Approach to Gout

WHO?

>3% adults (US) & rising

Majority cases: Men age 30+

(#1) Pacific Islander population

Predisposing conditions

(#1) Hyperuricemia

Metabolic (Obesity 6x, HTN)
Renal disease
Dietary (Etoh, meat, fructose)
Drugs (diuretics, bASA)
↑ Neoplastic cell turnover (TLS)

WHY?

Abnl metabolism, uric acid

↓

Monosodium urate crystals deposit (synovial fluid)

↓

Acute inflammation

WHAT?

Acute, typically single jt
(#1) 1st MTP
< 2 weeks, recurrent

→

EARLIER	LATER
Lower half	Upper half
Olecranon bursititis	Tophi

DX?

Joint Aspiration

R/o septic arthritis!
Needle-shaped
Neg birefringent

X-RAY

Punched-out lesions

TX?

Weight loss, diet, d/c culprit meds!

ACUTE	
NSAIDS	CKD, GIB, HF - Avoid!
Steroids:	Intra-articular if single jt
Anakinra	Severe, refractory, CKD
Colchicine	Both acute + chronic tx
CHRONIC (ULT)	
Xanthine oxidase inhibitors	Allopurinol (1st line), Febuxostat Allopurinol hypersensitivity: - HLA-B*5801 (Southeast Asian, African American), 97% CKD - Note: CKD ≠ contraindication, but should start at low dose
Pegloticase	Severe, refractory, tophi

↓

WHEN START ULT?

1) 2+ flares / year *
2) Gouty tophi
3) Radiographic damage
4) Urate nephropathy, renal stones

* Can consider w/ single poly-articular flare

Urate Lowering Therapy = ULT

Should combine with NSAIDs or Colchicine when initiating to avoid precipitating flare

TREAT TO TARGET

Serum urate < 6
(<5 if tophi)

Dx
The Clinical Problem Solvers