MANAGING GOUT IN GENERAL PRACTICE

The majority of patients with gout can be managed in primary care.

Diagnostic tips

- Serum urate may be low or normal in an acute attack
- Gout may be mistaken for infection eg cellulitis
- A high serum urate without symptoms does not mean gout but low purine diet may be appropriate
- (The most typical joints are 1st MTP/lower limb)

Management of acute attacks

- Early **regular** high dose NSAID deg Etorocoxib 90mg od
- Where NSAIDS are contraindicated options include
  - Colchicine – use at a dose of 200µg bd
  - Oral steroid 15mg od for 5-10 days (taper if slow to settle)
  - Intramuscular steroid (Depo-Medrone 120mg) (avoid if on anticoagulation due to haematoma risk)

When to introduce Allopurinol

- Suitable if > 2 attacks per year of tophaceous gout or renal stones
- Patient should be aware this is lifelong
- Advise patient not to stop/start drug
- Warn of risk of flare up when treatment begins
- Wait 4 weeks post attack
- Continue prophylaxis (NSAID/Colchicine) for 1 month before and 3-6 months after starting Allopurinol
- Intramuscular steroid can be given prior to Allopurinol initiation
- Always advise patient to stop the drug if they develop a rash
- Start dose low eg 100mg od/alternate day and titrate up by 100mg every 4-6 weeks. Doses of up to 600mg or more can be appropriate
- Aim of treatment is to reduce serum urate , 0.30
- The level should be measured 6 weekly to monitor response

Alternatives in Allopurinol allergy

- Febuxostat 80mg od (NICE approval)
- Similar starting regime to Allopurinol
- (Cautious in severe renal impairment
  - Cardiovascular disease
  - Liver disease

**General Advice**

- Low purine diet
- Alcohol intake reduction
- Weight loss

Always review relevant CVS risk factors Refer back to Trust in difficult cases