GOUT INFORMATION FOR HEALTHCARE PROFESSIONALS

MANAGEMENT OF ACUTE GOUT

In a patient with acute gout the following treatment plan should be followed

1. Exclude septic arthritis

2. **Continue allopurinol** if on this already

3. **NSAIDs** at maximum doses are the treatment of choice if no contra-indications

    a. No particular NSAID has benefit over another
    b. In those at risk of GI complications co-prescription of gastro-protective agents should follow standard guidelines
    c. The only COX II inhibitor which is licensed for the treatment of gout is etoricoxib

4. **Colchicine:** 0.5mg bd - qds is an alternative to NSAIDs

    a. No interaction with warfarin
    b. GI side effects at higher doses

5. **Corticosteroids** are an alternative in those where NSAIDs & colchicine are not tolerated or are contraindicated

    a. Oral prednisolone – 20mg od tapered over 1 to 2 weeks
    b. Intra-articular corticosteroids - useful for acute gouty monoarthritis

6. Continue treatment for 1-2 weeks

7. Stop diuretics if only being used for control of BP

8. Consider adjunctive non-pharmacological treatment (topical ice, rest)

9. **Review at 4-6 weeks**

    a. Assess lifestyle factors (diet exercise, alcohol, sugary drinks)
    b. Assess cardiovascular risk (obesity, hypertension, lipids, diabetes mellitus)
    c. Review prescribed medication (diuretics)
    d. Perform serum uric acid (sUA), renal function

WHEN TO START ALLOPURINOL (first line therapy)

1. Indications for allopurinol

    a. Two or more attacks of uncomplicated gout within one year

    b. One attack of gout and one of the following
        i. Gouty tophi
        ii. Renal insufficiency
        iii. Uric acid stones
        iv. Need to continue treatment with diuretics

2. Start allopurinol 1-2 weeks after inflammation has settled

3. The target uric acid is < 300 micromol/l

4. Start allopurinol at 50-100mg od and titrate the dose by 50-100mg (the maximum dose is 900mg od) every 4 weeks until target uric acid reached

5. Colchicine 0.5mg bd should be co-prescribed for 6 months during the initiation of treatment with allopurinol

6. In patients who are unable to take colchicine, NSAIDs are an alternative, but cover should be limited to 6 weeks.

7. Drug interactions
    a. Azathioprine should not be given with allopurinol.
    b. Ampicillin may augment the allergic rash of allopurinol.
    c. Warfarin - monitor INR closely as this may become elevated.

8. **Second line therapy**
    a. Consider if inability to tolerate allopurinol , renal function prevents sufficient dose escalation, or target uric acid not reached despite dose escalation
        i. Switch to febuxostat 80mg daily if no contraindications (e.g ischaemic heart disease)
        ii. If target sUA not reached increase dose to 120mg daily after 4 weeks
    b. Refer to rheumatology if considering switch to or addition of Sulfinpyrazone, Probenacid or Benzbromarone in cases of failure to achieve target sUA or drug intolerance.

MONITORING

Serum urate } Every 4 weeks until urate < 0.3 mmol/
Then every 3 months for 1 year
Then annually