Gout: diagnosis and management

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 02/02/2022 email: ManagementOfGout@nice.org.uk

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 response from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use.
- For copyright reasons, **do not include attachments** such as research articles, letters, or leaflets. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	Royal College of Physicians and Surgeons of Glasgow
Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry).	**None**
Name of person completing form	Dr Richard Hull FRCP Glas, Honorary Secretary, with assistance from experts within the field

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Comment number	**Document** [e.g. guideline, evidence review A, B, C etc., methods, EIA]	**Page number** **'General'** for comments on whole document	**Line number** **'General'** for comments on whole document	**Comments** • Insert each comment in a new row. • Do not paste other tables into this table, because your comments could get lost – type directly into this table. • Include section or recommendation number in this column.
Example	Guideline	16	45	Rec 1.3.4 – We are concerned that this recommendation may imply that ……..
Example	Guideline	17	23	Question 1: This recommendation will be a challenging change in practice because ……
Example	Guideline	37	16	This rationale states that…
Example	Evidence review C	57	32	There is evidence that …
Example	Methods	34	10	The inclusion criteria …
Example	Algorithm	General	General	The algorithm seems to imply that …
Example	EIA	10	2	We agree the barriers to access listed, and would also like to add ….
1	Guideline	General	General	The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the UK. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments. The College welcomes this guidance on Gout including diagnosis and management. It recognises Gout as an important cause of morbidity and disability which is often treated sub-optimally and badly reviewed within primary and secondary care. This review is timely.
2	Guideline	3	3	Gout is quite frequently overlooked as a possible diagnosis and patients may have the disease for many years. The significant morbidity cause by the disease is often under-recognised. In young and mid adulthood one acute joint may the presenting feature. As the individual ages multiple joints may be involved and the symptoms become less intense. In fact, it is not uncommon for tophaceous gout to present with minimal symptoms.
3	Guideline	4	2	The current British Society for Rheumatology Guideline considers the level of urate likely to cause crystal formation in a supersaturated medium is 420umol/l. This is within the normal range for many laboratories. Reduction of this level to 360umol/l will increase the number of patients with levels consistent with gout. However, the rationale does not appear to be discussed in the linked documents. Many laboratories do not routinely measure urate in their profiles. It is a specific request.

				There is a danger of over reliance on blood results and not as quite rightly stated a combination of clinical history, examination and blood tests. Recommendation 1.1.6 implies a raised serum urate in context of acute arthritis confirms diagnosis of gout. This most likely with 1st MTP joint inflammation presentation. It is less likely with other joints and multiple joints. As stated above the whole picture must be considered.
4	Guideline	4	8	We consider that the firm diagnosis of gout is important as it may infer lifelong treatment. Joint aspiration should be strongly recommended. We highlight the importance of false negative aspirates: *e.g*. If the clinical presentation is consistent with gout and the synovial fluid analysis fails to demonstrate crystals, the synovial fluid analysis result can be falsely negative. Crystal examination depends on access to a polarising microscope. In many hospitals this is in the Cytology Laboratory which may not offer an acute service. Examination for crystals is highly dependent of pH and temperature. Delay in examination will lead to false negative results. One should continue with treatment based on the overall clinical presentation.
5	Guideline	5	4	The association of elevated serum uric acid and features of the metabolic syndrome, including the risk of type II diabetes mellitus and adverse cardiovascular outcomes needs to be included. There is a need to be vigilant in assessing for these factors.
6	Guideline	5	17	Colchicine is commonly used for treatment of acute flares. However, the dosage is variable. Many pharmacists limit course to eight or ten tablets (0.5mg) which is not appropriate and not the practice of most rheumatologists and was a recommendation in the BNF. There is also a tendency to be given an excessive dose during 24 hours. Colchicine can be given for long periods safely in low dosage without side effects (usually diarrhoea). A reasonable regimen is 0.5mg bd or tds for up to seven days or longer if necessary. In polyarticular flares or presentations a short course of oral corticosteroids may be more effective.
7	Guideline	6	3	If available, ACTH can be used in acute gout treatment in those who do not tolerate or refractory to conventional treatments? Parenteral treatment can be used in patients who have had abdominal surgery and cannot take oral drugs.
8	Guideline	6	13	Splinting may be helpful in addition to ice packs.
9	Guideline	7	10	It is also appropriate to suggest avoiding dehydration. The advice of not using dietary manipulation is appropriate. However, it may be appropriate to avoid high-purine foods such as shellfish or offal (accepting there is no good quality evidence to support this advice).
10	Guideline	8	3	Generally speaking, it has been customary to use a urate of 500umol/l or above as a criterion.

				In addition, there is no mention of its use as a prophylactic treatment in those undergoing chemotherapy such that the purine load will increase.
11	Guideline	8	14	We agree that lifelong therapy with monitoring is appropriate. It is extremely common for therapy to be stopped in primary care either by a GP or community pharmacist.
12	Guidelines	8	15	Flares are common in the first three months of treatment particularly with introduction of allopurinol. A first line drug such as NSAID or Colchicine is commonly recommended in the first three months.
13	Guideline	9	5	The current UK recommendation of a target of 300umol/l or below has been in place since 2008. The EULAR recommendation is 360. However most British authorities use the BSR guidance. There is no clear rationale for this change in this guidance and in the supporting evidence. In practice many patients on treatment with a level between 300 and 360umol/l will continue to have attacks. It is slightly odd that the guidance suggests using the same value for diagnosis and target dose for therapy. We draw attention that the target level of treatment falls within the 'normal range' in most laboratory reference ranges. Therefore clinicians must be wary to that a urate level within the normal range can still be well above the target (and diagnostic) level in patients with known gout.
14	Guideline	9	12	Current NICE advice is that Allopurinol must be given prior to Febuxostat.
15	Guideline	10	1	1.5.9 Infers an ongoing and valid association between Febuxostat and adverse cardiovascular outcomes (presumably from CARES trial 2018) - Is this the basis for this advice here? There are now data against this association *e.g.*, FAST trial showed non-inferiority of febuxostat compared to allopurinol with a primary cardiovascular endpoint.
16	Guideline	10	9	Prophylaxis is most commonly missed part of management. Use of low dose colchicine or NSAID is effective in preventing attacks during instigation of ULT. Long term use of colchicine is often prevented by local policies. The BNF is unclear on its use for Prophylaxis (does not mention what is meant by "short term"). There is literature of this drug being used for long periods for gout.
17	Q1			1. **Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why**. The biggest impact on practice is likely to be from more definitive and updated diagnosis and treatment initiation. The challenges arise from offering patients with hyperuricemia/gout regular follow-up (e.g. annual review) outside of their acute flares. The other continuing challenge has always been supervision and guidance regarding titration of allopurinol (particularly increasing the dosage beyond 300mg or follow-on instructions to re-check serum uric acid and initiate urate-lowering therapy in primary care. The challenges fall to primary care predominantly but also to rheumatology departments who aim to follow-up these patients long-term in the more

				complex cases. Both primary and secondary care will struggle to adhere to guidance, primarily due to capacity issues within the NHS especially following the Pandemic crisis.
18	Q2			**2. Would implementation of any of the draft recommendations have significant cost implications?** Use of IL-1 inhibitors (in rare cases) has a significant and disproportionate cost implications as alluded to in the draft guideline already. There is also the cost implication of aiming to offer these increasing number of patients' regular follow-up (either in primary or secondary care). There are indirect costs associated with key co-morbidities related to gout, including the cost of type II diabetes mellitus (and its widespread complications), cardiovascular disease and other features of the metabolic syndrome.
19	Q3			3. **What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** The Department of Health patient literature needs to be adjusted (it promotes diet rather than drug treatment). There needs to be specific education focussed at primary care and community pharmacy to alter current practices of detection, monitoring and prevention. There is a particular issue where colchicine prescriptions are limited incorrectly. There is a need for additional resources/capacity which is difficult to address definitively.
20	Q4			4. **Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication.** Primary care has been nationally tasked with dealing with only 'urgent' problems at the current time. Although acute gout is an urgent problem, acute and chronic gout, may be and are often overlooked in terms of necessity for diagnosis and regular review. This may result in a delay in diagnosis, failure to commence or titrate serum urate lowering therapy, further disease flares and potential for joint damage and renal damage, more time off work and multiple other further consequences.

Insert extra rows as needed

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