ACR 2019 HIGHLIGHTS

Committee Proposes Updates to Guidelines for Management of Patients with Gout
By Alice Goodman

Atlanta, GA—New recommendations for the management of patients with gout were presented in draft form at the 2019 American College of Rheumatology (ACR) Annual Meeting. The ACR Practice Guidelines Committee determined that it was necessary to update the 2012 version of the guidelines, based on new evidence from clinical trials. The new guidelines are currently under peer review and the committee is hoping to have them published sometime in 2020.

“The updated guideline provides clinicians with evidence-based guidance on important topics, such as the optimal usage of urate-lowering therapy, treatment of gout flares, managing lifestyle factors, and other medication recommendations to help them be successful in optimally managing gout in their patients,” said Tuhina Neogi, MD, PhD, Professor, Medicine and Epidemiology, and Chief, Rheumatology, Boston University School of Medicine/Boston Medical Center, MA, and Co-principal Investigator on the treatment guidelines.

“These changes will improve the overall outcomes for patients with gout by reducing their gout flares and tophi, thereby improving their quality of life,” she noted.

PROPOSED UPDATES TO EXISTING GOUT GUIDELINES

Dr Neogi emphasized 4 key updates contained in the draft document:

- A strong emphasis on treat-to-target with a serum urate target of <6 mg/dL, supported by a broader evidence base considering newer

trials that have been conducted since the last treatment recommendations
- A strong recommendation for allopurinol as the appropriate first-line agent for lowering serum urate levels in the management of patients with gout
- Expanded indications for urate-lowering therapy (ULT) with a conditional recommendation to consider starting ULT in patients with infrequent gout flares and in patients after a first gout flare who also have stage ≥3 chronic kidney disease (CKD), serum urate levels >9 mg/dL, or kidney stones
- A strong recommendation to start concomitant prophylaxis with anti-inflammatory agents (eg, colchicine, nonsteroidal anti-inflammatory drugs, prednisone/prednisolone) when starting ULT for at least 3-6 months rather than <3 months, with ongoing evaluation and continued prophylaxis as needed if the patient continues to experience flares.

Regarding the treat-to-target strategy for all patients with gout included in the new recommendations, Dr Neogi explained that the draft guideline suggests a management strategy of starting with a low dose of a ULT medication and escalating the dosage to achieve and maintain a serum urate level of <6 mg/dL to optimize patient outcomes over a fixed-dose strategy. This strategy mitigates the risk of treatment-related adverse effects (eg, hypersensitivity), as well as flare risk accompanying ULT initiation.

“While the recommendation differs from the American College of Physicians, a treat-to-target approach was supported by randomized trial data, so we hope this will change how health care providers currently treat the condition,” said Dr Neogi. “Gout management remains largely suboptimal due to many providers only managing flares without also treating the underlying hyperuricemia that causes gout or starting a patient on a urate-lowering therapy medication without escalating the dose or monitoring the serum urate response to guide dose escalation.”