Summary Table of Recommendations

Level/Quality of Evidence	Recommendations
Phase 1: Asymptomatic Hyperuricemia	
Low *No* evidence to decrease risk of incident gout	1. In the general population, asymptomatic hyperuricemia should not be routinely treated with allopurinol. Well-known associated risk factors of hyperuricemia, ie. dyslipidemia, obesity, metabolic syndrome, psoriasis, malignancies, congestive heart failure, should foremost be addressed.
Low for low purine diet; *moderate* for high purine diet and alcohol *Low* (expert opinion)	2. A low purine diet and avoidance of alcoholic beverages, most especially beer, should be prescribed. Low impact and isometric exercise at least 45 minutes 4x a week, water intake of at least 8 glasses a day, and maintenance of appropriate BMI, are likewise advised.
Phase 2: Acute Gouty Arthritis	
High for traditional NSAIDs, and Cyclooxygenase-2 (COX-2) inhibitors *Moderate* for oral colchicine *Moderate* for "short course" corticosteroids *Low* (expert opinion)	3. In the absence of contraindications , ie. renal impairment or gastrointestinal ulcers, the use of colchicine, traditional non-steroidal anti-inflammatory drugs (NSAIDs), OR selective cyclo-oxygenase 2 (COX-2) inhibitors is recommended for the treatment of acute gouty arthritis. The expert panel recommends that colchicine should not exceed 4 tablets in divided doses per day. Prednisone, initially at 30 mg and rapidly tapered over 6 days, can be given as alternative if colchicine, traditional NSAIDs or COX-2 inhibitors are contraindicated or not tolerated by the patient. Absence of response after a week should prompt reevaluation of the diagnosis and referral to a rheumatologist.
Moderate	4. Ice compress is recommended in combination with pharmacologic agents for relief of joint pain and swelling of acute gouty arthritis.
Phase 3: Intercritical/Chronic Gout	
Moderate	5. Serum uric acid (SUA) level should be reduced to and maintained at < 6 mg/dl (0.36 mmol/L).
High	6. Continuous long term therapy with allopurinol is advised to achieve a target SUA level of < 6 mg/dl.
Low	7. Allopurinol should be started at 100 mg/day 2 weeks after the pain and swelling of gouty arthritis has subsided. The dose is titrated by 50-100 mg/day every 2 to 4 weeks to achieve SUA < 6 mg/dl. The maximum dose of allopurinol is 300 mg/day. SUA and serum creatinine should be periodically monitored. A referral to an internist or rheumatologist is recommended if SUA persistently remains > 6 mg/dl despite maximum dose.
High	8. Colchicine should be used at 0.5 mg/tab OD BID to prevent gout flares when initiating urate-lowering therapy with allopurinol. This should be maintained for 3-6 months from the last occurrence of gout flare and after the optimal SUA target is achieved. In the event that adverse events like diarrhea occur, a lower dose of colchicine should be used. NSAIDs should not be used for prevention of gout flares.
Moderate *Low (expert opinion)*	9. Dietary modification (to promote weight loss) and avoidance of alcohol should be prescribed. Low impact exercises (walking, biking, swimming, ballroom dancing) may also be advised.

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PHILIPPINE CLINICAL PRACTICE GUIDELINES *for* UNCOMPLICATED GOUT

convened by the

Philippine Rheumatology Association
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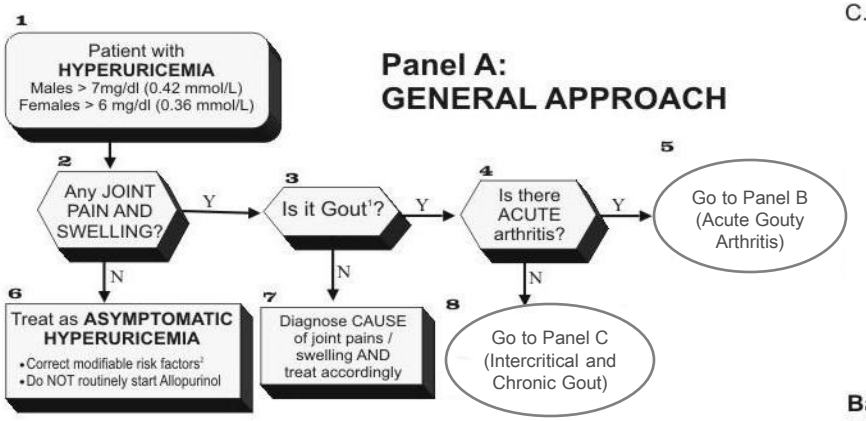
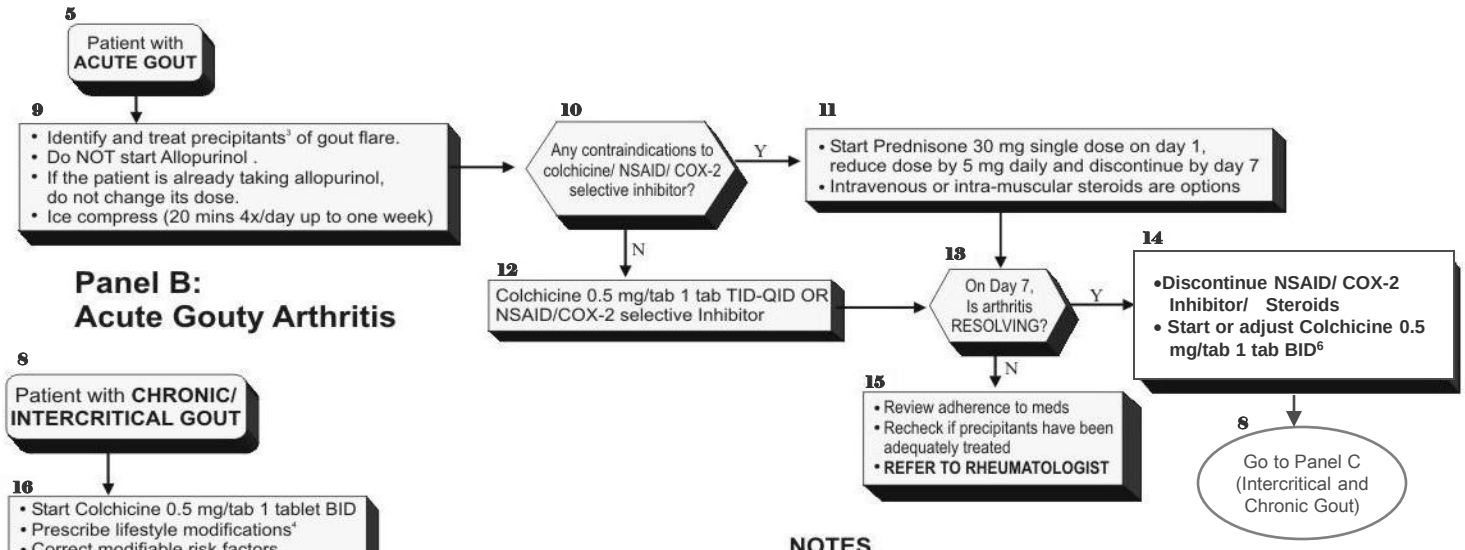
with the participation of

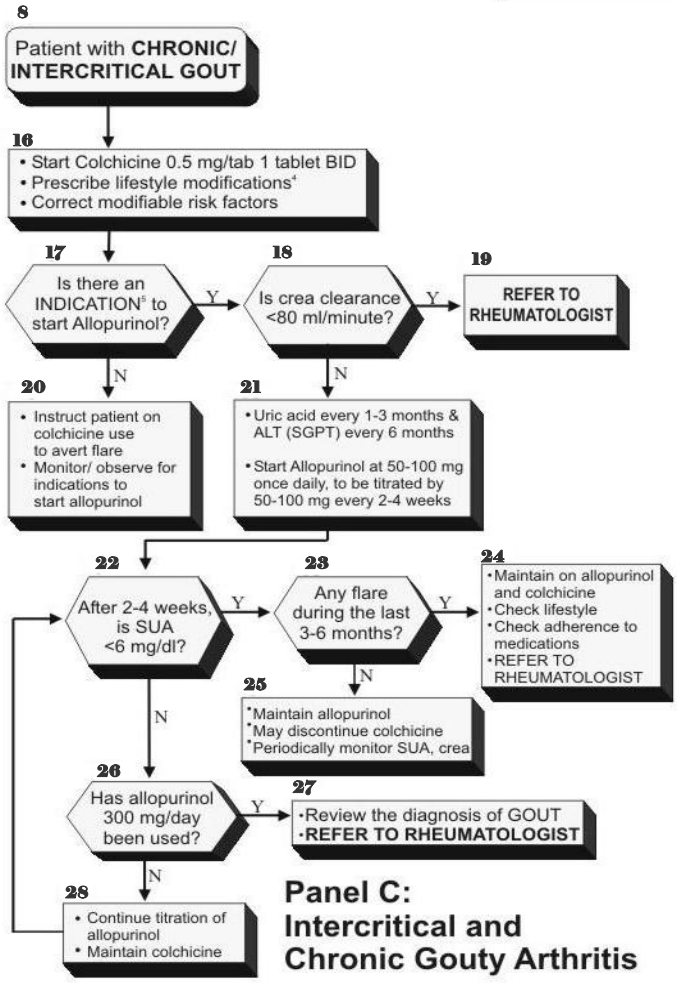
Department of Health

Nutritionist-Dietitian Association of the Philippines
Philippine Academy of Family Physician
Philippine Academy of Rehabilitation Medicine
Philippine Heart Association
Philippine Society of Endocrinology and Metabolism
Philippine Society of Hospital Pharmacists
Philippine Society of Nephrology

Algorithm on the MANAGEMENT OF A PATIENT WITH UNCOMPLICATED GOUT







[1]1977 AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR ACUTE ARTHRITIS OF GOUT*

A. Monosodium urate (MSU) monohydrate microcrystals in joint fluid during attack, OR
B. Tophus proved to contain urate crystals by chemical means or polarized light microscopy, OR
C. The presence of 6 of the following 12 clinical, laboratory, and x-ray findings:
   1. More than one attack of acute arthritis
   2. Maximum inflammation developed within 1 day
   3. Monoarthritis attack
   4. Redness observed over joints
   5. First metatarsophalangeal (MTP) joint painful or swollen
   6. Unilateral first metatarsophalangeal joint attack
   7. Unilateral tarsal joint attack
   8. Suspected tophus
   9. Hyperuricemia
   10. Asymmetric swelling within a joint on x ray
   11. Subcortical cysts without erosions on x ray
   12. Joint fluid culture negative for microorganisms during attack

Bacterial arthritis should always be considered as differential diagnosis in acute monoarthritis.

NOTES

[2]Risk Factors frequently found in association with hyperuricemia

A. Dyslipidemia
B. Obesity
C. Metabolic Syndrome
D. Congestive Heart Failure
E. Psoriasis
F. Malignancies

[3]Known precipitants of gout flares

Stress
Hospital admission or surgery
Infection
Dehydration
Drugs/ Medication (aspirin < 1 g/day, pyrazinamide, ethambutol, diuretics, etc)
Irregular intake of urate lowering medications

[4]Lifestyle modifications that should be prescribed to all patients with gout

A. Low to moderate purine diet
B. Intake of water (at least 2 L/day if without contraindication)
C. Avoidance of alcoholic beverages
D. Maintenance of appropriate body mass index
E. Engagement in low impact and isometric exercises at least 45 minutes per day 4 times a week

[5]Indications for starting urate lowering therapy

Recurrent arthritis, at least 2 episodes
Presence of tophaceous deposits
Radiographic evidence of chronic gout
Recurrent uric acid nephrolithiases