Management of gout

I thank Drs Robinson and Stamp for a well-written article about gout and the evolution of its management over the past five years (*AFP* May 2016).[1]

I'd like to direct attention to the 'acute flare treatment' of gout outlined in this article. The authors have put forward a regimen that is different from some guidelines currently available to Australian general practitioners (GPs). The authors suggest initiating 1.0 mg of colchicine as soon as gout symptoms commence and then 0.5 mg six hours later, followed by 1–2 tablets daily for the next two to three days.[1] They also state that 'this is not usually associated with the common gastrointestinal adverse effects commonly seen with higher doses'.[1] Although this statement of fewer adverse effects is hard to prove, the Acute Gout Flare Receiving Colchicine Evaluation (AGREE) trial showed no improvement in symptom control with doses higher than the 1.5 mg per acute episode recommended.[2] I would assume that using more colchicine in the same episode will not improve symptoms and is likely to increase the chance of adverse effects.

The 2012 American College of Rheumatology guidelines for gout recommend 1.0 mg of colchicine at symptom onset, followed by 0.5 mg an hour later.[3] No further colchicine is to be given for three days unless gout attack prophylaxis is needed (wait at least 12 hours before starting this). This regimen comes from the AGREE trial. The *Australian medicines handbook* recommends the same plan and this was also referenced in a recent *gplearning check* program case published by The Royal Australian College of General Practitioners.[4–5]

The current *Therapeutic Guidelines* and MIMS take a different approach and recommend 0.5 mg of colchicine every six to eight hours until the attack ceases for acute gout management.[6–7] This may put the patient at risk of having significant gastrointestinal side effects.

I agree that gout can be difficult to treat, but it is important to acknowledge that the information available to those treating gout must also be the same and up to date. I would recommend that commonly accessed guidelines and resources used by GPs are adjusted to reflect the current acceptable standards of treatment. This can be based on a resource such as the American Society of Rheumatology guidelines or recommendations put forward by a consensus of rheumatologists in Australia. I am aware that these recommendations may change in years to come.

Note that, as outlined in the original article, colchicine is only available as 0.5 mg tablets in Australia and so is used as a substitute for 0.6 mg when referenced here.

Dr Harishan Tharmarajah MBBS, BBiomedSc, DCH, General Practice Registrar, Melbourne, Vic

Acknowledgement
Dr Margherita Di Carlo MBBS, FRACGP, General Practitioner, Melbourne, Vic

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Reply

We thank Dr Tharmarajah for his letter in relation to our review article on gout management.[1]

In regard to the first point, guidelines often differ; however, the American College of Rheumatology guidelines are available for Australian GPs to review.[2] We would posit that the AGREE trial Dr Harmarajah references is a good demonstration that a lower dose colchicine regimen is associated with the same therapeutic effect but fewer gastrointestinal adverse events.[3]

The American College of Rheumatology guidelines related to colchicine dosing in acute attacks state that 'the TFP recommended that acute gout can be treated with a loading dose of 1.2 mg of colchicine followed by 0.6 mg one hour later (evidence B) (10), and this regimen can then be followed by gout attack prophylaxis dosing 0.6 mg once or twice daily (unless dose adjustment is required) 12 hours later, until the gout attack

resolves (evidence C)'.[2] The guideline does not state that colchicine should be ceased; on the contrary, it states it can be continued (see Figure 3-B of the guideline).

As far as specific differences in one-hour versus six-hour dosing, we do not have enough evidence to guide us as to the optimal strategy, and we would suggest being guided by clinical severity. We generally recommend colchicine is continued for a longer period because acute attacks are commonly not entirely resolved with the AGREE dosing strategy. Clinical trials such as AGREE are often designed to answer a specific question, and do not necessarily reflect the realities of everyday clinical practice.

We agree that the *Therapeutic Guidelines* state that colchicine can be used every six to eight hours until an attack has abated, but they also state that a maximum of 12 tablets should be taken over four days.[4] This regimen is broadly in line with the American College of Rheumatology guidelines, although the timing of administration is shorter. We have spoken to a member of the *Therapeutic Guidelines* revision panel (Paul Kubler, personal communication), who has stated that they are changing the recommendations to be in line with the American College of Rheumatology guidelines.

The management of acute gout is somewhat hampered by a lack of evidence and in this situation often a variety of approaches is recommended. The approach we recommend is supported by the American College of Rheumatology and the Therapeutic Guidelines (although not as yet published) and we agree with Dr Tharmarajah that guidelines should be consistent. We hope that as practitioners and societies change the guidelines, they will align with a common one. We feel the American College of Rheumatology guidelines have been put together in a robust and evidence-based process and hope to see them more widely disseminated and accepted.

Philip C Robinson MBChB, PhD, FRACP, Senior Lecturer, University of Queensland School of Medicine, Qld; and Staff Specialist in Rheumatology, Royal Brisbane and Women's Hospital, Herston, Qld.

Lisa K Stamp MBChB, PhD, FRACP, Professor of Medicine, Department of Medicine, University of Otago, Christchurch, New Zealand; and Rheumatologist, Rheumatology Department, Christchurch Hospital, Christchurch, New Zealand

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Erratum

Tan A, Foran T, Henry A. Managing nausea and vomiting in pregnancy in a primary care setting. Aust Family Physician 2016;45(8):564–67.

In the section 'Barriers to NVP treatment', 'doxylamine' was incorrectly printed as 'doxycycline' in the last sentence of the fifth paragraph.

Corrigendum

Samuel S. On the threshold. Aust Family Physician 2016;45(8):537.

In the second last paragraph of this article, the third sentence should read 'Australian women readily initiate breastfeeding (96%) but fewer sustain it exclusively at four months (39%).'

The corrections have been made to the HTML and PDF versions of these articles.

We apologise for these errors and any confusion they may have caused our readers.

Letters to the editor

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Email: afp@racgp.org.au
Mail: The Editor, *Australian Family Physician*
100 Wellington Parade
East Melbourne VIC 3002 Australia