**Resource CMP-3: Guidelines for the Management of Gout**

**Patient education on diet (avoid purine-rich foods including sweetbreads, sardines, anchovies, kidney, and liver), lifestyle (limit or avoid alcohol), treatment objectives, and management of comorbidities is a recommended core therapeutic measure in gout.**

**Treatment of Acute Gouty Arthritis Attack**

- An acute gouty arthritis attack should be treated with pharmacologic therapy, initiated within 24 hours of onset.
  - Nonsteroidal antiinflammatory drugs (NSAIDs), corticosteroids, or oral colchicine are appropriate first-line options for treatment of acute gout, and certain combinations can be employed for severe or refractory attacks.
- Established pharmacologic urate-lowering therapy should be continued, without interruption, during an acute attack of gout.

**Prevention of Acute Gouty Arthritis Attack**

- Xanthine oxidase inhibitor (XOI) therapy with allopurinol** or febuxostat (Uloric) is recommended as first-line pharmacologic urate-lowering therapy (ULT) approach in gout.
- Oral colchicine is an appropriate first-line gout attack prophylaxis therapy, including with appropriate dose adjustment in chronic kidney disease and for drug interactions, unless there is a lack of tolerance or medical contraindication.
- Low-dose NSAID therapy is an appropriate choice for first-line gout attack prophylaxis, unless there is a lack of tolerance or contraindication.
- Serum urate level should be lowered sufficiently to durably improve signs and symptoms of gout, with the target <6 mg/dl at a minimum, and often <5 mg/dl.
- Combination oral ULT with 1 XOI agent and 1 uricosuric agent is appropriate when the serum urate target has not been met by appropriate dosing of an XOI.
- Pegloticase (Krystexxa) is appropriate for patients with severe gout.
- Pharmacologic antiinflammatory prophylaxis is recommended for all gout patients when pharmacologic urate lowering is initiated, and should be continued if there is any clinical evidence of continuing gout disease activity and/or the serum urate target has not yet been achieved.


*Prudent practice dictates including an evaluation of renal function and appropriate medication dose adjustment as needed.

**Prior to initiation of allopurinol, rapid polymerase chain reaction–based HLA–B*5801 screening should be considered as a risk management component in subpopulations where both the HLA–B*5801 allele frequency is elevated and the HLA–B*5801–positive subjects have a very high hazard ratio (“high risk”) for severe allopurinol hypersensitivity reaction (e.g., Korean ancestry with >= stage 3 CKD and all those of Han Chinese and Thai descent).