RECOMMENDATIONS FOR ANTI-ACID PREPARATIONS POST WITHDRAWAL OR UNAVAILABILITY OF RANITIDINE

Introduction

Paediatric patients receiving ranitidine should be assessed at the next convenient opportunity or when a repeat prescription is requested in Primary or Secondary care.

At the moment the MHRA (October 2019) do NOT require patients to stop taking their medication immediately and hence conversion to other medicines may be carried out in a controlled manner.

It should be noted that within the following recommendations, omeprazole suspension should NOT be prescribed under any circumstances as per Lothian guidance from 2015.

Recommendations

1. **Patients on Ranitidine only**

    a) Stable, asymptomatic patients should be considered for stopping ranitidine. Either half the dose keeping the same frequency and stop after two or more weeks OR keep the same dose and reduce the frequency to once daily then stop over the same time frame.
    b) Depending on age, consider the use of Gaviscon Infant® or Peptac®, either "as required" or regularly to ease the cessation of ranitidine if symptoms are uncontrolled.
    c) If concerned that a straight withdrawal will not be possible, introduce omeprazole first then withdraw the ranitidine as above.
    d) Omeprazole MUPS® is the preparation of choice.
    Use dose increments of 5mg (with 5mg being the smallest accurately measurable dose) for children under 2 years to a maximum daily dose of 3mg/kg/day in 1-2 divided doses (max 20mg/day).
    For children over 2 years follow LJF dosing guidelines.

2. **Patients on Ranitidine and a PPI (including those with nasogastric/gastrostomy tubes)**

    a) Try stopping the ranitidine as in 1a) above.
    b) If not possible to stop ranitidine, review whether the omeprazole dose been maximised or stepped up to the next highest practical dose according to 1d). This may allow a gradual withdrawal of ranitidine, after which assess if the omeprazole may be reduced over the next weeks to months to keep symptoms under control.

3. **Patients on Ranitidine (with any type of jejunal tubes) OR those with nasogastric/gastrostomy tubes blocked using Omeprazole MUPS® OR those intolerant of Omeprazole MUPS®**

    a) Those patients transferred to omeprazole but having difficulty with MUPS® tolerance or having tube blockage problems OR those patients with jejunal tubes, should switch to esomeprazole granules.
    b) Children under 1 year: 0.5mg/kg once daily to a maximum of 1.33mg/kg once daily. Alternatively dose incrementally as follows: 3-5kg = 2.5mg, >5-7.5kg = 5mg, >7.5kg = 10mg. See BNF-C for dosing guidelines for children over 1 year.

4. **Patients requiring more than a PPI**

    a) For those requiring more than monotherapy with a PPI that has been increased to maximum daily dosage, consider adding domperidone (see LJF for guidance).

5. **Patients on Maximal Therapy**

    a) For those patients on ranitidine and a PPI in whom the withdrawal of ranitidine and the addition of domperidone has proven ineffective or unsuitable, consider cimetidine (200mg/5ml oral solution or 200mg or 400mg tablets) as an alternative.
    b) <1month = 5mg/kg qds, >1month-12years = 5-10mg/kg qds, >12 years 400mg bd up to 400mg qds. Note for the under 12s the total daily dose may be given in 2 divided doses.
    c) NOTE cimetidine solution contains methyl and propyl hydroxybenzoates as preservatives, propylene glycol and maltitol. The drug also interacts with a large number medicines and care should be taken to check for potential interactions before prescribing.

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