

## DIAGNOSIS OF GOUT

The diagnosis of gout can be made according to the American College of Rheumatology (ACR)/Wallace criteria<sup>1</sup>:

**A. The presence of characteristic urate crystals in the joint fluid,**

**B. A tophus proved to contain urate crystals by chemical means or polarized light microscopy** (images are available in the online version of this article visit [www.bpac.org.nz](http://www.bpac.org.nz))

OR

**C. Six of the following 12 clinical criteria**

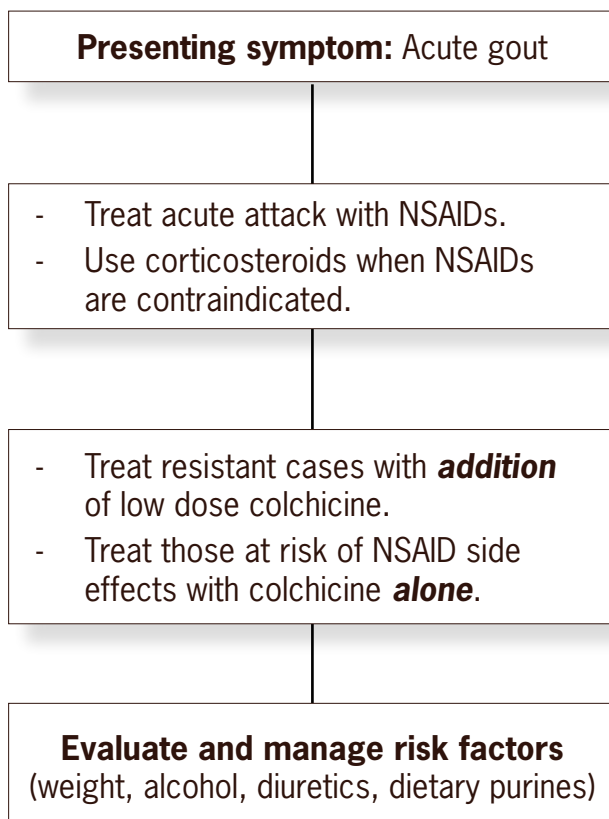
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| a. Maximum inflammation within the first day   | g. Unilateral tarsal joint attack              |
| b. More than one attack of acute arthritis     | h. Suspected tophus                            |
| c. Monoarticular arthritis                     | i. Hyperuricaemia                              |
| d. Redness observed over joints                | j. Asymmetric swelling within a joint on x-ray |
| e. First metatarsophalangeal joint pain attack | k. Subcortical cysts with no erosions on x-ray |
| f. Unilateral metatarsophalangeal joint attack | l. Negative bacterial culture of joint fluid   |

It is important to note that gout and sepsis can co-exist. The presence of urate crystals in synovial fluid does not exclude a diagnosis of sepsis.<sup>2</sup>

Although hyperuricaemia is a key risk factor for gout, it is not sufficient to make the diagnosis of gout; **only 20% of patients with hyperuricaemia will develop gout**, and serum urate concentrations may be normal in patients during an acute gout flare.<sup>3</sup>

## TREATMENT OF GOUT

### Treatment of acute gout flares



- **NSAIDs:** given at regular intervals until the severe pain abates, at which time the dose may be reduced (e.g. starting with naproxen 500 mg bd or diclofenac 75 mg bd). Always watch for renal impairment, heart failure and peptic ulceration. If patients are already taking low dose aspirin for cardiovascular risk reduction it should be continued.
- **Oral corticosteroids:** in view of the toxicity of colchicine, corticosteroids may be preferred to treat acute gout in patients in whom NSAIDs are contraindicated, provided sepsis has been excluded. The initial dose is 15–40 mg prednisone daily, gradually reduced over 10 days. Intra-articular corticosteroids are useful if monoarthritis is present to reduce risks of systemic therapy.
- **Colchicine:** can be a useful adjunct to NSAIDs in resistant cases, particularly when tophi are present, as monotherapy or to prevent flares when starting allopurinol.
- **Allopurinol:** If a patient has been taking allopurinol regularly at the time of developing an acute attack it should be continued at the same dose. “Allopurinol should not be started at the time of the attack”