Gout Guidelines Highlight Risk Factor Analysis

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The optimal treatment for gout requires both pharmacologic and nonpharmacologic therapy to reduce the severity of acute attacks and prolong the period between them, according to new guidelines issued by the European League Against Rheumatism.

The guidelines and accompanying set of diagnostic recommendations are similar to the quality care indicators for gout published in 2004 (Arthritis Rheum. 2004;50:937-43), said Dr. Kenneth Saag, di- rector of the University of Alabama’s Center for Education and Research on Thera-peutics of Musculoskeletal Disorders, Birmingham. The indicators are used mostly by researchers of quality care issues.

Diagnostic Criteria Draw On Research and Expert Opinion

The presence of monosodium urate monohydrate crystals in synovial fluid remains the gold standard for gout diagnosis, with a sensitivity of 84% and a specificity of 100%, accord- ing to new gout diagnostic guidelines issued by the European League Against Rheumatism.

The guidelines put forth 10 diagnostic criteria for gout; ranked not only upon extent research but also on benefit and risk, and the clinical expertise re- quired to effectively use the criteria.

1. Clinical symptoms of rapidly devel- oping severe joint pain and swelling, es- pecially with overlying erythema, are highly indicative of crystal formation but have low sensitivity (23%) for a gout diagnosis without further evidence.

2. Monosodium urate monohydrate (MSU) crystals in synovial aspirate have both high sensitivity and high specifici- ty, although variability in lab expertise may affect the accuracy of the sample findings.

3. A clinical diagnosis of classic recur- rent podagra with hyperuricemia can be reasonably assumed to be gout but requires MSU crystal confirmation.

4. All patients with inflamed joints should have their synovial fluid exam- ined for MSU crystals.

5. MSU testing can also be performed between bouts of inflammation, be- cause urate crystals persist in intercriti- cal periods in up to 70% of patients.

6. Because gout and sepsis may occur simultaneously, all possible gout pa- tients should also have Gram staining of synovial fluid. The test should be performed even if the fluid is positive for MSU crystals, because sep- tic arthritis can progress rapidly and carries a significant risk of morbidity and mortality.

7. Serum uric acid can’t be used exclu- sively as a diagnostic tool. Many people with high serum uric acid don’t devel- op gout, and some patients with con- firmed MSU crystals have normal serum uric acid.

8. Gout patients under age 25 years who have a family history of the disease or who have renal calculi should have a 24-hour urinary uric acid/creatinine ra- tio done. The 24-hour screen appears to be more accurate and cost effective than an early morning spot sample.

9. Radiographs might be useful for a differential diagnosis, but they can’t confirm gout. There are radiographic changes in all stages of gout, but many affected joints can be radiographically normal. Patients with intraarticular tophi are more likely to show severe radiographic changes.

10. Male gender, diet, alcohol use, and diuretics increase the risk of gout, but don’t ignore other important risk factors. These include hypertension (rela- tive risk of 4, compared with controls), coronary heart disease (odds ratio, 1.75), chronic renal failure (odds ratio, up to 5), and obesity (odds ratio, 3.8).

Diacerein Found More Effective Than NSAIDs in Osteoarthritis

Diacerein has advantages over placebo and nonsteroidal anti-inflammatory drugs in treat- ing hip and knee osteoarthritis, according to a new meta-analysis.

Diacerein is a member of the symptomatic slow-acting drugs in osteoarthritis group. They are of improving function, reduce car- tilage degradation while im- proving symptoms. They tend to start working slowly, but they have a prolonged residual effect after treatment is stopped.

For the meta-analysis, pub- lished in the Sept. 25, 2006, issue of Archives of Internal Medicine, Dr. Bernhard Rintelen and col- leagues from the Lower Austrian Center for Rheumatology, Stock- enegg, Austria, analyzed 19 ran- domized controlled trials involv- ing a total of 2,637 patients (Arch. Intern. Med. 2006;166:1899-906).

Eight of the trials were place- bo controlled, while 11 had active controls, which mainly compared diacerein with nonsteroidal anti-inflamatory drugs (NSAIDs).

During the active treatment phase, diacerein was significantly superior to placebo in reducing pain and improving function using a Glass score (standardized mean difference) of 1.50, the authors wrote. NSAIDs showed similar efficacy to diacerein during active treatment, but at treatment end, diacerein’s efficacy lasted up to 3 months longer, whereas NSAIDs did not (Glass score of 2.06).

Diacerein seemed well tolerat- ed, even after long-term use. The most common adverse event was mild to moderate diarrhea, start- ing in early treatment and resolv- ing during continuing therapy. The only other frequent adverse event was darker-than-normal urine, which had no clinical sig- nificance. There were no statistically significant differences be- tween diacerein and NSAIDs in tolerability, though patients taking NSAIDs had a greater number of severe events. Diacerein is mar- keted in Asia, Australia, Europe, and Latin America. It is not yet available in the United States.