ADDRESS LETTERS TO
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Colchicine in acute gout

Dear Editor

The Cochrane Musculoskeletal Group's attempt to find the place of colchicine in the management of acute gout (*AFP* July 2007)[1] is unsatisfactory, despite excellent case studies, because the Cochrane acceptable evidence is scanty: one randomised controlled trial (RCT) against placebo.

I searched my recent conflicting tests for answers to two issues in acute gout: drug choice and colchicine dose.

All agree that first drug choice is NSAIDs, unless comorbidities contraindicate.[2] Second choice varies. The *Australian Medicines Handbook*[3] promotes corticosteroids with colchicine reserved for when the former are also contraindicated. *Therapeutic Guidelines*[4] prefers colchicine; corticosteroids are reserved for when NSAIDs and colchicine are contraindicated or ineffective.

The total maximum dose of colchicine most often stated is 6 mg over 3 days, but 3 mg if glomerular filtration rate is <60 mL/min.[5] Pharmacokinetics and urgency support dosages of 0.5 mg 8 hourly after an initial larger dose.[5]

Winzenberg concludes: 'research needs to determine the lowest effective dose of colchicine and compare its efficacy and adverse affects with NSAIDs'. This will not be funded or occur other than in general practice and general practice academic units.

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References

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3. Australian Medicines Handbook Pty/Ltd. Adelaide: AMH, 2007.
4. Therapeutic Guidelines Group. Analgesic: Version 2. Victoria: Therapeutic Guidelines Ltd, 1992.
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Reply

Dear Editor

We agree the evidence around the use of colchicine for the management of acute gout is scant and as a result that its exact role is controversial, as evidenced by the conflicting views of two well recognised Australian sources of guidelines for medication use, the *Australian Medicines Handbook* and *Therapeutic Guidelines*, although there is consensus that colchicine is not a first line treatment. Furthermore, we agree, as described in both the review of Schlesinger[1] and our article, that the most appropriate dose for colchicine is unclear due to lack of evidence. The dosage we use in the case study is conservative due to the individual factors complicating the presentation in this case. We believe that our article accurately reflects the level of uncertainty, which is unavoidable when evidence is this sparse. The issues raised by Dr Morgan underline the important role of the GP in assessing both the evidence and the individual patient and working with their patient to determine the most appropriate treatment option in situations where not all the answers are yet known.

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TIA assessment

Dear Editor

The November 2007 issue of *AFP*, themed around 'stroke', was most timely given the recent launch of the *Clinical guidelines for acute stroke management* by the National Stroke Foundation (NSF). However, the delivery of the educational resource on transient ischaemic attacks (TIAs) mentioned in the article 'Stroke resources for GPs', is yet to commence.[1]

While Dhanihia and Donnan[2] hinted at the need to recognise TIA symptoms and signs as a medical emergency, we were disappointed that this issue did not include an article on TIA assessment and management specifically.

General practitioners can play a vital role in the early assessment and management of TIAs, yet the difficulty has been to determine the risk of stroke after a TIA. Johnston et al[3] validated an ABCD2 score to predict this, with patients scoring 6–7 at high risk (8%) of a stroke within 48 hours. With the current limitations of resources both of acute hospital beds and outpatient clinics, those patients at low risk could appropriately be managed in general practice. Rothwell et al[4] determined that early initiation of treatment after TIA was associated with an 80% reduction in the risk of early recurrent stroke.

The NSF are developing guidelines specifically for general practice, but the reality of busy clinical work can limit the successful implementation of new guidelines. As such, the delivery of education and the dissemination of new guidelines must be considered in multiple modes, in order to improve clinical practice.

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