Gout

A summary based on NICE guidance (NICE 2022, NG219)

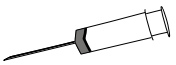
Red Whale
GEMS
Guidelines & Evidence Made Simple

Diagnosis and investigations

Suspect gout: Rapid-onset (often overnight) severe pain, redness and swelling in one or both 1st **metatarsophalangeal (MTP) joints** OR **presence of tophi.**

Consider gout: Rapid-onset severe pain, redness and swelling in joints **other than 1st MTP joint** OR in those with **chronic inflammatory joint pain.**

Differentials: SEPTIC ARTHRITIS (admit!), pseudogout, other inflammatory arthritis.



Measure serum uric acid (SUA) in people you consider or suspect to have gout.

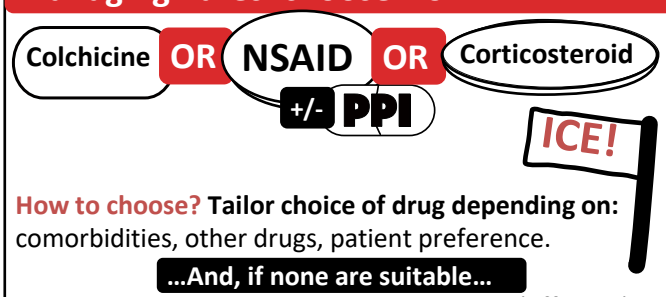
If SUA ≥360micromol/l, this confirms the clinical diagnosis.

If SUA <360micromol/l and gout strongly suspected, repeat at least 2 weeks *after the flare has settled*.

Diagnosis uncertain? Consider joint aspiration (with microscopy of aspirate), or consider imaging with Xray, ultrasound or dual-energy CT if aspiration cannot be carried out**.**

At Red Whale, we would also do U&E, lipids, HbA1c and LFT if no recent results (see full Gout article).

Managing flares: choose from:



How to choose? Tailor choice of drug depending on: comorbidities, other drugs, patient preference.

...And, if none are suitable...

Consider intra-articular or IM corticosteroid (off-label).

NICE does not specify specific doses (see BNF).

Give information/support, including:

- Symptoms and signs.
- Causes of gout.
- That gout progresses without treatment.
- Explain/address risk factors (genetics, BMI, drugs, comorbidities, e.g. hypertension or CKD).
- How to manage flares.
- That gout is a lifelong condition benefitting from urate-lowering therapy to eliminate crystals.
- See resources box in main article for a useful leaflet from Versus Arthritis.

Follow-up after flare:

Consider follow-up to:

- Measure urate level.
- Review medications.
- Assess lifestyle and comorbidity: CVD risk & CKD.

- **Do not** recommend *a specific diet.*
- Discuss that excess body weight/obesity, or excess alcohol, may exacerbate gout.
- Discuss pros/cons of **urate-lowering therapies (ULT).**

Urate-lowering therapies (ULT): shared decision and targets

Offer ULT *if: multiple flares, CKD 3–5, diuretic therapy, tophi, chronic gouty arthritis.*

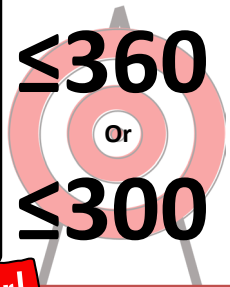
Discuss ULT *after a first attack of gout (if not included in the groups above).*

Explain that ULT is usually a life-long treatment.

When? Start 2–4w after flare settles, but *can be started during a flare* if attacks frequent.

Treat-to-target strategy: aim for SUA ≤360micromol/l for most people; reduce target to ≤300micromol/l if tophi, chronic gouty arthritis or flares despite SUA <360micromol/l.

Check SUA annually once target level achieved.



Choosing a ULT and monitoring

If MAJOR CVD, choose allopurinol, e.g. previous MI, stroke, unstable angina.

If NO major CVD, choose either allopurinol OR febuxostat based on comorbidities/preferences (see BNF for doses – NICE does not specify).

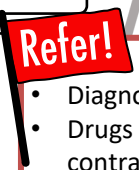
Preventing flares: discuss benefits and risks of taking medication to prevent flares.

First line: colchicine.

Second line: NSAID/low-dose oral corticosteroid (off label) +/- PPI.

Switch agent if target SUA not reached or drug is not tolerated.

Monitoring: monthly SUA to guide dose increases until target is reached. **Annual monitoring** thereafter.



- Diagnostic doubt.
- Drugs contraindicated.
- Drugs not tolerated.
- Drugs ineffective.
- eGFR <45.
- Transplant.
- Considering IL-1 inhibitor.