Management of Gout –

D & G Guidance for Health Professionals

Acute Management

- Fast-acting oral **NSAIDs** at maximum doses are drug of choice eg diclofenac 50 mg tds, or Etoricoxib 120 mg daily, unless contraindicated.
- Co-prescription of gastro-protective agents should follow standard guidelines for the use of NSAIDs and **Coxibs** if increased risk of peptic ulcers, bleeds or perforations.
- **Colchicine** is an alternative but much slower to work. 1mg stat, then 0.5 mg tds until the attack resolves. More frequent dosing is poorly tolerated. Reduce the dose if diarrhoea occurs.
- Intra-articular **corticosteroids** are highly effective in acute gouty monoarthritis and I.A., oral, I.M. or I.V. corticosteroids can be effective in patients unable to tolerate NSAIDs or refractory to other treatments.
- **Allopurinol** should not be commenced during an acute attack but in patients already established on allopurinol, it should be continued and the acute attack treated conventionally as above.
- **Opiate** analgesics can be used as adjuncts.
- Rest, cold packs and splintage can be helpful.

Referral to Rheumatology

Refer as new patient or refer back if –

- Diagnostic uncertainty.
- Chronic arthritis.
- True intolerance of allopurinol.
- Unable to reach target SUA of 0.3 mmol/l despite maximum or maximum tolerated doses of allopurinol.

Contacts for Advise

- Rheumatology helpline – 01387 241095
- anne.drever@nhs.net , l.maggiori@nhs.net or mike.mcmahon@nhs.net
- Full BSR guideline can be found at www.rheumatology.org

Prophylaxis

- Aim to maintain serum uric acid (SUA) below 0.30 mmol/l.
- Uric acid lowering drug therapy should be started if a second attack occurs within 1 yr and in patients with tophi, uric acid stones or who need to continue treatment with diuretics.
- Delay starting uric acid-**lowering** drug therapy until 1-2 weeks after inflammation has settled.
- **Allopurinol** starting in a dose of 50-100 mg/day is drug of choice. Increase by 50-100 mg increments every few weeks, adjusted for renal function (see BNF), until the therapeutic target is reached (maximum dose 900 mg). See note 1 below.
- **Febuxostat** has been approved by NICE for people who are intolerant or have contraindication to allopurinol. Recommended starting dose of 80mg per day. For those with SUA of 0.36mmol/l after 2-4 weeks can consider increasing to 120mg per day. No dose adjustment required in renal impairment. Available in the UK from March 2010. SMC appraisal awaited.
- Uricosuric agents can be used as second-line drugs in patients who are under-excretors of uric acid and in those resistant to, or intolerant of, allopurinol. The preferred drugs are **sulphinpyrazone** (200-800 mg/day) in patients with normal renal function or **benzbromarone** (50-200 mg/day) in patients with mild/moderate renal insufficiency.
- **Colchicine** 0.5 mg bd should be co-prescribed following initiation of treatment with allopurinol or uricosuric drugs, and continued for up to 6 months. In patients who cannot tolerate colchicine, an **NSAID** or **Coxib** can be substituted provided that there are no contraindications, but the duration of NSAID or Coxib cover should be limited to 6 weeks

Notes-

1. If normal renal function suggest commencing allopurinol at 100mg per day, increasing by 100mg per month then checking renal function and SUA at 3 months. If elevated SUA at baseline it is likely at least 300mg per day will be required to reach target.
2. **Aspirin** in low doses (75-150 mg/day) has insignificant effects on the plasma urate, and should be used as required for cardiovascular prophylaxis. However, aspirin in analgesic doses (600-2400 mg/day) interferes with uric acid excretion and should be avoided.