bpacnz PRIMARY CARE UPDATE SERIES

GOUT:
WHAT'S IN AND WHAT'S OUT

Delayed initiation and non-adherence to urate-lowering treatment (ULT) continues to be the most significant obstacle to effective gout management, with many patients instead focusing on self-management using medicines that relieve pain and inflammation only when flares occur. While gout can never truly be "cured", appropriate and timely use of ULT – alongside strict adherence to treatment targets – can prevent flares from occurring and essentially eliminate its impact on daily life in most patients.

Key practice points:

- Non-steroidal anti-inflammatory drugs (e.g. naproxen), corticosteroids (e.g. prednisone), or low-dose colchicine are all considered to be equally effective for treating gout flares – the choice of medicine depends on the patient's preference, safety, co-morbidities and other medicine use
- Following the first flare, lifestyle changes are important but alone are insufficient for the management of gout; long-term adherence to urate-lowering treatment (ULT) is ultimately required to prevent additional flares, along with ongoing management of cardiovascular risk factors
- The role of ULT should be discussed at the first presentation of gout and if there is an immediate clinical need, then ULT can be initiated even during a flare in some patients
- Allopurinol is the first line ULT and probenecid can be used second-line (either as monotherapy or in combination with allopurinol)
  - Febuxostat or benzbromarone* can be considered as alternative medicines for ULT if allopurinol and/or probenecid is ineffective or intolerable; however, these medicines are associated with cardiovascular and hepatotoxic adverse effects and patients must meet Special Authority criteria for funding
- Medicines for flare prophylaxis should usually be used for at least six months when initiating urate-lowering treatment (longer if symptoms continue), i.e. naproxen or very low dose colchicine†
- A serum urate level of < 0.36 mmol/L should be aimed for (or < 0.30 mmol/L if tophi are present) to prevent the formation of urate crystal deposits and to dissolve currently existing ones
  - By starting ULT at a low-dose and up-titrating gradually every four weeks as needed while monitoring serum urate levels, the risk of adverse effects with allopurinol and other urate lowering medicines is reduced
- A review of serum urate levels, renal function and co-morbidities should take place at least every 6–12 months once serum urate targets have been reached or after a flare
- There is insufficient evidence to support the use of ULT for patients with asymptomatic hyperuricaemia (>0.36 mmol/L)

* As of May 2020, benzbromarone is out of stock at a wholesaler level in New Zealand, and PHARMAC has advised that it will likely delist this ULT from the Pharmaceutical schedule (no date is currently set)

† In some cases, stopping prophylaxis may be considered within three to six months of starting ULT, e.g. if the patient has not experienced any subsequent flares and urate levels have reduced significantly