

DIAGNOSIS AND MANAGEMENT OF GOUT

Gout is the most common form of inflammatory arthritis and affects around 2.5% of adults in the UK. This bulletin summarises current guidelines on the diagnosis and management of gout, along with findings from recent research with gout patients. More detailed information can be found in a new 'gout' section on www.healthtalk.org.



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Gout Diagnosis

Clinical diagnosis is relatively straightforward when classic features such as sudden onset of severe joint pain, swelling, tenderness and erythema affect the first metatarsophalangeal (MTP) joint. When these features are not present, or joints other than the first MTP joint are affected, definitive diagnosis requires confirmation of the presence of monosodium urate (MSU) crystals in synovial fluid or tophi. Serum uric acid (SUA) levels should not be used to confirm or refute a suspected gout diagnosis. Previous research suggests that up to 26% of clinical diagnoses of gout are incorrect.

Knowing about other people's experiences can help patients to ask questions and make decisions about their own care.

www.healthtalk.org provides information on peoples' experiences of gout.

Key findings and recommendations to improve gout diagnosis

Our research shows that the limitations in using SUA levels for diagnostic purposes are generally not communicated effectively to patients.

Recommendation: Communicating this information to patients will help to prevent and/or correct false beliefs.

Delays to diagnosis more often occur for women and those presenting with attacks in joints other than the first MTP joint. Gout is not uncommon in women, and patients may present with gout in joints other than the first MTP joint, such as the midfoot, knee, ankle, wrist, elbow and small joints of the hands.

Recommendation: If classical symptoms are reported, and the patient does not recall physical injury, then gout should be considered as a potential diagnosis.

A diagnosis of gout is often surprising to patients, and can be particularly distressing for women because of perceptions that it is a male condition. Men and women may be concerned about other people's perceptions of gout being caused by 'rich living'.

Recommendation: Increased sensitivity in communicating the diagnosis (including dispelling myths about it being a male condition) will help to reduce any negative psychological impacts.

Patients often believe that their lifestyle choices have caused gout, whereas genetic factors, comorbid medical conditions and medications are also important. Patients often make extensive changes to their diets, regardless of whether these are scientifically proven and/or have been recommended by their GP.

Recommendation: Diagnosis provides an opportunity to emphasise: a) the chronic nature of the condition; b) that the causes are not always lifestyle-related; and c) that the patient should return to discuss long-term treatment.

Gout Management

Gout is one of the most treatable rheumatological conditions. In addition to the treatment of acute attacks to reduce pain and inflammation, current international guidelines encourage urate-lowering therapy (ULT) for patients who have two or more acute attacks of gout, tophi, renal stones, radiological damage or impaired renal function. Long-term management of gout is often suboptimal, with many patients experiencing recurrent gout attacks that are preventable.

ULT (e.g. allopurinol) should be prescribed and titrated according to serum uric acid (SUA) levels to achieve and maintain a target SUA of $\leq 360 \mu\text{mol/l}$. Monitoring of SUA and up-titration of ULT to achieve this target are not performed in most patients. Only around 30% of patients with gout are prescribed ULT. Less than half of these patients adhere to treatment, and up to 70% have gaps in taking ULT – the majority within the first year of treatment.



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Key findings and recommendations to improve gout management

Patients often perceive gout as an intermittent disease and do not understand the need for ULT to prevent long-term joint damage. Many patients believe that diet can be as effective as medication, but most patients are not able to reduce SUA levels enough without medication.

Recommendation: ULT should be discussed with all patients with a diagnosis of gout, emphasising that it is a chronic condition. A clear explanation of the purpose of ULT will improve adherence.

Patients may not return to the GP after their first attack, choosing to self-treat subsequent attacks.

Recommendation: Patients should be advised that the treatment of acute attacks is not sufficient as a long-term strategy. They should be advised to return if they experience subsequent attacks.

Patients are often concerned about potential adverse effects of taking long-term medication.

Recommendation: Being informed about plans for regular monitoring (e.g. SUA, kidney and liver function) can reassure patients and improve

adherence. Monthly blood tests are needed after starting ULT to check SUA levels. If levels are above the target, the dose of allopurinol should be increased gradually. Once target SUA levels are reached, blood tests should be done every 1-2 years to check that target levels are being maintained.

Patients can stop taking ULT because of various reasons including: not noticing immediate impacts on attack frequency; frustration with the titration process; and experiencing a ULT induced attack.

Recommendation: Patients should be informed about how the titration process works, and that it can take up to 2 years for crystals to be completely cleared from the body so they may continue to have attacks initially. Patients should be advised that initiating ULT can trigger a gout attack, but that they should not stop taking medication if this occurs.

Patients' views about ULT treatment can become more positive over time and with increasing knowledge of the condition.

Recommendation: Opportunities to revisit and discuss patients' initial decisions not to take long-term treatment should be utilised whenever possible.