

BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

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GOUT

You'll hear about an advocacy group pushing for withdrawal of the gout med febuxostat (Uloric)...due to concerns it increases risk of death.

Patients with gout are already at elevated CV risk.

Early studies signaled a higher risk of CV events in patients on febuxostat compared to allopurinol...so FDA required a safety trial.

Now the results are in. For every 91 gout patients with CV disease treated with febuxostat instead of allopurinol for about 3 years, one will die from CV-related causes.

But the findings have limitations...and it's too soon to say why febuxostat would increase mortality.

Continue to recommend allopurinol first for most chronic gout patients...and save febuxostat as second-line.

Consider whether high-CV-risk patients already taking febuxostat should switch to allopurinol...if they can tolerate it with proper dosing.

Advise starting allopurinol at 100 mg/day in patients with normal renal function...or 50 mg/day if CrCl is 30 mL/min or less.

Then suggest titrating every few weeks as needed...up to 800 mg/day in normal renal function, or 300 mg/day or even higher in kidney disease.

Advise patients to stop allopurinol immediately if they develop rash, itching, or other hypersensitivity reactions.

See our chart, *Comparison of Gout Therapies*, for gene testing with allopurinol, the role of probenecid, and how to manage gout flares.

(For more on this topic, see Clinical Resource #340903 at PharmacistsLetter.com.)

Primary Reference – White WB, Saag KG, Becker MA, et al. Cardiovascular safety of febuxostat or allopurinol in patients with gout. *N Engl J Med* 2018;378:1200-10.

See LEADER NOTES for answers to discussion questions.

DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. **What is known about gout, xanthine oxidase inhibitors, and cardiovascular (CV) disease?**

ANALYSIS OF NEW STUDY

2. **What type of study was this? How were the patients selected for inclusion?**

3. **How were the study groups defined?**

4. **How were the outcomes evaluated?**

See [LEADER NOTES](#) for answers to discussion questions.

5. What were the outcomes of this trial?

6. What were the strengths and weaknesses of this study?

7. Were the results expressed in terms we care about and can use?

HOW SHOULD THE NEW FINDINGS CHANGE CURRENT THERAPY?

8. Do the results change your practice? How?

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

Mr. Jones is a 68-year-old male who presents to establish care with you after moving here about two months ago. He reports a past medical history significant for peripheral vascular

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disease, nicotine dependence, and arthritis. He was discharged from the hospital a week ago for a work up of chest pain. Per the discharge summary, he had normal cardiac enzymes, a normal EKG, and a nuclear medicine stress test that revealed reversible coronary artery disease. Mr. Jones declined cardiac catheterization and possible stent placement as he wants to discuss this with his children first. He did not bring in his medications today, but the discharge summary lists his medications as ASA 81 mg once daily, nitroglycerin sublingual 0.3 mg every five minutes as needed up to three doses, metoprolol 25 mg twice daily, atorvastatin 40 mg once daily, and he was encouraged to quit smoking. You note that his estimated CrCl was 55 ml/min during hospitalization. Today his vitals are all within normal limits. He denies having any further chest pain but is complaining that his right knee is very painful and hot since last night. This morning he could barely walk. He states the hospital did not give him his "arthritis medicine" and that is why he thinks his knee is causing him trouble today. On exam, his right knee is red, warm, and very tender to palpation. This happened about four months ago in his left big toe.

9. What is known about diagnosis of gout?

After further questioning, you realize Mr. Jones' "arthritis" is actually gout, and you don't see any medication for this on the discharge summary. You call his pharmacy and confirm he has been taking febuxostat 80 mg daily.

10. What factors and treatment options might you consider?

See [LEADER NOTES](#) for answers to discussion questions.

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Khanna D, Fitzgerald JD, Khanna PP, et al. 2012 American College of Rheumatology guidelines for management of gout. Part 1: systematic nonpharmacologic and pharmacologic therapeutic approaches to hyperuricemia. *Arthritis Care Res (Hoboken)*. 2012;64:1431-46.

Gaseem A, Harris RP, Forciea MA; Clinical Guidelines Committee of the American College of Physicians. Management of acute and recurrent gout: a clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2017;166:58-68.

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Additional Pharmacist's Letter Resources available at PharmacistsLetter.com

Chart, Managing NSAID Risks. *Pharmacist's Letter/Prescriber's Letter*. July 2018.

Toolbox, Corticosteroids: Selection, Tapering, and More. *Pharmacist's Letter/Prescriber's Letter*. March 2018.

Article, Duzallo (doo-ZAL-oh) will be a new chronic gout med that combines lesinurad with allopurinol. *Pharmacist's Letter/Prescriber's Letter*. November 2017.

Article. New concerns will raise questions about when it's appropriate to use SHORT courses of oral corticosteroids in adults. *Pharmacist's Letter/Prescriber's Letter*. July 2017.

Chart, Safety Comparison of NSAIDs. *Pharmacist's Letter/Prescriber's Letter*. December 2016.

Article, Corticosteroids will be used more often for ACUTE gout flares. *Pharmacist's Letter/Prescriber's Letter*. December 2016.

Chart, Comparison of Gout Therapies. *Pharmacist's Letter/Prescriber's Letter*. October 2016.

Article. Zurampic (zer-AM-pik, lesinurad) will be a new ADD-ON med for managing chronic gout. *Pharmacist's Letter/Prescriber's Letter*. October 2016.

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