Trends in primary care theme: Gout

The following questions can be used as discussion points for peer groups or self-reflection of practice. The questions for this peer group discussion relate to a two-part series on managing gout in primary care from the recent "Trends in primary care" theme. It is strongly recommended that the linked articles are read before considering the questions.

Managing gout in primary care

Part 1 – Talking about gout: time for a re-think **www.bpac.org.nz/2018/gout-part1.aspx**

Part 2 – Controlling gout with long-term urate-lowering treatment **www.bpac.org.nz/2018/gout-part2.aspx**

Gout and CV outcomes – Gout is much more than an intensely painful condition. People with gout are more likely than those without gout to die at a younger age due to cardiovascular and renal complications. In New Zealand, 40% of people with gout have diabetes and/or cardiovascular disease. Despite this, many patients consider gout to be a condition that merely requires analgesics to control and are not aware of the potential long-term consequences.

Disparities exist – Māori and Pacific peoples are disproportionately affected by gout and often receive sub-optimal care. Gout is more frequent and more severe in Māori and Pacific peoples and they are not receiving the medicines they need to manage their health effectively.

Delaying initiation – Urate-lowering treatment is often delayed well beyond the point when it is indicated. Furthermore, once urate-lowering medicines are started, monitoring is often sub-optimal and many patients will still have serum urate concentrations above recommended levels. The barriers to the early and optimal use of urate-lowering medicines are multi-factorial. The limited time that is available in consultations in primary care and the intermittent nature of gout flares also makes the long-term management of gout difficult.

Urate-lowering treatment and monitoring – Allopurinol is started at a low dose and slowly titrated upwards, to minimise adverse effects, until the patient reaches the target serum urate level. Allopurinol can be safely used in patients who have reduced renal function, with a lower starting dose and slower titration. Dose reductions are not routinely required in patients with declining renal function who are already established on allopurinol. Once allopurinol has been initiated, regular follow-up with serum urate testing is required while the dose of allopurinol is titrated upwards, until the serum urate target is reached.

Monitoring patients with gout – Patients with gout need to be monitored to:

- Ensure serum urate levels are reached and remain below saturation point
- Encourage ongoing treatment adherence
- Manage cardiovascular risk factors
- Treat any co-morbidities that may emerge

Regular exercise and weight loss, where appropriate, should underlie all strategies to prevent the development of diabetes and cardiovascular disease. Patients with gout that is well-controlled with urate-lowering medicines should have at least annual assessments of serum urate, renal function, HbA_{1c} and blood pressure.

1. In your experience do you think that patients understand that gout can have other implications for their future health? Do you find that patients are receptive to this information or just want their pain settled?
2. Were you aware of the extent of the disparities among Māori and Pacific peoples in regards to gout? What strategies, if any, do you have in place in your practice to help address these disparities?
3. Around 50% or less of patients with gout are prescribed urate-lowering medicines such as allopurinol, although statistics vary. Do you find this figure surprising? If so, what do you think are the barriers in your community and your practice that might reduce optimal management of gout?
4. There is increasing evidence that supports initiation of urate-lowering treatment at the time of a flare rather than delaying until the flare has resolved. Have you prescribed allopurinol during a flare? Do you think this will assist with improved management of gout in the longer term?
5. Allopurinol is the first-line urate-lowering medicine, however, there are others available if allopurinol is not tolerated, is contraindicated or targets are not achieved. What is your experience of prescribing urate-lowering medicines other than allopurinol? If you have not prescribed these medicines, has reading this article made you feel more confident to now do so?