Managing Gout in Primary Care

Dr Andrew Jackson
Meet the speaker

Dr Andrew Jackson
GP with Special Interest in MSK Medicine

• GP Partner and GP Trainer in Bingley Medical Practice
• Bradford University Diploma in MSK and Rheumatology Lead Tutor
• Versus Arthritis Clinical Lead for Core Skills programme
Session aims

1. Management of acute gout
2. Management of gout long-term
3. Gout and co-morbidities
What is life like for primary care professionals?

- Busy workloads
- Varied levels of experience
- High volume of MSK-related presentations
- Limited training and education on MSK

10-minute consultations are not enough

4.6 million musculoskeletal related GP appointments each year

Gout
Who should manage gout?

Practice nurse-led care better than GP care for treating gout

By David Swan, Editor, Nursing in Practice
Friday 19th October, 2018
Findings

• 517 patients were enrolled: 255 were assigned nurse-led care and 262 usual GP care.
• Nurse-led care was associated with higher uptake of and adherence to urate-lowering therapy.
• More patients receiving nurse-led care had achieved target urate levels at 2 years than those receiving usual GP care.
• At 2 years all secondary outcomes favoured the nurse-led group. The cost per QALY gained for the nurse-led intervention was £5066 at 2 years.
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What is gout?

Gout is a very painful form of arthritis caused by crystals that form in and around the joints.

An attack of gout can be extremely painful and continuing crystal formation can cause long-term joint damage.

www.versusarthritis.org/about-arthritis/conditions/gout/
Gout – one chronic disease, best described by 4 stages

Asymptomatic hyperuricaemia
Elevated serum urate with no clinical manifestation of gout

Acute flares
Acute inflammation in the joint caused by urate crystallisation

Intercritical segments
The intervals between acute flares reduces

Advanced gout
Long-term gout complications of uncontrolled hyperuricaemia

Uncontrolled hyperuricaemia

Cohen M. Hyperuricemia and Gout. Medscape.
Evolution of hyperuricaemia and gout

Over time, untreated, chronic hyperuricaemia increases body urate stores, advancing the severity of the disease.
Mr Chris P. Bacon – Age 46

- **PC:** Acutely swollen, hot big toe and forefoot
- **HPC:**
  - Acute onset over last few days since attending a family celebration, intensely painful, severe night pain – cannot sleep and cannot walk without limping
  - Seen in OOH: given flucloxacillin for cellulitis, but no improvement
- **PMH:** Dyspepsia and hypertension
- **MEDICATION:** Lansoprazole 15 mg prn, bendroflumethiazide 2.5 mg mane and ramipril 10 mg nocte
Management

- What is your differential diagnosis?
- How would you manage him today?
- What would be your longer-term management plan?
- What target would you aim for?
- P.S. his BP today is 154/92 mmHg, BMI = 31 kg/m²
Question:

What is your differential diagnosis?

A. Cellulitis
B. Septic arthritis
C. Gout
D. Something else
Question:

How would you manage him today?

A. Prescribe NSAIDS (type and dose)
B. Prescribe colchicine (dose)
C. Inject the joint with steroid
D. Something else
Question:

What would be your longer-term management plan?

A. Arrange bloods and FU to commence allopurinol
B. As it is his first attack provide advice only
C. Change his anti-hypertensive meds
D. Something else
Question:

What urate level should you aim for in primary care?

A. No specific target
B. Within the normal lab range
C. 300 umol/l
D. 360 umol/l
• Don’t forget the co-morbidities!

• Screen and manage the:

‘metabolic syndrome’
Managing GOUT

Acute attacks
- Consider other diagnoses (e.g. sepsis)
- Consider joint aspiration ± steroid injection
- Oral NSAIDs ± PPIs
- Oral colchicine 500 µg bd-qds
- Oral steroids 30 mg for five days
- IM steroids (Depo-Medrone 120 mg/Kenalog 80 mg)
- Check urate levels 4–6 weeks post-attack
- Continue urate-lowering therapies if already taking

Long-term urate levels
- The challenge: long-term compliance
- Provide information
- BSR guidelines recommend treating after first confirmed attack
- Review diet (see PIL in handbook)
- Review medications
- Aim to get long-term urate levels down to <360 µmol/L with allopurinol or febuxostat
- Manage comorbidities (e.g. cardiovascular risk)

BSR guideline May 2017, DTB January 2018
Allopurinol

- Wait 2–4 weeks after attack (usually)
- Start on low dose: 50–100 mg OD
- Adjust dose slowly: increase by 100 mg per month
- Maximum dose of 900 mg OD
- Co-prescribe low-dose NSAID or colchicine until target urate reached
- Special considerations: renal impairment/CKD
- eGFR <35: start allopurinol at 50 mg OD
- CKD4/5: consider referring to rheumatologist
- Monthly bloods: urate, U&E, LFT, FBC
- **FEBUXOSTAT 80–120 mg can be used in the second line if allopurinol not tolerated**
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QIP Ideas

Audits:
What proportion of patients with gout are on prophylaxis?
What proportion of patients on prophylaxis have achieved their target urate level?

Organisation:
How does your practice recall/monitor patients with gout?
Consider introducing nurse led practice or PCN long term management!
Core Skills Workshops

Remaining workshop dates for 2019:

Wednesday 23 October – Leeds
Tuesday 26 November – London
Tuesday 10 December – Glasgow

To book your place visit: www.coreskillsinmsk.co.uk

For local workshops in your areas please contact Versus Arthritis on stand K92

For free educational resources join the Versus Arthritis professional network:

Visit https://www.versusarthritis.org/about-arthritis/healthcare-professionals/
Thank you

Any questions?