

BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

April 2023

The following succinct analysis appeared in *Pharmacist's Letter*. Based on vol. 36. No. 7

GOUT

You'll get questions about managing chronic meds to prevent gout flares...as febuxostat (*Uloric*) continues to fall out of favor.

Last year, FDA warned about febuxostat increasing CV death compared to allopurinol. Now guidelines are catching up with the evidence.

Stick with allopurinol if a med is needed for chronic gout...such as patients with joint damage or 2 or more gout flares/year.

In general, suggest waiting 1 or 2 weeks after a flare resolves to start...but continuing chronic gout meds during any future flares.

Recommend starting allopurinol at 100 mg/day...or 50 mg/day in renal impairment...to reduce the risk of a hypersensitivity reaction.

Be aware, some experts advise "treating to target" uric acid levels...while others titrate meds based on flares. Consider a blended approach that weighs both.

If needed, suggest titrating every 2 to 4 weeks up to 800 mg/day in normal renal function...or 300 mg/day or even higher in kidney disease.

Emphasize adherence. Fewer than 1 in 5 patients on chronic gout meds take them as prescribed.

Advise to report a new rash or itching and stop allopurinol if it occurs...especially within 2 months of a dose increase.

Save other meds for when patients can't take allopurinol.

Point out febuxostat's CV risk...probenecid's many interactions and risk of kidney stones...and that lesinurad products (*Duzallo*, *Zurampic*) are off the market due to low demand.

Keep in mind, starting any uric acid-lowering med can trigger a flare. Ensure that patients are also on an NSAID, colchicine, or oral steroid when starting chronic therapy.

Reinforce dietary measures...limiting alcohol, red meat and shellfish, sugary beverages, etc. And review profiles for meds that may raise uric acid...diuretics, testosterone, topiramate, etc.

See our chart, *Comparison of Gout Therapies*, for more on managing acute flares...and the role of HLA genotype testing with allopurinol.

(For more on this topic, see Clinical Resource #360705 at [PharmacistLetter.com](https://www.pharmacistletter.com).)

Fitzgerald JD, Dalbeth N, Mikuls T, et al. 2020 American College of Rheumatology guideline for the management of gout. *Arthritis Rheumatol* 2020;72:879-95.

See LEADER NOTES for answers to discussion questions.

DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. What are the new guidelines for the management of gout?

ANALYSIS OF NEW GUIDELINE

2. What are the criteria for development or evaluation of practice guidelines?
3. Are the new guidelines for gout evidence based? Is evidence linked to recommendations with a strength of recommendation grading system?
4. Are the guidelines unbiased and representative of a wide range of clinicians?
5. Are the guidelines based on outcomes important to patients?
6. Are the interventions proposed in the guidelines feasible in all practice settings?

See [LEADER NOTES](#) for answers to discussion questions.

7. Have the guidelines been prospectively validated?

8. What are the major recommendations of the guidelines?

9. Are the guidelines expressed in terms we care about and can use?

HOW SHOULD THE NEW GUIDELINES CHANGE CURRENT THERAPY?

10. Do the guidelines change your practice? How?

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

BD is a 50-year-old Caucasian male who presents to the clinic for left great toe pain, redness and swelling for the past 3 days. He cannot recall any specific associated injury. He is having trouble walking due to the pain. His only chronic condition is hypertension, which is well controlled on hydrochlorothiazide 25 mg daily. When asked about any changes in his diet over the past few days, BD tells you he recently celebrated his 50th birthday at the local steakhouse, with a "surf-and-turf" meal along with some cocktails and a bottle of fancy red wine.

Based on your history and physical examination, you suspect BD is having his first gout attack. Further laboratory evaluation reveals he has an elevated uric acid level of 8.7 mg/dL.

See [LEADER NOTES](#) for answers to discussion questions.

11. What treatment recommendations do you initially recommend to BD to help control his symptoms?

You counsel BD on lifestyle modifications to help limit further gout flares. You decide to treat BD's gout flare with naproxen, and his symptoms slowly resolve within a week.

Over the next 6 months, BD has 3 additional gout attacks, in his feet and ankles. When he sees you following resolution of the most recent flare, he expresses frustration at the impact of the disease on his life.

12. What medication adjustments might you consider for BD?

Since BD is having frequent flares, you recommend adding a medication to lower BD's uric acid level, and discuss its possible side effects. At the same time, you recommend that BD restart naproxen, to prevent a flare when starting urate-lowering therapy. You also recommend changing BD's antihypertensive to a different medication.

At his 3-month routine follow-up appointment, BD happily reports he's had no further gout attacks and is tolerating allopurinol 300 mg/day without any side effects. He recently had labs completed and has a normal renal function and serum uric acid level of 7.0 mg/dL. He has lost weight and altered his lifestyle to a low-purine diet, with no red meat or shellfish. He still enjoys a glass of wine occasionally but even this is limited, and he no longer drinks spirits or beer.

13. What guidance do you provide BD regarding dosing of allopurinol now that his symptoms are under control, but his serum uric acid level remains elevated?

After hearing of BD's significant lifestyle modifications, coupled with having no further gout attacks, you decide to keep him on allopurinol 300 mg/day with continued close monitoring and agree to titrate the dose up if attacks occur in the future.

See [LEADER NOTES](#) for answers to discussion questions.

REFERENCES

- American College of Rheumatology Policy and Procedure Manual for Clinical Practice Guidelines. https://www.rheumatology.org/Portals/0/Files/ACR%20Guideline%20Manual_Appendices_updated%202015.pdf Accessed June 6, 2020.
- Doherty M, Jenkins W, Richardson H, et al. Efficacy and cost-effectiveness of nurse-led care involving education and engagement of patients and a treat-to-target urate-lowering strategy versus usual care for gout: a randomised controlled trial. *Lancet* 2018;392:1403-12.
- Fitzgerald JD, Dalbeth N, Mikuls T, et al. 2020 American College of Rheumatology guideline for the management of gout. *Arthritis Rheumatol* 2020;72:879-95.
- Hayward RS, Wilson MC, Tunis SR, et al. Users' guides to the medical literature. VIII. How to use clinical practice guidelines. A. Are the recommendations valid? The Evidence-Based Medicine Working Group. *JAMA* 1995;274:570-4.
- Khanna D, Fitzgerald JD, Khanna PP, et al. 2012 American College of Rheumatology guidelines for management of gout. Part 1: Systematic nonpharmacologic and pharmacologic therapeutic approaches to hyperuricemia. *Arthritis Care Res (Hoboken)* 2012;64:1431-46.
- Qaseem A, Harris RP, Forciea MA, et al. Management of acute and recurrent gout: a clinical practice guideline from the American College of Physicians. *Ann Intern Med* 2017;166:58-68.
- Shoji A, Yamanaka H, Kamatani N. A retrospective study of the relationship between serum urate level and recurrent attacks of gouty arthritis: evidence for reduction of recurrent gouty arthritis with antihyperuricemic therapy. *Arthritis Rheum* 2004;51:321-5.
- Stamp LK, Chapman PT, Barclay ML, et al. A randomized controlled trial of the efficacy and safety of allopurinol dose escalation to achieve target serum urate in people with gout. *Ann Rheum Dis* 2017;76:1522-28.
- White WB, Saag KG, Becker MA, et al. Cardiovascular safety of febuxostat or allopurinol in patients with gout. *N Engl J Med* 2018;378:1200-10.
- Yamanaka H, Togashi R, Hakoda M, et al. Optimal range of serum urate concentrations to minimize risk of gouty attacks during anti-hyperuricemic treatment. *Adv Exp Med Biol* 1998;431:13-8.

Additional Pharmacist's Letter Resources available at PharmacistsLetter.com

- Chart, Comparison of Gout Therapies. *Pharmacist's Letter/Prescriber's Letter*. July 2020.
- Chart, Colchicine Dosing and Interactions. *Pharmacist's Letter/Prescriber's Letter*. February 2020.
- Chart, Severe Cutaneous Adverse Reactions: Stevens-Johnson Syndrome and More. *Pharmacist's Letter/Prescriber's Letter*. December 2019.
- Chart, Potentially Harmful Drugs in the Elderly: Beers List. *Pharmacist's Letter/Prescriber's Letter*. March 2019.
- Chart, Managing NSAID Risks. *Pharmacist's Letter/Prescriber's Letter*. July 2018.
- Chart, Safety Comparison of NSAIDs. *Pharmacist's Letter/Prescriber's Letter*. December 2016.
- Toolbox, Weight Loss: Helping Your Overweight and Obese Patients. *Pharmacist's Letter/Prescriber's Letter*. May 2015.
- Chart, Drugs for Weight Loss. *Pharmacist's Letter/Prescriber's Letter*. December 2016.

Pharmacist's Letter Journal Club Editors:

Lori Dickerson, PharmD, FCCP, Editor; Jennifer Nieman, PharmD, BCPS, Associate Editor; Alpa Desai, DO, Department of Community Health & Family Medicine, University of Florida, College of Medicine, Newbury, FL; Lisa D. Mims, MD, Department of Family Medicine, Medical University of South Carolina, Charleston, SC, Contributing Editors.

DISCLOSURE:

The editors of this activity and its publisher, Therapeutic Research Center (TRC), have no relevant financial interests related to the products or services covered by this activity. TRC does not receive any commercial support and does not accept any advertising. It is completely independent and is supported entirely by subscriptions. TRC focuses on delivering completely objective, unbiased drug information and advice for the benefit of subscribers.

See **LEADER NOTES** for answers to discussion questions.