Gout treatment guidelines uk

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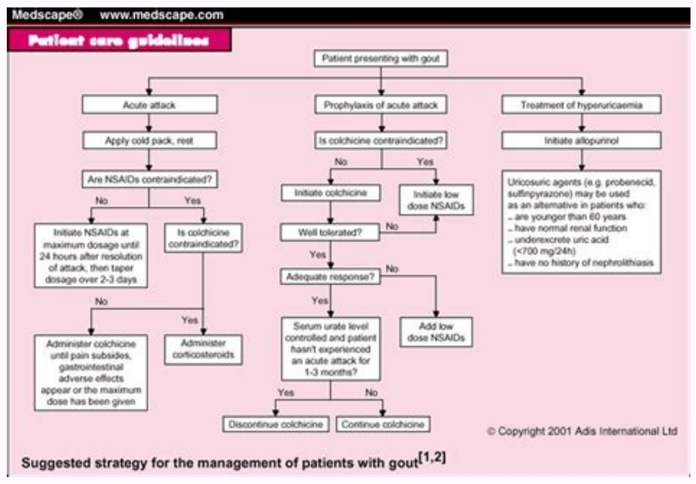
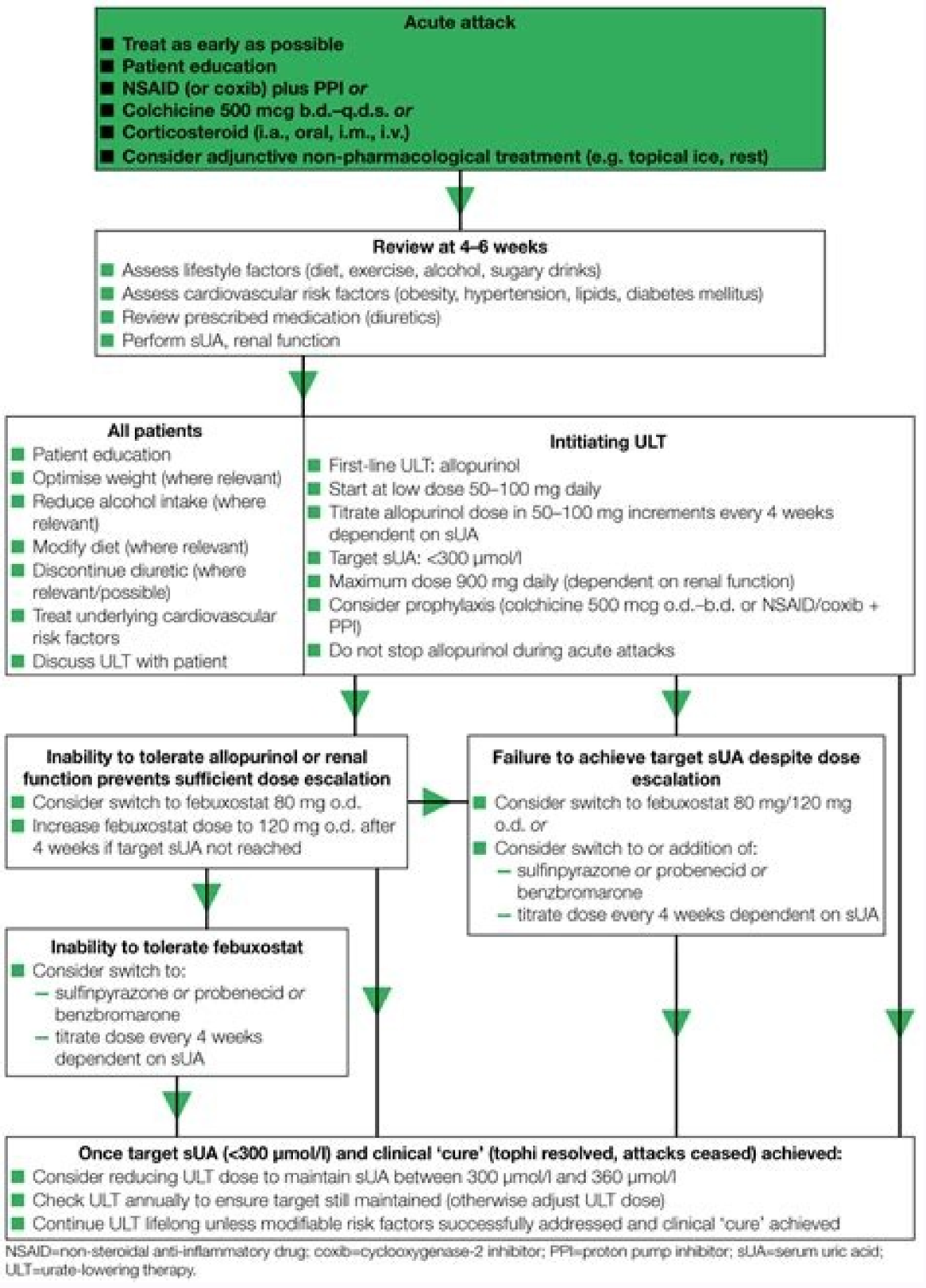
Acute Gout Management			
Drug	Dose	Common AE	SAE
NSAIDs	Indocin* 150 mg/d taper 5-7d	GI toxicity, CNS, HTN, ↑LFTs	PUD, renal dz bleeding, allerxn
COX-2 inhibitors	Per PDR qd or bid	?less GI toxicity? RenalHTN,edem	PUD, renal, MI, CVA
Colchicine	1.2 mg po then 0.6 q1-2h (not to exceed 8mg)	Diarrhea, N/V, abdominal pains	Neuromyopathy, ARF, BM suppression
Cortico-steroids	IA Methylpred 10-40 mg PO:30-60 qd	HTN, ↑BS, fluid retention, insomnia	Risk of infection osteoporosis
ACTH	40-80 IU IM q 6-12h	HTN, ↑BS, fluid retention, insomn	Risk of infection osteoporosis

* or equivalent antiinflammatory dose



Suggested strategy for the management of patients with gout[1,2]



NSAID=non-steroidal anti-inflammatory drug; coxib=cyclooxygenase-2 inhibitor; PPI=proton pump inhibitor; sUA=serum uric acid; ULT=urate-lowering therapy.

* Patient education on nonpharmacologic measures is fundamental.

* XOI treatment is first-line ULT in gout to achieve a serum urate level <6 mg/dL.

* An attack of acute gouty arthritis should be treated pharmacologically within 24 hours of onset with NSAIDs, corticosteroids, or oral colchicine.

* Pharmacologic prophylaxis against gout attacks is recommended when pharmacologic ULT is initiated.

Recommendation	PICO question	Certainty of evidence
For patients experiencing a gout flare, we strongly recommend using oral colchicine, NSAIDs, or glucocorticoids (oral, intraarticular, or intramuscular) as appropriate first-line therapy for gout flares over IL-1 inhibitors or ACTH (the choice of colchicine, NSAIDs, or glucocorticoids should be made based on patient factors and preferences). When colchicine is the chosen agent, we strongly recommend low-dose colchicine over high-dose colchicine given its similar efficacy and fewer adverse effects.	32	High†
For patients experiencing a gout flare for whom other antiinflammatory therapies are poorly tolerated or contraindicated, we conditionally recommend using IL-1 inhibition over no therapy (beyond supportive/ analgesic treatment).	33	Moderate
For patients who may receive NPO, we strongly recommend glucocorticoids (intramuscular, intravenous, or intraarticular) over IL-1 inhibitors or ACTH.	32	High†
For patients experiencing a gout flare, we conditionally recommend using topical ice as an adjuvant treatment over no adjuvant treatment.	31	Low

Strongly recommend | Conditionally recommend | Strongly recommend against | Conditionally recommend against

* PICO = population, intervention, comparator, outcomes; NSAIDs = nonsteroidal antiinflammatory drugs; IL-1 = interleukin-1; ACTH = adrenocorticotropic hormone; NPO = nothing by mouth (nulla per os).
† High quality of evidence from network meta-analyses supporting canakinumab, which has superior mean pain score reduction and mean day-2 joint tenderness reduction. However, the Voting Panel raised concern that the comparator was weak (triamcinolone 40 mg) and that cost issues significantly favor other agents.

Gout treatment guidelines 2020. Gout treatment guidelines canada. Gout flare up treatment guidelines. Gout attack treatment guidelines. Gout treatment guidelines 2020 uk.

Every gift to the Arthritis Foundation will help people with arthritis across the U.S. live their best life. Join us and become a Champion of Yes. There are many volunteer opportunities available. Take part to be among those changing lives today and changing the future of arthritis. Proud Partners of the Arthritis Foundation make an annual commitment to directly support the Foundation's mission. Every gift to the Arthritis Foundation will help people with arthritis across the U.S. live their best life. Whether it is supporting cutting-edge research, 24/7 access to one-on-one support, resources and tools for daily living, and more, your gift will be life-changing. Make a Donation Help millions of people live with less pain and fund groundbreaking research to discover a cure for this devastating disease. Please, make your urgently-needed donation to the Arthritis Foundation now! Become a Member Become an Arthritis Foundation member today for just $20 and you'll receive access to helpful tools..... and more. Make a Honor or Memorial Gift Honor a loved one with a meaningful donation to the Arthritis Foundation. We'll send a handwritten card to the honoree or their family notifying them of your thoughtful gift. Gift Planning I want information on ways to remember the AF in my will, trust or other financial planning vehicles. Other Ways to Give Match Gift Donate a Car Donor-Advised Funds By taking part in the Live Yes! INSIGHTS assessment, you'll be among those changing lives today and changing the future of arthritis, for yourself and for 54 million others. And all it takes is just 10 minutes. Your shared experiences will help: - Lead to more effective treatments and outcomes - Develop programs to meet the needs of you and your community - Shape a powerful agenda that fights for you Now is the time to make your voice count, for yourself and the entire arthritis community. Currently this program is for the adult arthritis community. Since the needs of the juvenile arthritis (JA) community are unique, we are currently working with experts to develop a customized experience for JA families. By sharing your experience, you're showing decision-makers the realities of living with arthritis, paving the way for change. You're helping break down barriers to care, inform research and create resources that make a difference in people's lives, including your own. Get Started As a partner, you will help the Arthritis Foundation provide life-changing resources, science, advocacy and community connections for people with arthritis, the nations leading cause of disability. Join us today and help lead the way as a Champion of Yes. Trailblazer Our Trailblazers are committed partners ready to lead the way, take action and fight for everyday victories. They contribute $2,000,000 to $2,749,000 Visionary Our Visionary partners help us plan for a future that includes a cure for arthritis. These inspired and inventive champions have contributed $1,500,00 to $1,999,999. Pioneer Our Pioneers are always ready to explore and find new weapons in the fight against arthritis. They contribute $1,000,000 to $1,499,999. Pacesetter Our Pacesetters ensure that we can chart the course for a cure for those who live with arthritis. They contribute $500,000 to $999,000. Signature Our Signature partners make their mark by helping us identify new and meaningful resources for people with arthritis. They contribute $250,000 to $499,999. Supporting Our Supporting partners are active champions who provide encouragement and assistance to the arthritis community. They contribute $100,000 to $249,999. More About Partnerships Gout is the most common cause of inflammatory arthritis worldwide Clinical manifestations of gout resulting from monosodium urate crystal deposition include tophi, chronic arthritis, urolithiasis and renal disease as well as recurrent acute arthritis, bursitis and cellulitis Gouty arthritis and tophi are associated with chronic disability, impairment of health-related quality of life, increased use of healthcare resources and reduced productivity Gout is also frequently associated with co-morbidities such as obesity, dyslipidaemia, diabetes mellitus, chronic renal insufficiency, hypertension, cardiovascular disease, hypothyroidism, anaemia, psoriasis, chronic pulmonary diseases, depression and osteoarthritis as well as with an increase in all-cause mortality and urogenital malignancy Sustained hyperuricaemia is the single most important risk factor for the development of gout. Hyperuricaemia occurs secondarily to reduced fractional clearance of uric acid in >90% of patients with gout Age, male gender, menopausal status in females, impairment of renal function, hypertension and the co-morbidities that comprise the metabolic syndrome are all risk factors for incident gout associated with decreased excretion of uric acid, as are the use of diuretic and many anti-hypertensive drugs, ciclosporin, low-dose aspirin, alcohol consumption and lead exposure Tophi and chronic arthritis, alcohol consumption and recent use of diuretic drugs are important risk factors for recurring flares Educate patients to understand that attacks should be treated as soon as an attack occurs and ensure that patients are aware of the importance of continuing any established urate-lowering therapy (ULT) during an attack Affected joints should be rested, elevated and exposed in a cool environment. Bed-cages and ice-packs can be effective adjuncts to management A non-steroidal anti-inflammatory drug (NSAID) at maximum dose or colchicine in doses of

500 mcg b.d.–q.d.s. is the drug of choice when there are no contraindications. Choice of first-line agent will depend on patient preference, renal function and co-morbidities. Patients on NSAIDs or cyclooxygenase-2 inhibitors (coxibs) should be co-prescribed a gastro-protective agent Joint aspiration and injection of a corticosteroid are highly effective in acute monoarticular gout and may be the treatment of choice in patients with acute illness and co-morbidity. A short course of oral corticosteroid or a single injection of an intramuscular corticosteroid is an alternative in patients who are unable to tolerate NSAIDs/colchicine and in whom intra-articular injection is not feasible. Such systemic therapy is also appropriate for oligo or polyarticular attacks of gout In patients with acute gout where response to monotherapy is insufficient, combinations of treatment can be used Interleukin-1 (IL-1) inhibitors may be considered in patients who have previously not responded adequately to standard treatment of acute gout (although not approved by the National Institute for Health and Care Excellence [NICE]) If diuretic drugs are being used to treat hypertension rather than heart failure, an alternative antihypertensive agent can be considered as long as blood pressure is controlled All patients with gout should be given verbal and written information about the following: the causes and consequences of gout and hyperuricaemia; how to manage acute attacks; lifestyle advice about diet, alcohol consumption and obesity; and the rationale, aims and use of ULT to target urate levels. Management should be individualized and take into account co-morbidities and concurrent medications. Illness perceptions and potential barriers to care should be discussed In overweight patients, dietary modification to achieve a gradual reduction in body weight and subsequent maintenance should be encouraged. Diet and exercise should be discussed with all patients with gout, and a well-balanced diet low in fat and added sugars, and high in vegetables and fibre should be encouraged: sugar-sweetened soft drinks containing fructose should be avoided; excessive intake of alcoholic drinks and high purine foods should be avoided; and inclusion of skimmed milk and/or low fat yoghurt, soy beans and vegetable sources of protein, and cherries in the diet should be encouraged Patients with gout and a history of urolithiasis should be encouraged to drink >2 l of water daily and avoid dehydration. Alkalinization of the urine with potassium citrate (60 mEq/day) should be considered in recurrent stone formers Cardiovascular risk factors and co-morbid conditions such as cigarette smoking, hypertension, diabetes mellitus, dyslipidaemia, obesity and renal disease should be screened for in all patients with gout, reviewed at least annually and managed appropriately Algorithm reproduced with kind permission from Hui, Carr, and Cameron et al and the British Society for Rheumatology. The option of ULT should be explained to patients when the diagnosis is confirmed and they are being given information about gout. Patients should be fully involved in the decision as to when to commence ULT. The importance of taking ULT regularly and continually to prevent the return of gout attacks should be explained. Patients should be supported during the process of lowering their serum uric acid levels as it can cause an increase in gout flares during this time ULT should be discussed and offered to all patients who have a diagnosis of gout. ULT should particularly be advised in patients with the following: recurring attacks (≥2 attacks in 12 months); tophi; chronic gouty arthritis; joint damage; renal impairment (estimated glomerular filtration rate [eGFR]

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