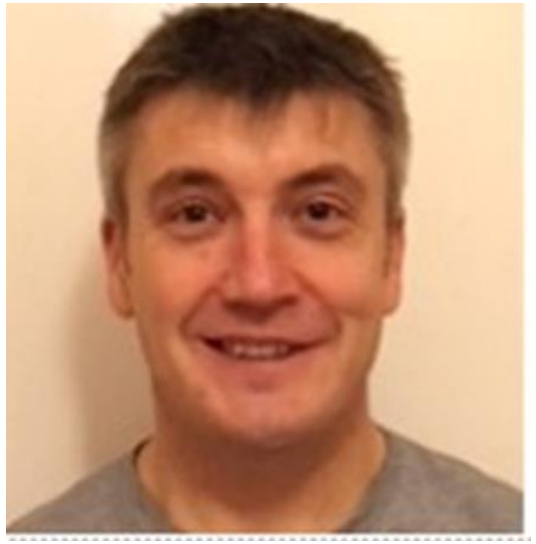
Managing Gout in Primary Care

Dr Andrew Jackson

VERSUS ARTHRITIS

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

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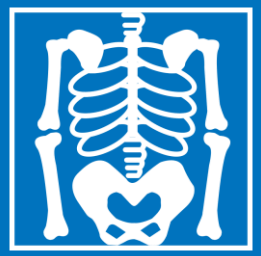
What is life like for primary care professionals?

Busy workloads

Varied levels of experience

High volume of MSK-related presentations



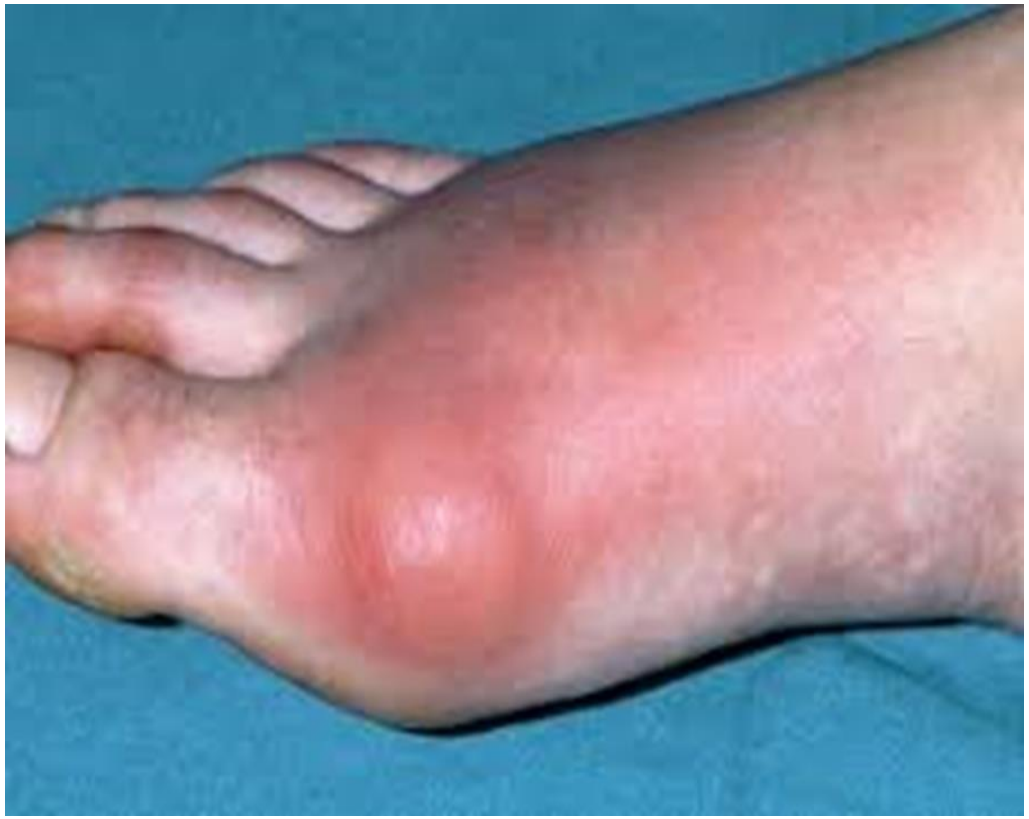
Limited training and education on MSK

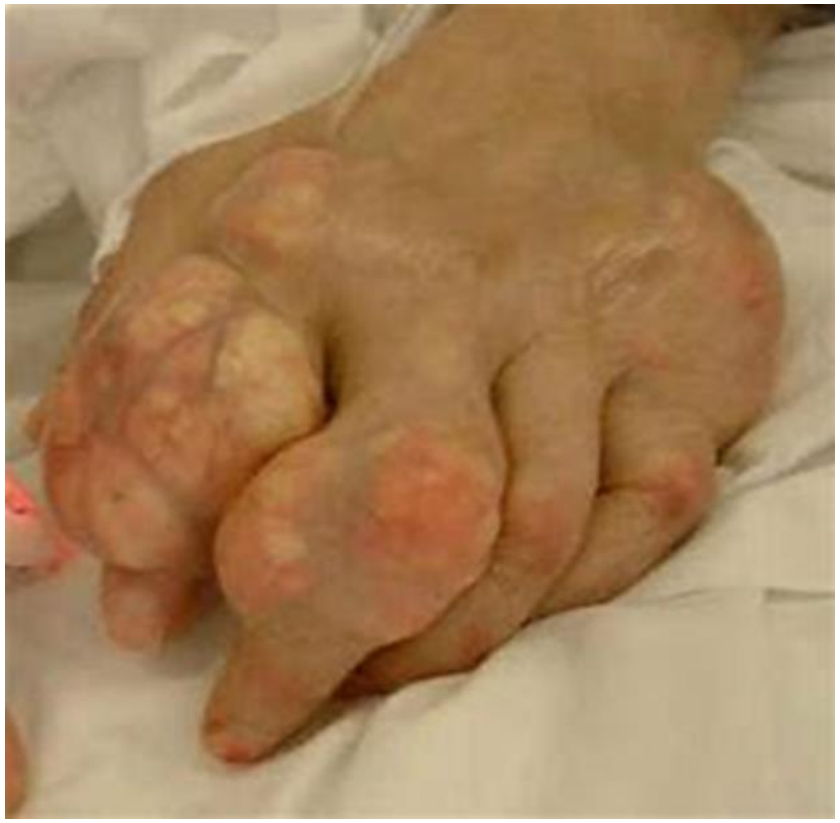
10 -minute consultations are not enough

4.6 million musculoskeletal related GP appointments each year

Versus Arthritis (2017) State of musculoskeletal health.

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

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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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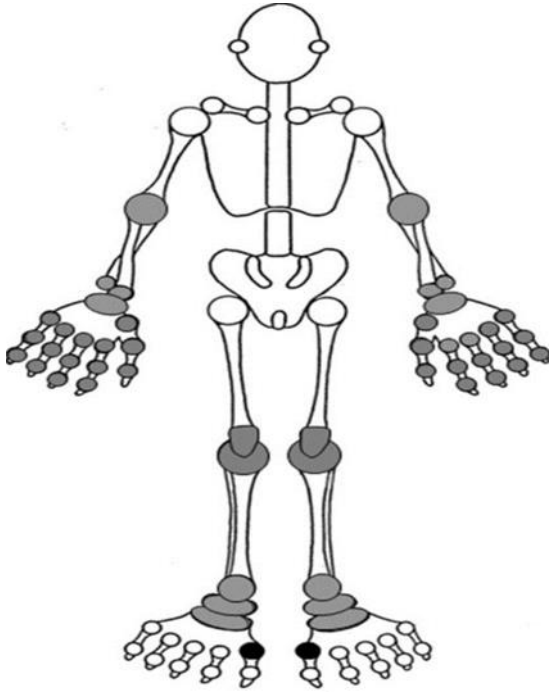
Self assessment

How do I diagnose gout?	?	10
How do I treat an acute attack?	?	10
Does this differ for young men, drinkers, patients with renal problems, patients with heart failure, patients with diabetes?	?	10
What information source do you give to patients to aid self management?	?	10
How do you investigate gout?	?	10
When and how do you start prophylactic treatment?	?	10
What targets do you aim for?	?	10
How does gout affect your treatment of other co-morbidities?	?	10

What is gout?



70%

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/

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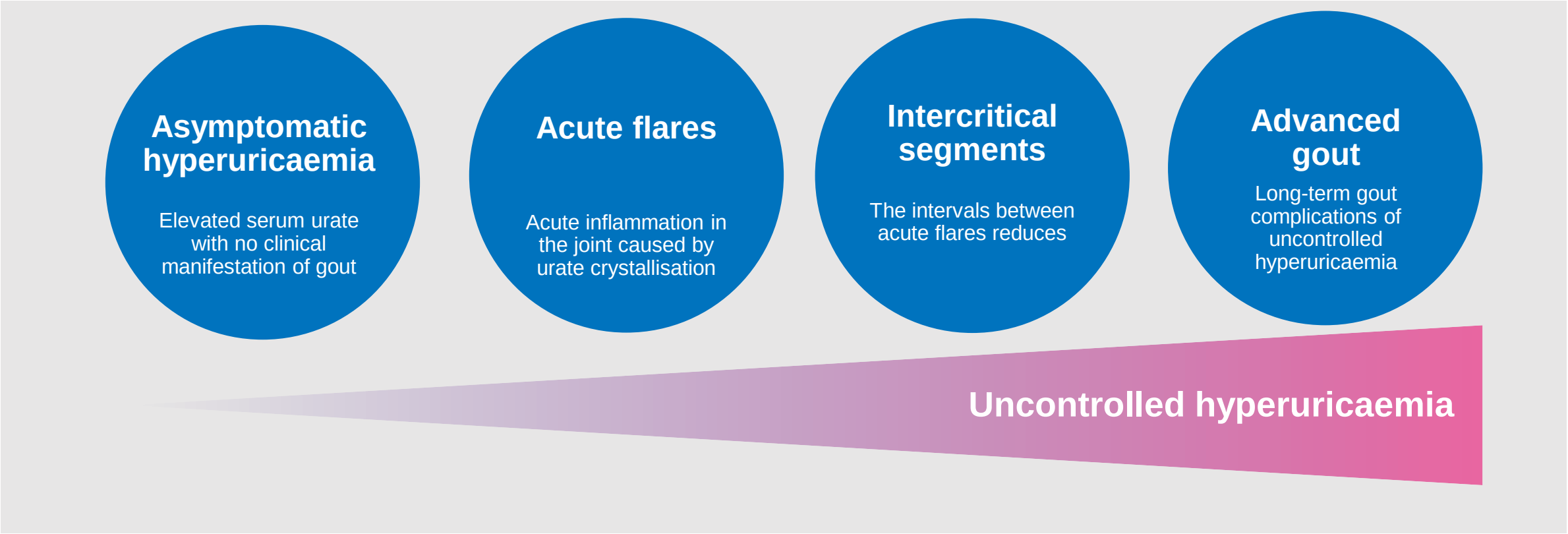
Roddy E et al. Gout. In: RCGP Guide to MSK Disorders in Primary Care. Ed: Warburton L

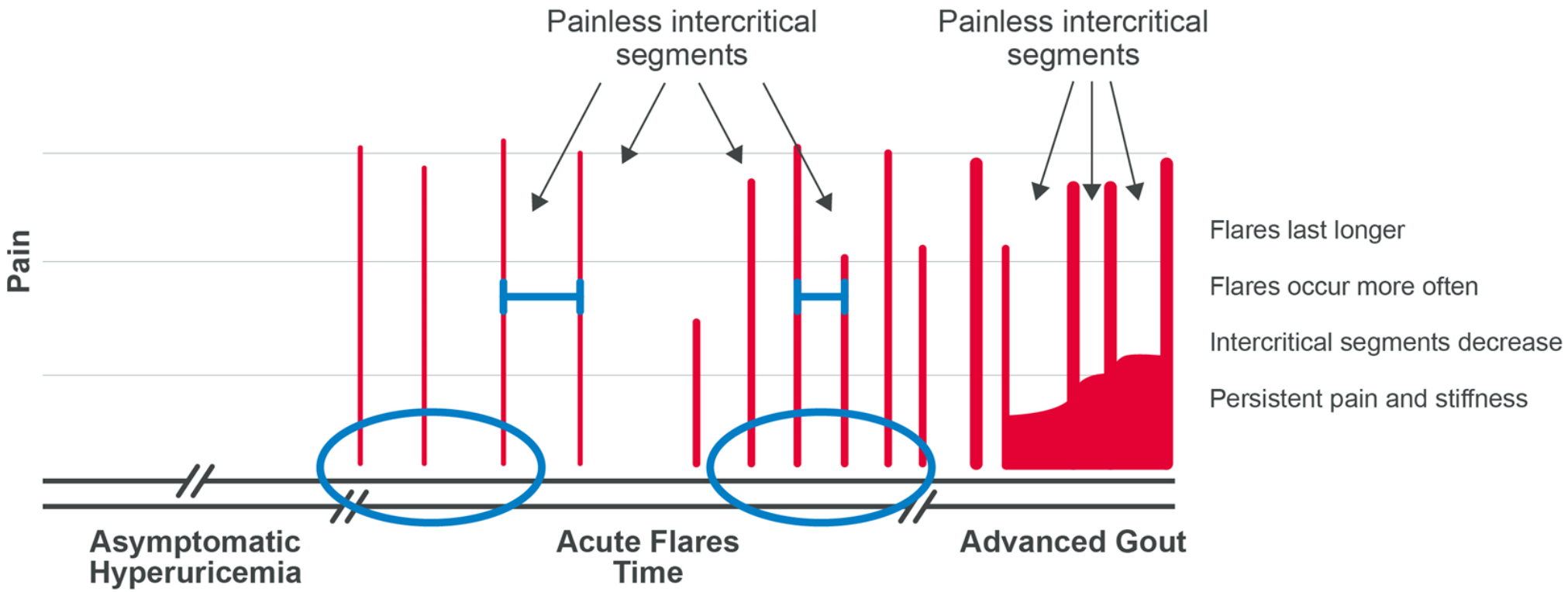
Gout – one chronic disease, best described by 4 stages



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



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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/m^2

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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

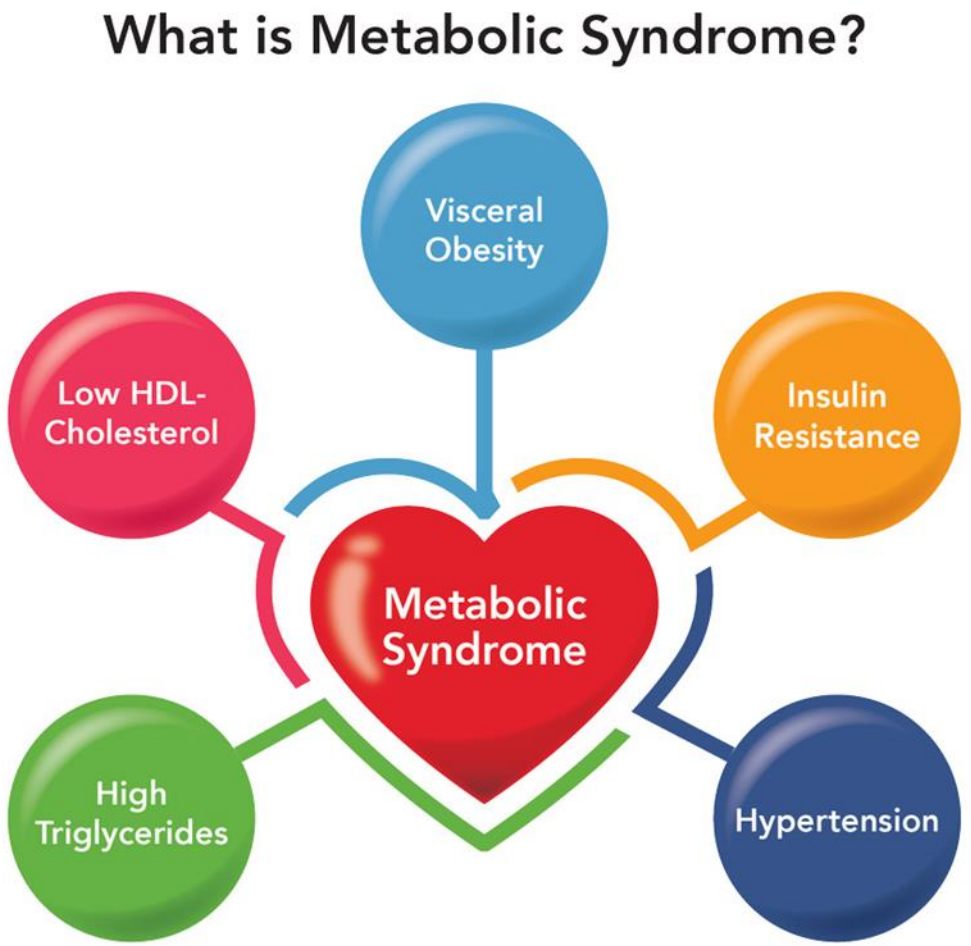
Question:

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’



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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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European League Against Rheumatism (2016); British National Formulary NICE Evidence Services (2017).

(Repeat) Self Assessment

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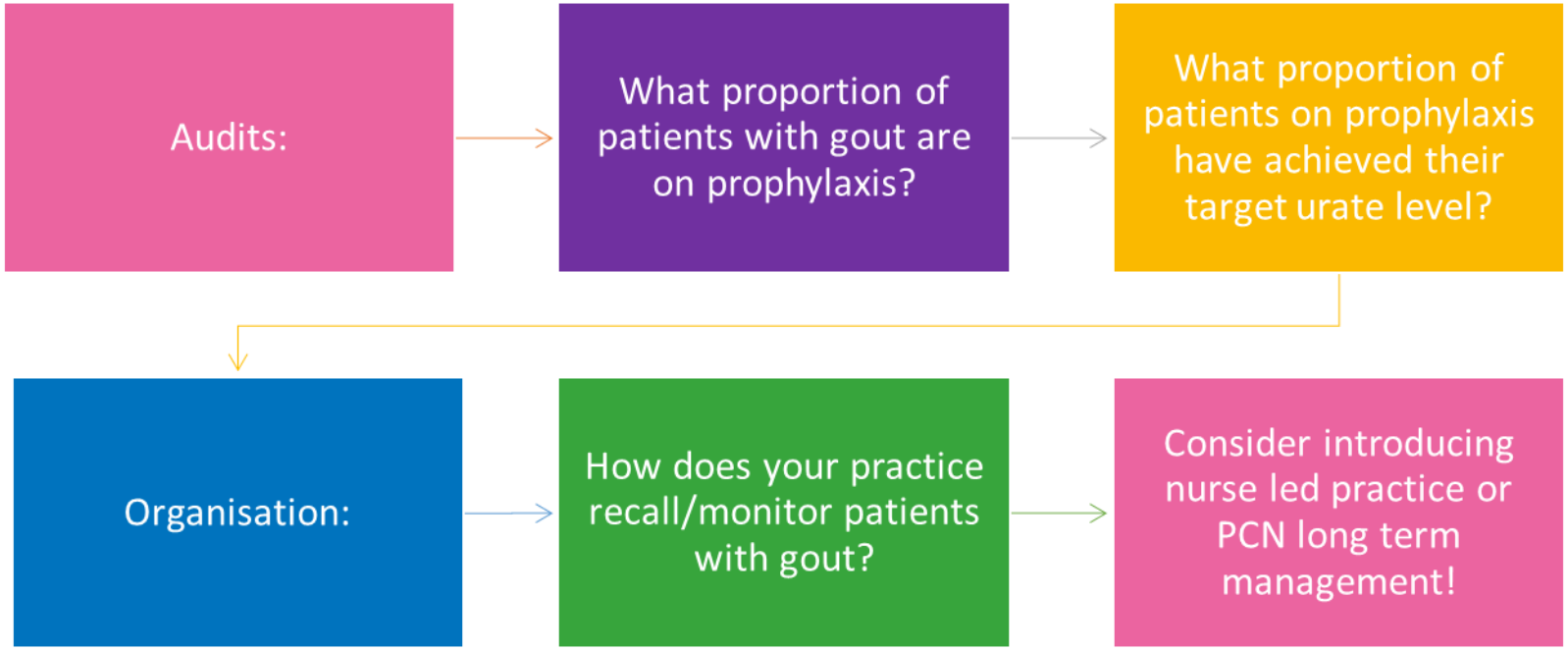
QIP Ideas



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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?

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