**(Lec 1)**

**Fourth year. Clinical Pharmacy**

**Rheumatologic Disorders**

 **Gout and Hyperuricemia**

**Introduction**

Gout involves an **inflammatory response to precipitation of monosodium urate (MSU) crystals in both articular and nonarticular tissues**.

**Acute gouty arthritis : pathophysiology**

1-An increased urate pool in individuals with gout may result from **overproduction** or **underexcretion**.

2-Overproduction of uric acid may result from **abnormalities in enzyme systems that regulate purine metabolism**. Cytotoxic drugs can result in overproduction of uric acid due to **lysis and the breakdown of cellular matter**.

**3-Dietary purines are insignificant** in generating hyperuricemia without some derangement in purine metabolism or elimination.

4-**Two-thirds of uric acid produced daily is excreted in urine**. The remainder is eliminated through gastrointestinal (GI) tract after degradation by colonic bacteria. Decline in urinary excretion leads to hyperuricemia.

5-Some drugs **decrease renal uric acid clearance like** diuretics.

6-Deposition of urate crystals in synovial fluid results in **inflammation**.

7-**Uric acid nephrolithiasis occurs in ∼10% of patients with gout**. Predisposing factors include excessive urinary excretion of uric acid, acidic urine (pH <6), and highly concentrated urine.

8-**In acute uric acid nephropathy**, acute kidney injury occurs because of blockage of urine flow from massive precipitation of uric acid crystals in collecting ducts and ureters. **Chronic urate nephropathy** is caused by long-term deposition of urate crystals in the renal parenchyma.

9-**Tophi** (**urate deposits**) are uncommon and are a late complication of hyperuricemia.

**Clinical presentation**

1-**Acute gout attacks are characterized by** rapid onset of excruciating pain, swelling, and inflammation. The attack is typically monoarticular, most often affecting the first metatarsophalangeal joint (podagra), and then, in order of frequency, the insteps, ankles, heels, knees, wrists, fingers, and elbows.

2-Attacks commonly begin at **night**, with the patient awakening with excruciating pain. Affected joints are erythematous, warm, and swollen.

3-**Fever** and l**eukocytosis** are common. Untreated attacks last from 3 to 14 days before spontaneous recovery.

4-**Acute attacks may occur without provocation or be precipitated by** stress, trauma, alcohol ingestion, infection, surgery, rapid lowering of serum uric acid by uric acid-lowering agents, and ingestion of drugs known to elevate serum uric acid concentrations.

**Diagnosis**

1-Definitive diagnosis requires **aspiration of synovial fluid from the affected joint** and identification of intracellular MSU crystals in synovial fluid leukocytes.

2-When joint aspiration is not feasible, the diagnosis can be made based on **presence of characteristic signs and symptoms as well as the response to treatment.**

**Treatment**

**Goals of Treatment**: **Terminate the acute attack**, **prevent recurrent attacks**, and **prevent complications** associated with chronic deposition of urate crystals in tissues.

**Nonpharmacologic Therapy**

1-**Local ice** application is the most effective adjunctive treatment.

2-Dietary **supplements** (eg, flaxseed, cherry, celery root) **are not recommended.**

**Pharmacologic Therapy**

Most patients are treated successfully with **NSAIDs**, **corticosteroids**, or **colchicine**. Treatment should begin **as soon as possible after the onset of an attack**.

**A-NSAIDS**

1-NSAIDs have **excellent efficacy and minimal toxicity** with short-term use. Indomethacin, naproxen, and sulindac have FDA approval for gout, **but others are likely to be effective**.

2-Start therapy **within 24 hours of attack** onset and **continue until complete resolution** (usually 5–8 days). Tapering may be considered after resolution.

3-**Selective cyclooxygenase-2 inhibitors** (e.g., celecoxib) **may be an option** for patients unable to take nonselective NSAIDs, but the cardiovascular risk must be considered.

**B-Corticosteroids**

1-Corticosteroid efficacy is equivalent to NSAIDs; **they can be used systemically or by intra-articular (IA) injection**. If only one or two joints are involved, either IA or oral corticosteroids are recommended. **Systemic therapy is necessary for polyarticular attacks**.

2-**Tapering** is often used to reduce the hypothetical risk of a rebound attack upon steroid withdrawal.

3-**IA corticosteroids should be used with an oral NSAID**, **colchicine**, or **corticosteroid therapy**. Alternatively, **IM corticosteroid monotherapy** may be considered in patients with multiple affected joints who cannot take oral therapy.

**4-Avoid long-term use because of risk for** osteoporosis, hypothalamic–pituitary–adrenal axis suppression, cataracts, and muscle deconditioning.

**C-Colchicine**

1-Colchicine is **highly effective** in relieving acute gout attacks; **when it is started within the first 24 hours of onset**, about two-thirds of patients respond within hours.

2-Colchicine causes **dose-dependent GI adverse effects** (nausea, vomiting, and diarrhea). **Non-GI effects include** neutropenia and axonal neuromyopathy, which may be worsened in patients taking other myopathic drugs (e.g., statins) or with impaired kidney function.

3-Use colchicine with **caution in patients taking P-glycoprotein or strong CYP450 3A4 inhibitors** (e.g., **clarithromycin**) due to increased plasma colchicine levels and potential toxicity; colchicine dose reductions may be required.

**Hyperuricemia in gout**

Recurrent gout attacks can be prevented by maintaining low uric acid levels, but nonadherence with nonpharmacologic and pharmacologic therapies is common.

**Nonpharmacologic Therapy**

1-Promote **weight loss** through caloric restriction and exercise in all patients to enhance renal urate excretion.

2-**Alcohol restriction** is important because increased consumption has been associated with an increased risk of gout attacks.

3-**Dietary recommendations** include limiting consumption of high-fructose corn syrup and purine-rich foods (organ meats and some seafood) which have been linked to uric acid elevation.

4-**Evaluate the medication list for potentially unnecessary drugs that may elevate uric acid levels**. **Low-dose aspirin for cardiovascular prevention should be continued** because aspirin has a negligible effect on elevating serum uric acid.

**Pharmacologic Therapy**

1-After the first attack of acute gout, **prophylactic pharmacotherapy is recommended** if patients have two or more attacks per year, even if serum uric acid is normal or only minimally elevated.

2-**Other indications include** presence of tophi, and radiographic evidence of damage attributable to gout.

3-Urate-lowering therapy can be started during an acute attack **if anti-inflammatory prophylaxis has been initiated.**

4-**Xanthine oxidase inhibitors are recommended first-line therapy**, with uricosurics reserved for patients with a contraindication or intolerance to xanthine oxidase inhibitors.

5-In refractory cases, **combination therapy with a xanthine oxidase inhibitor plus a drug with uricosuric properties** (probenecid, losartan, or fenofibrate) is suggested.

6-**Pegloticase** may be used in **severe cases** in which the patient cannot tolerate or is not responding to other therapies.

7-The ACR guideline goal of urate-lowering therapy is to achieve and maintain serum uric **acid <6 mg/Dl.** Urate lowering should be prescribed for long-term use.

**A-Xanthine Oxidase Inhibitors**

1-Xanthine oxidase inhibitors reduce uric acid by impairing conversion of hypoxanthine to xanthine and xanthine to uric acid.

2-Because they are effective in both overproducers and underexcretors of uric acid, **they are the most widely prescribed agents for long-term prevention of recurrent gout attacks**.

3-**Mild adverse effects of allopurinol include** skin rash, leukopenia, GI problems, headache, and urticaria. A **more severe adverse reaction** **known as allopurinol hypersensitivity syndrome**, which includes severe rash (toxic epidermal necrolysis, erythema multiforme, or exfoliative dermatitis), occurs rarely but is associated with **a 20%–25% mortality rate.**

4-**Febuxostat**: also lowers serum uric acid in a dose dependent manner. Clinical trial evidence demonstrated an **increase in all cause and cardiovascular mortality compared to allopurinol**, resulting in a warning that febuxostat should be reserved for patients unable to take allopurinol.

**B-Uricosurics**

1-Uricosuric drugs increase renal clearance of uric acid by inhibiting renal tubular reabsorption of uric acid.

2-Patients with a **history of urolithiasis should not receive uricosurics**. **Maintaining adequate urine flow and urine alkalinization** during the first several days of therapy may also decrease likelihood of uric acid stone formation.

**C-Pegloticase**

1-Pegloticase is a pegylated recombinant uricase that reduces serum uric acid by converting uric acid to allantoin, which is water soluble.

2-Pegloticase is indicated for antihyperuricemic therapy in **adults refractory to conventional therapy.**

3-Because of potential **infusion-related allergic reactions**, patients must be pretreated with antihistamines and corticosteroids.

4-Pegloticase is substantially **more expensive than first-line urate-lowering therapies**. The **ideal duration of pegloticase therapy is unknown**. Patients may develop pegloticase antibodies that result in loss of efficacy after several months.

5-**Because of its limitations**, reserve pegloticase for patients with refractory gout who are unable to take or have failed all other urate-lowering therapies.

**D-Miscellaneous Urate-Lowering Agents**

1-**Fenofibrate** is thought to increase clearance of hypoxanthine and xanthine, leading to a susained reduction in serum urate concentrations of 20%–30%. **However, ACR guidelines recommend against changing cholesterol lowering agents to fenofibrate because it is not a preferred therapy in current lipid guidelines.**

3-**Losartan** inhibits renal tubular reabsorption of uric acid **and increases urinary excretion**, properties that are not shared with other angiotensin II receptor blockers. It also **alkalinizes the urine**, which helps reduce the risk for stone formation. Guidelines recommend **choosing losartan preferentially as antihypertensive therapy in patients with gout when feasible**.

**Anti-Inflammatory Prophylaxis During Initiation of Urate-Lowering Therapy**

1-**Initiation of urate-lowering therapy can precipitate an acute gout attack due to remodeling of urate crystal deposits in joints after rapid lowering of urate concentrations**.

2-**Prophylactic anti-inflammatory therapy is recommended to prevent such gout attacks.**

3-The ACR guidelines strongly recommend **low dose oral colchicine**, **low dose NSAIDs, or prednisone 10 mg daily** during the **first 3 to 6 months of urate lowering therapy initiation**, and longer as needed if gout flares persist.

**Evaluation of therapeutic outcomes**

1-**Check the serum uric acid level** in patients suspected of having an acute gout attack, however, acute gout can occur with normal serum uric acid concentrations.

2-**Monitor patients with acute gout for** **symptomatic relief** of joint pain.

3-**Because of the high rates of comorbidities associated with gout** (diabetes, chronic kidney disease, hypertension, obesity, myocardial infarction, heart failure, and stroke), elevated serum uric acid concentrations or gout should prompt **evaluation for cardiovascular disease and the need for appropriate risk reduction measures.**

**Reference**

**Joseph T. DiPiro, Robert L. Pharmacotherapy: A Pathophysiologic Approach,**

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