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American College of Physicians releases clinical practice guidelines for acute gout

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Physicians should use corticosteroids, nonsteroidal anti-inflammatory drugs (NSAIDs), or colchicine to treat patients with acute gout, the American College of Physicians (ACP) recommends in a new evidence-based clinical practice guideline for the management of the painful form of arthritis published today in *Annals of Internal Medicine*. ACP's guideline for diagnosing gout was published in the same issue.

"Physicians should consider using corticosteroids first in patients without contraindications because they are one of the most effective anti-inflammatory medications available and they are as effective as NSAIDs for managing acute gout but have fewer adverse effects," said Nitin S. Damle, MD, MS, MACP, president, ACP. "Although a generic formulation of colchicine is now available, it is more expensive than NSAIDs or corticosteroids. This is an important consideration for patients, especially as prescription drug prices continue to increase."

If colchicine is used to treat acute gout, ACP recommends that physicians use a low dose. The evidence showed that lower doses are as effective as higher doses at reducing pain and are associated with fewer gastrointestinal adverse effects. Possible adverse effects associated with colchicine include diarrhea and other gastrointestinal symptoms.

ACP found insufficient evidence to determine the effectiveness of dietary changes on symptomatic outcomes for the treatment of gout. Low-quality evidence from one study showed that gout-specific counseling about dietary changes—such as reducing red meat, shellfish,

yeast-rich foods, and increasing low-fat dairy, vegetables, and cherries—is not more effective than general dietary counseling—such as promoting weight loss and reducing alcohol intake—for reducing serum urate levels in gout patients.

ACP recommends against initiating long-term uric acid-lowering therapy in most patients after a first gout attack or in patients with infrequent attacks.

While the evidence supports the benefits of using uric acid-lowering therapy for shorter duration to reduce gout flares, the benefits of long term usage for 12 or more months in patients with a single or infrequent gout attacks have not been studied. In most patients, it is not clearly necessary, based on the evidence, to start uric acid-lowering therapy in cases where the individuals would have no or infrequent recurrences, ACP states in the guideline.

In cases of recurrent gout, ACP recommends that physicians and patients discuss the benefits, harms, costs, and individual preferences before initiating uric acid-lowering therapy. Patients who decide not to initiate uric acid-lowering therapy can revisit their decision if and when they have multiple recurrent attacks of gout.

ACP called for the need for comparative effectiveness studies to evaluate the incremental benefits and harms of a treat-to-target strategy over a treat-to-avoid-symptoms strategy.

For diagnosing gout, ACP recommends that physicians use synovial fluid analysis when clinical judgement indicates that diagnostic testing is necessary in patients with possible gout.

"While joint aspiration with synovial fluid analysis for uric acid crystal analysis is the reference standard for diagnosing gout, most patients are

seen initially by their primary care physician or an emergency room physician where synovial fluid analysis is less frequently and less easily performed," Dr. Damle said. "In certain situations, physicians should use clinical judgement so that patients can begin treatment if gout is suspected."

Misdiagnosis or delayed diagnosis of gout can result in unnecessary surgery, hospitalization, delays in adequate treatment such as antibiotics for septic joints, and unnecessarily prescribing long-term treatment to patients.

More information: *Annals of Internal Medicine*, annals.org/aim/article/doi/10.7326/M16-0570

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