CLINICAL STUDY

Physician Preferences and Clinical Experience with Rabeprazole–Domperidone in Acid-Related Disorders: Insights from the Power Physician Survey 3.0 in India

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ABSTRACT

Background: Gastroesophageal reflux disease (GERD) is a common and chronic acid-related disorder that significantly affects quality of life. Proton pump inhibitors (PPIs) remain the cornerstone of therapy, often prescribed in combination with prokinetics such as domperidone to enhance symptomatic relief. This survey aimed to assess physician perceptions, prescribing patterns, and key factors determining the choice of PPI–domperidone combinations in India. **Methods:** A cross-sectional, perception-based digital survey (Power Physician Survey 3.0) was conducted among 3,260 physicians across India. A structured questionnaire captured information on patient load, preferred treatment strategies, time to symptom relief, recurrence rates, and factors guiding the selection of specific PPI–domperidone combinations. Responses were analyzed using descriptive statistics. **Results:** Over half of the respondents (51.6%) preferred prescribing a PPI–domperidone combination rather than PPI monotherapy. The rabeprazole–domperidone (RD) combination emerged as the most preferred regimen (80.1%), primarily for its rapid acid inhibition (46.6%), better tolerability (18.3%), and cost-effectiveness (13%). About half of the physicians observed symptomatic relief within 2 to 3 days (50.6%), with 82.8% perceiving lower recurrence rates and 88.7% reporting improved patient adherence. On preference ranking, RD was selected as the first choice by 80.1% of physicians, followed by pantoprazole–domperidone (10.4%), omeprazole–domperidone (4.8%), and esomeprazole–domperidone (4.7%). The combination was also rated most effective for night-time heartburn (90%) and preferred for patients with comorbidities (86.3%). **Conclusion:** The findings highlight a strong real-world preference for the RD combination in GERD management, driven by its rapid action, safety, and patient-centered benefits including improved adherence, symptom control, and reduced recurrence. These insights emphasize the importance of balancing efficacy, tolerability, and affordability in clinical decision-making for acid-related disorders in India.

Keywords: Gastroesophageal reflux disease, proton pump inhibitors, real-world evidence, physician perception, domperidone-based combinations

Gastroesophageal reflux disease (GERD) is a prevalent disorder characterized by the reflux of gastric contents into the esophagus, leading to symptoms or complications. Worldwide, about 783.95 million people suffer from GERD[1]. In India, 5% to 28.5% people suffer from GERD according to a population-based study. GERD is a chronic disease with the potential to cause complications such as peptic stricture, Barrett's esophagus, and esophageal adenocarcinoma. It also negatively impacts quality of life in multiple domains. While obesity, smoking, and sedentary behavior are recognized risk factors, genetic determinants may act as additional contributors to disease susceptibility[2].

Proton pump inhibitors (PPIs) have been the foundation of GERD therapy due to their effectiveness in suppressing acid secretion; however, many patients experience persistent symptoms despite appropriate treatment, a condition recognized as PPI-refractory

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GERD. Emerging approaches to GERD management such as potassium-competitive acid blockers like vonoprazan, and prokinetic medications including itopride are being investigated for their capacity to improve symptoms by facilitating motility and accelerating gastric emptying[3].

Inadequate lifestyle changes and poor adherence to therapy can exacerbate symptoms and adversely impact quality of life[4]. Other challenge with managing GERD is that the reflux-like symptoms are nonspecific making it difficult to diagnose GERD. Persistent symptoms do not always indicate inadequate reflux control, and intensifying antireflux therapy may not necessarily provide relief. Considerable uncertainty remains regarding the evaluation of patients with ongoing symptoms, including differentiation between refractory GERD, functional heartburn, esophageal hypersensitivity, and motility disorders. Likewise, treatment decisions remain unclear depending on whether symptoms are associated with persistent reflux, absence of reflux, or non-acid reflux[5].

Although clinical guidelines are available, studies report widespread inappropriate use of PPIs. These drugs are often prescribed alongside nonsteroidal anti-inflammatory drugs (NSAIDs) even when no additional risk factors are present, leading to unnecessary costs and a higher likelihood of adverse effects. While short-term PPI therapy is generally safe, prolonged use has been linked to increased risks such as infections, osteoporosis, fractures, bone marrow suppression, community-acquired pneumonia, and *Clostridium difficile*-associated diarrhea[6]. Hence, awareness amongst the health care professionals regarding the management of GERD is crucial. In view of this, the present survey aims to evaluate knowledge and practices among health care professionals regarding the management of GERD. The survey seeks to identify gaps, enhance awareness, and encourage adherence to best practices, thereby supporting more coordinated and effective GERD management to improve patient outcomes.

METHODS

Study Design

This study was a perception-based survey (Power Physician Survey 3.0) conducted digitally between June and August 2025 among physicians in India.

Participants

A total of 3,260 physicians and gastroenterologists participated in the survey, representing diverse clinical specialties and practice settings. The group reflected health practitioners working in both urban and semi-urban areas, offering a well-rounded view of real-world clinical practice.

Measurement Tools and Data Collection

A structured electronic case report form (eCRF) was designed to capture physician preferences, prescribing patterns, and clinical experiences with different PPI–domperidone combinations in the management of GERD. The questionnaire included multiple-choice questions, covering domains such as patient volume, preferred therapeutic approach, indications for specific combinations, time to symptom relief, recurrence rates, and factors influencing prescribing decisions.

The questionnaire was distributed electronically through a secure online platform, allowing physicians to respond at their convenience within the predefined study period. Participation was voluntary, and informed consent was obtained electronically from all respondents prior to survey initiation. Responses were recorded anonymously to minimize reporting bias. Only fully completed questionnaires were included in the final analysis. Data were collated automatically through the survey platform using a Google form and exported for analysis.

Data Analysis

Responses were automatically compiled in a spreadsheet, and descriptive statistics, including counts and percentages, were used to summarize physician responses. Since the data were entered directly in the Google form, percentages were calculated automatically based on response frequencies, without additional statistical testing.

RESULTS

Demographics of Participants

A total of 3,260 physicians participated in the survey, yielding 3,259 valid responses. One response was excluded due to incomplete data. Region-wide distribution showed higher participation of doctors from Kolkata (n = 334), Patna (n = 302), Pune (n = 300), Hyderabad (n = 287), and Lucknow (n = 278), indicating broad geographic coverage across major zones.

Analysis of Physician Responses

Average weekly patient consultations: On average, most physicians reported consulting fewer than 10 patients with acid-related disorders in a typical week (42.3%),

while another 38.5% attended to 10 to 30 patients. Only a minority reported higher caseloads, with 14.8% managing 30 to 50 patients and 4.3% treating more than 50 patients per week (Fig. 1).

Preferred treatment approach: When asked about the preferred therapeutic approach, nearly half of the respondents (48.4%) opted for monotherapy with a PPI, while a slightly higher proportion (51.6%) preferred prescribing a combination of PPI with domperidone. The combinations suggested were rabeprazole + domperidone (RD), pantoprazole + domperidone, omeprazole + domperidone and esomeprazole + domperidone.

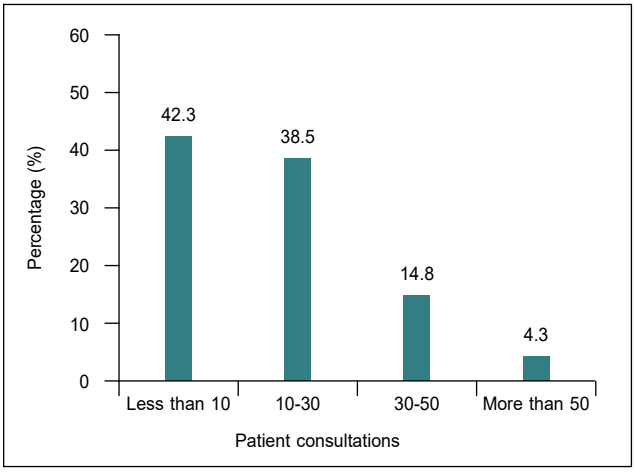

Figure 1. Graph representing average patient consultations in the physicians practice.

Factors influencing preferred choice of PPI–Domperidone combination: Among the key factors influencing the choice of a specific PPI–domperidone combination, rapid inhibition of gastric acid and faster symptomatic relief emerged as the most decisive criterion, reported by nearly half of the physicians (46.6%). Other influential considerations included a lower side-effect profile (18.3%) and the combination of fast action with favorable tolerability and cost-effectiveness (over 13% of responses) (Fig. 2).

Physician ranking of preferred PPI + domperidone combinations: RD was ranked as the most preferred combination by 80.1% of physicians, followed by pantoprazole + domperidone (10.4%), omeprazole + domperidone (4.8%), and esomeprazole + domperidone (4.7%).

Preferred indication for RD: Regarding indications, RD was most frequently preferred for GERD (43.8%) and gastritis (38.4%), followed by dyspepsia (9.6%) and acid peptic disease (6.4%) (Fig. 3).

Time to symptomatic relief with RD: Physicians observed that patients typically experienced symptomatic relief from GERD within 2 to 3 days of initiating RD therapy (50.6%), while an additional 36.9% reported noticeable improvement within 3 to 4 days (Fig. 4).

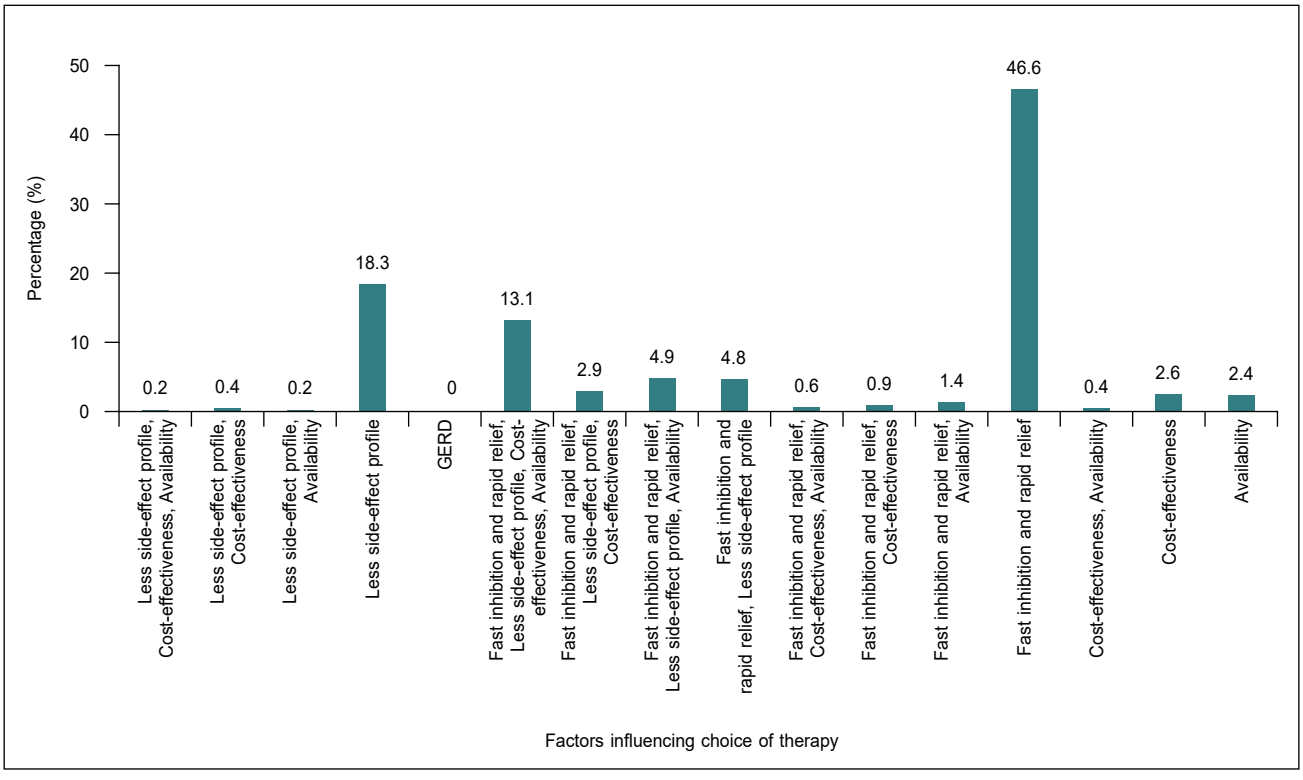

Figure 2. Graphical representation of factors influencing choice of PPI–domperidone combination.

Recurrence rate of acid-related symptoms: A striking majority (82.8%) perceived that RD was associated with a lower recurrence rate of acid-related symptoms compared to other PPI–domperidone combinations. In contrast, only 8.1% favored pantoprazole–domperidone, while esomeprazole- and omeprazole-based combinations were rarely cited.

Key prescribing parameters for RD vs. pantoprazole + domperidone: In terms of prescribing drivers, 64.2% of physicians reported choosing RD primarily for its ability to achieve the fastest acid inhibition within 5 minutes. Sustained relief for 24 hours was the next most common rationale (12.9%), followed by fewer drug–drug interactions (10.3%) and efficacy regardless of food intake (8.8%) (Fig. 5).

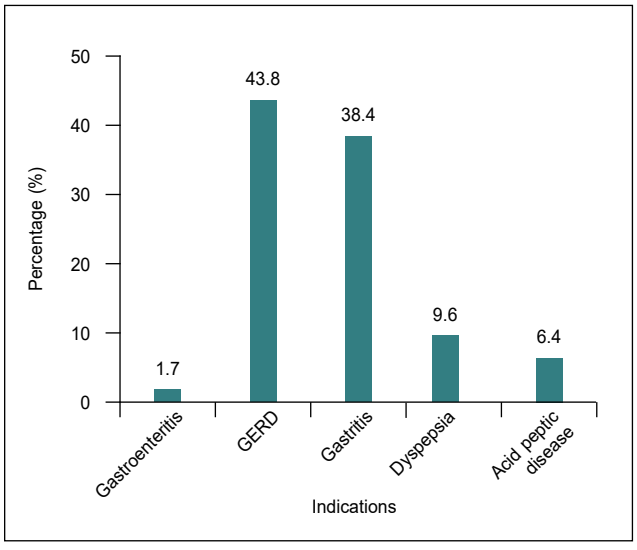

Figure 3. Preference of rabeprazole + domperidone in various indications.

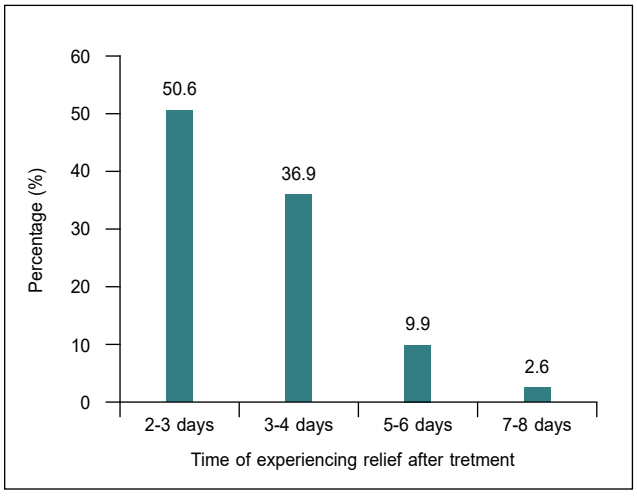

Figure 4. Graphical representation of time to symptomatic relief with rabeprazole + domperidone combination.

Longer action in managing night-time heartburn: When asked about efficacy in managing night-time heartburn in GERD, a substantial 90% of respondents endorsed RD as the most effective, with pantoprazole–domperidone (5.8%) trailing far behind (Fig. 6).

Preferred combination for patients with comorbidities: Similar preferences were expressed for special populations: 86.3% considered RD the most suitable for patients with comorbidities such as diabetes and hypertension (Fig. 7).

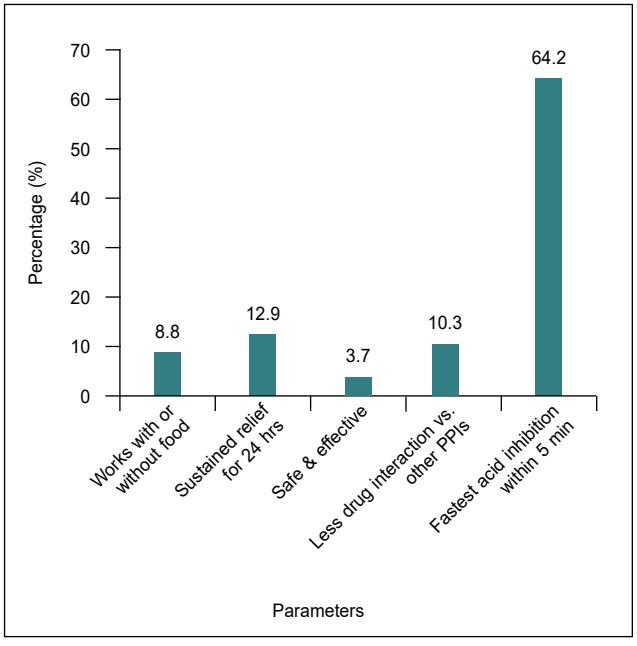

Figure 5. Graphical representation of parameters for prescribing rabeprazole + domperidone combination.

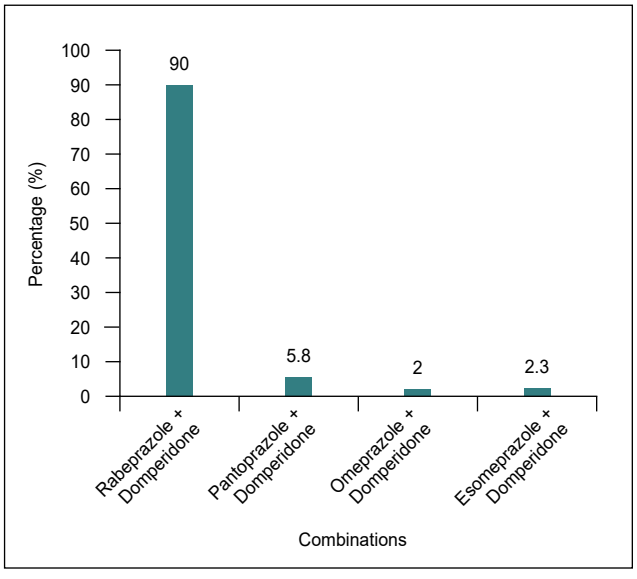

Figure 6. Clinician's opinion on the efficacy of different drug combinations for longer night-time action.

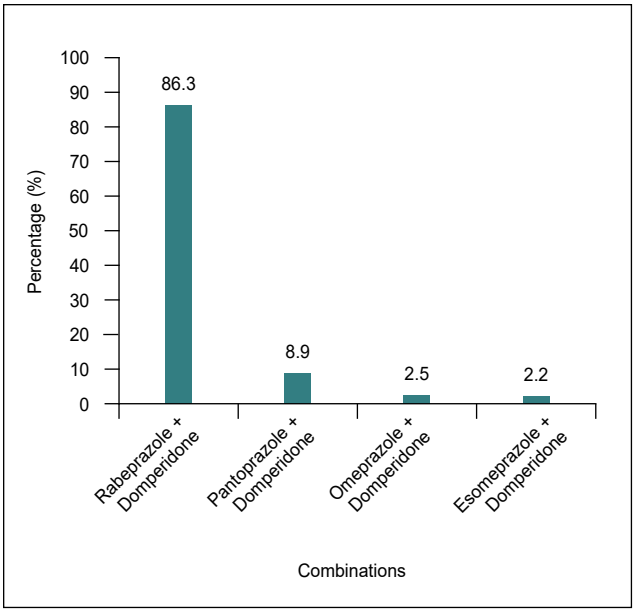

Figure 7. Graphical representation of choice of PPI in diabetes and hypertension patients.

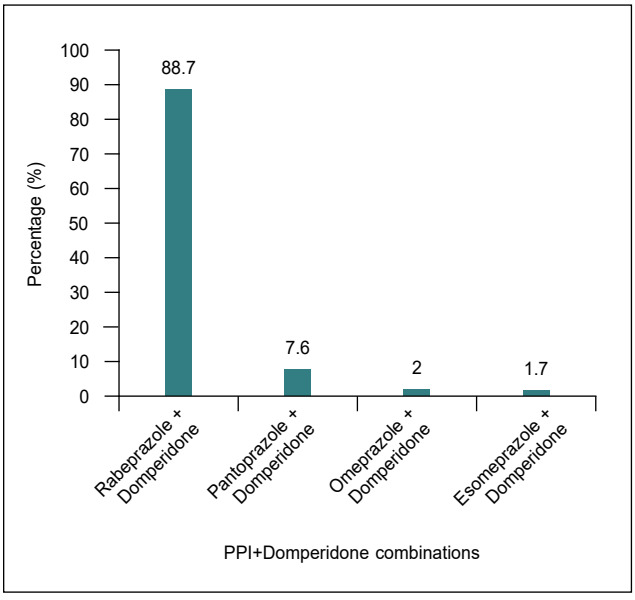

Figure 8. Patient adherence and compliance for different PPI–domperidone combinations.

Patient adherence and compliance: Finally, patient adherence and compliance were also rated highest for RD, with 88.7% of physicians indicating better tolerability and compliance compared to pantoprazole (7.6%) or other PPI combinations (<2%) (Fig. 8).

DISCUSSION

The present survey highlights a strong physician preference for the RD combination in the management of acid-related disorders.

Most clinicians reported seeing fewer than 30 patients with such conditions per week (80.8%), suggesting that perceptions are shaped primarily by day-to-day practice in general outpatient settings rather than high-volume gastroenterology clinics. Despite this, more than half of the respondents (51.6%) favored prescribing combination of PPI with domperidone over PPI monotherapy (48.4%), highlighting the perceived clinical value of combining acid suppression with a prokinetic agent. This is supported by a recent systematic review and meta-analysis, which demonstrated that PPI plus domperidone provided superior symptom control in GERD compared to PPI monotherapy, with no significant increase in adverse events[7]. In another cross-sectional study, around 32% of clinicians reported prescribing PPIs and PPI-based combination therapies to patients with acid reflux as well as to those with GERD, with domperidone being the most commonly preferred prokinetic agent in combination with PPIs[8].

Rapid inhibition of gastric acid emerged as the most significant factor influencing prescription of RD, cited by 46.6% of physicians, followed by its favorable tolerability and sustained symptom relief. These findings are consistent with pharmacodynamic studies showing that rabeprazole achieves faster onset of acid suppression than other PPIs, demonstrating a faster onset of acid suppression than other PPIs due to its higher pKa and rapid activation, reaching near-maximal proton pump inhibition within about 5 minutes in experimental models, compared with approximately 30 minutes for omeprazole and lansoprazole and only partial inhibition even after 50 minutes for pantoprazole[9].

Miner et al also reported that rabeprazole maintained a significantly higher mean intragastric pH than pantoprazole over a 24-hour period, including both daytime and night-time phases[10]. Similarly, Wang et al found that rabeprazole exerted greater control over nocturnal intragastric acidity and acid output from the very first dose[11]. Such evidence provides a strong rationale for physicians' emphasis on rapid onset action as a decisive factor.

The favorable safety and tolerability profile of the PPI–domperidone combination was another major factor influencing the preference for RD, as reported by 18.3% of respondents. Domperidone is widely regarded as a gastroprokinetic with a favorable safety profile compared with metoclopramide, owing to its minimal central nervous system penetration and lower risk of extrapyramidal reactions[12]. This explains physicians' inclination toward combinations that balance rapid action with lower side effects. Furthermore,

cost-effectiveness and availability, reported by around 13% of respondents–when combined with efficacy and safety considerations, reflect the practical constraints and prescribing realities in the Indian clinical setting. A study by Desai et al similarly found that Indian physicians primarily choose PPIs based on their cost and the specific clinical indication[13]. GERD and gastritis were the leading indications for which RD was preferred over pantoprazole–domperidone, accounting for 43.8% and 38.4% of responses, respectively. This is similar to an Indian cross-sectional study by Manjula et al, which showed that physicians preferred RD for treating GERD[14]. Another key survey finding was that RD is perceived to have a lower recurrence rate of acid-related symptoms compared to other PPI–domperidone combinations as reported by 82.8% of physicians. A study suggested that rabeprazole inhibits gastric acid secretion in a manner proportional to the dose administered[15]. This explains why physicians favored RD for patients with comorbidities such as diabetes and hypertension (86.3%), where managing polypharmacy and adherence are critical concerns.

RD emerged as the most preferred combination for GERD management, chosen by 80.1% of participating physicians, followed by pantoprazole + domperidone (10.4%), omeprazole + domperidone (4.8%), and esomeprazole + domperidone (4.7%). This pattern is consistent with findings from recent clinician surveys in India, which also highlight a strong inclination toward rabeprazole-based regimens. In one multicenter survey of 269 clinicians, about 89% reported prescribing the RD combination routinely, noting faster symptom relief and better patient outcomes compared with other PPIs[16]. The study by Manjula et al showed that 95.65% preferred this combination for managing nocturnal heartburn and incomplete symptom relief[14].

Night-time heartburn, a common unmet need in GERD management, was another domain where RD was perceived to provide superior benefit. Indeed, 90% of respondents endorsed RD as the most effective in controlling nocturnal symptoms, which is similar to the results of a cross-sectional study by Manjula et al, where 95.65% of clinicians reported preferring the rabeprazole–domperidone combination for the management of night-time heartburn in patients with GERD[8]. Rabeprazole has consistently demonstrated higher efficacy than pantoprazole in controlling nocturnal acid breakthrough and maintaining intragastric pH above 4 throughout the night[10,11]. This pharmacological advantage is clinically relevant, as nocturnal reflux is strongly associated with impaired sleep quality and reduced quality of life. Improved tolerability and patient compliance with RD, as reported by nearly 89% of respondents, further reinforces its clinical utility. Faster symptom relief, fewer breakthrough symptoms, and better tolerability are well-recognized drivers of adherence[7,17].

STUDY LIMITATIONS

This perception-based digital survey relied on self-reported information, which may not fully reflect actual prescribing patterns. Some of the observed differences in the data may also reflect response bias, as all findings were based on subjective perceptions rather than validated clinical records. As a cross-sectional survey, results capture physician opinions at a single time point and may not reflect evolving practice trends.

CONCLUSION

The Power Physician Survey 3.0 highlighted a clear physician preference for the RD combination in the management of acid-related disorders. These findings indicate that Indian clinicians prioritize speed of relief, safety, and sustained efficacy when selecting therapy. RD appears to best fulfill these expectations, supporting its continued clinical relevance in optimizing GERD outcomes. Beyond its pharmacological advantages, RD is valued for its patient-centered benefits, including faster relief, reduced symptom recurrence, and improved adherence, supporting its continued clinical relevance in optimizing GERD outcomes.

However, most of the supporting evidence is limited to short-term studies, and robust long-term randomized trials comparing RD with other PPI–prokinetic combinations are lacking. Future studies should evaluate recurrence rates, safety in comorbid populations, and patient-reported outcomes over extended treatment durations.

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