of a step-up approach. This treatment strategy is difficult for patients to understand and it is likely that omeprazole may be used by consumers as a first line treatment, contrary to the guidance.

Posology and pack size rationale

The consultation mentions that advice will be provided to the pharmacist on recommending the product. However, any training information provided to pharmacy staff must make it clear exactly where omeprazole fits into the pharmacist's therapeutic armamentarium.

The document also states "omeprazole can be recommended for regular sufferers who wish to control their symptoms. These patients may still need to take the occasional simple antacid to provide rapid relief from an acute attack between periods of taking omeprazole." This is not made clear from the information in the licence application.

Specific P requirements

Pharmacists are familiar with counter prescribing for heartburn and with the circumstances in which a patient should be referred to their GP for further investigation. However, if consumers were to purchase omeprazole for acute heartburn they may lose confidence when they do not gain immediate relief from their symptoms. Pharmacists would only be able to recommend omeprazole for frequent heartburn sufferers and this is not made clear by the indication. Lansoprazole has also been shown to be more effective than omeprazole when used on a "as required basis".

Safety profile

As omeprazole is an inhibitor of liver enzymes, it interacts with many other drugs. Other PPIs such as lansoprazole have fewer drug interactions than omeprazole.

The FDA also expressed concerns about omeprazole due to the dangers to pregnant women (embryo related toxicity was seen in animal studies). There is a possibility that women may take omeprazole before realising that they are pregnant.

The dosage requirements of omeprazole in the licence application, unlike OTC H2 receptor antagonists, are that it be taken continuously on a daily basis for up to 4 weeks. This longer-term treatment schedule may predispose patients to take omeprazole for long periods, despite pack warnings, thus increasing the risks of masking more serious disease and of long-term adverse effects. Evidence of long term safety of PPIs is inconclusive at present, there have been concerns raised regarding atrophic gastritis and gastric tumours.

We hope these concerns are considered when considering the request to reclassify omeprazole from POM to P.

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[i] NICE Guidelines on the Use of Proton Pump Inhibitors (PPI) in the Treatment of Dyspepsia
[ii] Merec Bulletin Volum 9 NO.11 1998
[iii] PRODIGY Guidance – Dyspepsia – proven GORD www.prodigy.nhs.uk