Standards of Care for people with













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ARMA is the umbrella organisation for the UK musculoskeletal community. ARMA is a registered charity No 1108851. Our member organisations are:

- Arthritis Care
- Arthritis Research UK
- BackCare
- Birmingham Arthritis Resource Centre
- British Chiropractic Association
- British Health Professionals in Rheumatology
- British Institute of Musculoskeletal Medicine (BIMM)
- British Orthopaedic Association
- British Osteopathic Association
- British Sjogren's Syndrome Association (BSSA)
- British Society for Paediatric & Adolescent Rheumatology (BSPAR)
- British Society for Rheumatology (BSR)
- British Society of Rehabilitation Medicine
- Chartered Society of Physiotherapy
- COT Specialist Section Rheumatology
- Early Rheumatoid Arthritis Network (ERAN)
- Fibro Action
- Fibromyalgia Association UK

- Lupus UK
- MACP
- McTimoney Chiropractic Association
- National Ankylosing Spondylitis Society (NASS)
- National Association for the Relief of Paget's Disease
- National Rheumatoid Arthritis Society (NRAS)
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- The Psoriasis Association
- Rheumatoid Arthritis Surgical Society
- Royal College of Nursing Rheumatology Forum
- RSI Action UK
- Scleroderma Society
- Scottish Network for Arthritis in Children
- Scottish Society for Rheumatology

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The contents of this document and further resources including contact details for our member organisations, further information about our work and this project, including additional examples of good practice and resources to support implementation, are available on the ARMA website at www.arma.uk.net.

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Gout – The size of the problem

Gout is a true "crystal deposition disease" and occurs when sodium urate crystals form in and around joints as a result of levels of uric acid (which we all have in our blood) rising above a certain critical level - the "saturation point" for urate crystal formation. In some people, whose uric acid levels are persistently raised above the saturation point, urate crystals slowly but continuously deposit in and around joints over several years. This goes undetected because it doesn't cause symptoms. However, once a lot of crystals have accumulated, some of them may shake loose from the cartilage in which they form and spill over into the joint cavity - so-called "crystal shedding". This shower of hard, needle-shaped crystals causes the joint to become very inflamed, resulting in an "attack" of gout with severe pain, swelling and redness of an affected joint, most commonly the "bunion" joint at the base of the big toe. Other commonly affected joints are the feet, ankles, knees, fingers, wrists and elbows, whereas the hips, shoulders and spine are only rarely affected. Pain is usually very severe, often so severe that shoes cannot be worn or the weight of bedclothes is too heavy to bear. The pain typically develops very rapidly, often over a few hours or overnight. Treatment leads to complete improvement over a few days although attacks will get better over two to three weeks even without treatment. With time the person may suffer from further attacks which may become more severe, more frequent and affect different joints. Eventually, without treatment, chronic joint pain and hard nodules of crystals under the skin – known as tophi – may develop. Tophi typically occur at the big toe, heel, knee, fingers, and elbows and can cause pressure damage to cartilage, bone and other tissues.

Gout is one of the most common causes of inflamed joints and affects approximately one in a hundred adults in the UK.¹ In contrast to other causes of inflamed joints such as rheumatoid arthritis, which are usually treated by hospital specialists, gout is largely managed in primary care. Gout is more common in men than women - four out of five people with gout are male - and becomes more common as people get older.^{1, 2} It is the most common cause of inflamed joints in men. Gout appears to be becoming more common³.

Why do people get gout?

There are many reasons why people get gout. Gout commonly runs in families, particularly in men, and recent research has identified genes which may predispose people to getting gout.⁴ Life-style factors such as being overweight, drinking too much alcohol (particularly beer) and eating purine-rich foods such as red meat, offal, dark fish and shell-fish excessively can also lead to raised uric acid levels and predispose to gout.⁵⁻⁷ Having certain medical problems such as high blood pressure, high levels of cholesterol in the blood, diabetes and heart or kidney problems also puts people at risk of developing gout.⁵ Certain medicines which people take to treat those medical problems, most importantly diuretics ("water tablets") can also predispose to gout.⁵

What is the impact of gout?

As well as causing pain and difficulty using joints, gout has several important effects on the lives of people who have it. Recent research studies have shown that having gout leads to poorer quality of life and difficulty performing day-to-day tasks.^{8,9} People of working age with ongoing, symptomatic gout take ^{4,5} more health-related days off work per year and incur almost twice the health costs of people who do not have gout.^{10, 11} Patients who fail to respond to treatment, developing chronic tophaceous gout, suffer a disproportionately high disease burden and incur significantly higher health care costs. Attacks of gout very commonly affect the toes and feet



and it is known that gout causes more long-term problems in the feet such as bunions, chronic pain in the big toe and difficulty in walking.^{12,13} Perhaps, most importantly, it has recently been recognised that people with gout are at risk of developing heart disease.¹⁴⁻¹⁷ It is not known for certain why this is the case but it is likely to be due to several factors including high uric acid levels, persistent inflammation inside joints, and other medical problems associated with gout such as high blood pressure, high cholesterol and diabetes, all of which may increase the risk of heart disease.

What is the importance of raised uric acid levels (hyperuricaemia) in people who do not have gout?

Most people with raised uric acid levels do not develop gout; only one-fifth of people with the very highest levels of uric acid develop gout over a five-year period.¹⁸ Measuring the uric acid level in the blood therefore is not a useful test to diagnose gout but is extremely useful to monitor the success of treatments which lower uric acid levels, such as allopurinol. The significance of having a high uric acid level without gout is not fully understood. Some research studies suggest that having a high uric acid level without gout may still put people at risk of heart and kidney disease but this is a controversial subject.¹⁹ UK and European recommendations for the treatment of gout do not currently recommend using medications such as allopurinol to lower uric acid levels in people who do not have gout.^{20,21} However, finding that a patient who does not have gout has a raised uric acid level offers an important opportunity to consider why the level is raised and to screen for common causes of high uric acid levels such as lifestyle factors, high blood pressure, high cholesterol, diabetes, kidney disease and medications, particularly diuretics.

Why we need Standards of Care

Gout is one of the few "curable" types of arthritis. Lowering uric acid levels, by changing lifestyles and using medications such as allopurinol, prevents the formation of new sodium urate crystals and causes existing crystals to dissolve, which stops attacks of gout from occurring and leads to tophi reducing in size and eventually disappearing. However, recent research studies show that gout is often poorly treated. Patients infrequently receive advice to restrict consumption of alcoholic drinks or purine-rich foods or to keep their weight down.²² Risk factors for heart disease such as high blood pressure, high cholesterol and diabetes commonly affect people with gout, yet only one-quarter of people who see their GP about gout are checked to see if they have these associated conditions.²³ Less than one-third of people with gout are prescribed medications such as allopurinol to lower their uric acid levels and even those taking allopurinol are often not on a high enough dose to lower the uric acid levels in their blood sufficiently, or do not take their medication regularly.²²

It is not known why the treatment of gout is so unsatisfactory. However, it is likely that factors relating to both health-care practitioners and patients are responsible. Certainly, gout is often thought of as a trivial intermittent condition and it is not widely recognised that, although attacks of gout may be episodic, the crystals persist inside joints, leading to inflammation and joint damage if not treated.

Standards of care for gout are therefore needed to make both practitioners and patients aware of the importance of gout and the impact it has on patients' lives and how this curable arthritis should best be treated.

ARMA's Standards of Care for people with gout are intended to support people of all ages with gout to lead independent lives and reach their full health potential through:

- access to information, support and knowledge that optimise musculo-skeletal health for everyone and enable self-management
- access to the right services that enable early diagnosis and treatment
- access to ongoing and responsive treatment and support.

The Standards define what services are appropriate under these three themes and suggest ways of providing them effectively and in a measurable way, in the form of key interventions. A detailed rationale for the Standards draws on available evidence and examples of good practice in line with ARMA's ongoing call for good practice: a database giving details of these and other examples is available at www.arma.uk.net

The Standards are not guidelines, or algorithms of care, though they refer to these where available.

The Standards of Care for people with gout form part of a suite of Standards; other Standards published to date are available at www.arma.uk.net.

The Standards acknowledge the fact that those planning and delivering services around the UK face differing demographic, geographic and economic factors, which will affect how the Standards are implemented in each locality. We hope the Standards will act as a tool for all stakeholders - service users, providers, commissioners and policy-makers - to work together to review and improve their local musculoskeletal services.

Key principles - the user-centred approach

The project has been driven by the needs of people living with musculoskeletal conditions. It began with the establishment of a set of key principles for care, developed by a group of people living with musculo-skeletal conditions and consulted upon widely. These principles have underpinned the development of each set of condition-specific Standards. The key principles, which can be found on ARMA's website www.arma.uk.net, affirm that 'patients' are individuals who need different types of advice and support at different times and who need integrated services providing advice and support that cover all aspects of managing and living with the condition – clinical, personal, social and employment/educational. In particular the Standards recognise that health services play a key role in supporting people to maintain or return to employment or education.

Nevertheless, whilst these Standards focus on health services, it must be recognised that people with gout and other musculo-skeletal conditions have wide-ranging needs. Social care often plays a key role in ensuring that people can remain as active and independent as possible. Factors such as access to transport and the built environment may have a major impact on quality of life. More work is needed to understand and meet these needs.

Musculo-skeletal conditions affect families and carers as well as individuals. Indeed, many people with these conditions may be carers themselves. The Standards do not make specific recommendations on issues relating to carers: this needs to be the subject of further work to ensure that carers' needs are understood and addressed.

How the Standards were developed

These Standards of Care for people with gout were developed through wide collaboration, as in previous ARMA Standards of Care. An expert working group was established from the member organisations of ARMA and allied medical specialities, including Primary Care and Primary Care Commissioning. As for previous ARMA Standards of Care, input from people with gout was central to the development of this set of Standards.

Starting with a review of the needs of people with gout and of the established clinical treatment guidelines, the expert group met in May 2011 to plan the process.

Subsequently the Standards were developed by electronic communication, with outline Standards being widely distributed and consulted upon. The Acknowledgements on page 15 give details of the working group membership.

Clinical experts have identified the evidence base and the relevant national and international clinical treatment guidelines for the management of gout. Evidence has not been formally graded for this exercise as this has occurred in the development of the clinical management guidelines.

These Standards are based firmly on best practice and the preferences of people with gout. They are aimed at ensuring best practice at a local commissioning level, in order to alleviate the burden of gout to the individual and to the health and social services.

Access to diagnosis

Standard 1

People with symptoms of gout should have access to health professionals in primary care and the community, who have the training to identify risk factors that can lead to development of gout, to identify various presentations of gout and to commence appropriate multidisciplinary care.

Standard 2

Septic arthritis is the most important differential diagnosis. Health care professionals should manage all people with a suspected septic arthritis in accordance with national guidelines. (e.g. BSR,BOA) This will include urgent referral to secondary care for investigation (including joint aspiration and blood tests) and commencement of intravenous antibiotics and other necessary treatments.

Assessment of Needs

Standard 3

Healthcare professionals undertaking the management of people with gout should be trained and have knowledge of the associated comorbidities and their management.

Standard 4

At diagnosis, the person with gout should have a full assessment of their disease, be screened for comorbidities and referred for multidisciplinary care where appropriate, in accordance with national and European guidelines (e.g., BSR, EULAR).

The rationale

- Diagnosis of a typical acute attack can usually be made confidently according to the clinical features alone.²⁴ Taken together, the speed of development of an acute attack (at its worst within 6-24 hours), the severity of the pain and tenderness ("worst ever"), and the self-limiting nature of the episode are highly characteristic of crystal-induced inflammation, and if this affects the big toe bunion joint in a 40 year old man then gout is by far the likeliest cause.^{1,24} However, calcium pyrophosphate crystals can cause identical acute attacks, although these usually occur in older people and tend to target different joints (mainly knees, wrists, shoulders). Also, other joint conditions can present with some of these features and lead to misdiagnosis. Therefore, for less typical presentations, and even for classical presentations, it is ideal to make a definite "gold standard" diagnosis by confirming the presence of urate crystals in joint fluid or by aspiration of a tophus.^{21,24} Diagnostic joint aspiration can be done during the acute attack, but also between attacks²⁵, and has a very high likelihood of showing a positive result in people with gout.
- Both types of crystal urate and calcium pyrophosphate can cause identical acute attacks in joints that are targeted by both conditions (e.g. knees, ankles, elbows, wrists) and both types of crystal can occur in the same joint. Therefore, joint aspiration for investigation for both crystals should be undertaken in anyone in whom the diagnosis is uncertain.

- Septic arthritis also causes pain, swelling and tenderness of a single joint and can look similar to gout. Furthermore gout and sepsis can coexist in the same joint.^{21, 24} Septic arthritis is a medical emergency. Therefore in atypical cases of acute joint inflammation where septic arthritis is considered to be a possibility, the patient should be referred urgently to hospital for joint aspiration and appropriate investigation and treatment. The British Society for Rheumatology have published guidelines on the management of hot swollen joints in adults that provides further information which some readers might find useful.²⁶
- Tophi can present a highly characteristic appearance that may assist diagnosis and their presence is used to judge the staging and severity of gout. Therefore, a person with gout requires a full clinical examination (predominantly peripheral arms and legs) to look for tophi.
- Although high blood serum levels of uric acid are a key risk factor for gout, blood serum levels are unhelpful in making the diagnosis. This is because many people with high levels do not develop gout, and at the time of an acute attack the levels temporarily drop and may be in the normal range. Therefore a high level does not confirm, and a low level does not exclude the diagnosis.^{21, 24} Sequential monitoring of serum uric acid levels, however, is very important in terms of tailoring long-term urate lowering treatment and "cure".²⁰
- Gout eventually can cause joint damage that resembles osteoarthritis (OA). ²⁴ Conversely OA itself is a risk factor for urate crystal deposition.²⁷ Therefore patients with gout require clinical assessment to detect the presence of OA. This may require an x-ray of certain joints (e.g. feet, knees, hands) in addition to a thorough clinical examination of all joints.
- X-ray changes that are characteristic of gout are a late feature. Therefore x-rays are rarely useful in terms of making the diagnosis.²⁴ However, ultrasound of joints (feet, knees, hands) is increasingly being used to demonstrate urate crystal deposits in joint cartilage,²⁴ even at first presentation. With increasing availability of ultrasound, this assessment may begin to be used to assist early diagnosis of gout.
- There are a number of recognised risk factors for gout, some of which are potentially modifiable.^{4, 5-7} Therefore, people with gout should be assessed for these risk factors and should be informed of those that have been found, so that they understand why they specifically have developed gout. These risk factors include:
 - gout occurring in first degree relatives (usually reflecting inheritance of kidneys that although otherwise healthy, are relatively inefficient at excreting uric acid)
 - being overweight or obese
 - having an excess intake of beer or food rich in purines
 - being on long-term drugs (e.g. water tablets) that elevate uric acid levels
 - having chronic kidney problems
- High blood pressure, high cholesterol and diabetes commonly associate with gout and high uric acid levels.⁵ These conditions, collectively termed "metabolic syndrome", may not be causing any specific symptoms, but can each independently increase the risk of future heart disease and stroke. However, if detected and effectively treated this increased risk can be greatly reduced. Therefore people presenting with gout should be screened for these conditions.

Putting the Standards into Practice: key interventions

- i People presenting with gout should receive a full and holistic assessment from a trained health professional to determine the diagnosis with confidence. Wherever practicable, this should involve aspiration of a joint, bursa or tophus and examination of the fluid for presence of urate crystals (the gold standard for diagnosis). Especially for atypical cases, if this expertise is not locally available, the person should be referred for joint aspiration and definitive diagnosis (for example, by a rheumatologist).
- The person with gout should be assessed for the presence of tophi and OA (i.e. joint damage), and for the recognised risk factors that have resulted in gout in that individual. The patient should receive a full explanation of these findings.
- iii People with gout should be screened, and appropriately treated for associated comorbidities. An assessment of overall cardiovascular risk should be undertaken and the results discussed with the patient.
- iv If septic arthritis is considered to be a possible explanation of an acutely inflamed joint, even in a person with known gout, the patient should be urgently referred to hospital for investigation and management.

Good Practice Example - A

A group of GPs in the North-East, who meet on a regular basis to discuss clinical topics, had a presentation of an audit on gout management. As a result of this the regional biochemistry lead was asked to document the BSR recommendations for serum urate being <0.3 in patients being treated for gout. This was actioned in the Durham and Darlington area and local GPs have commented that they have noticed the change and believe it will lead to an improvement in their management of gout.



standards **5-12**

Standard 5

Patients should be made aware of the signs and symptoms of an impending attack of gout so that they may seek help at the earliest opportunity. They should be informed about where to go and whom to consult for prompt treatment.

Standard 6

Once gout is diagnosed, all patients should be screened for commonly associated conditions and have their medication reviewed by a health professional with appropriate training in the management of gout.

Standard 7

People with flares of gout should have rapid access (within 48 hours) to health care professionals, who are able to treat the acute flare immediately and offer self management advice.

Standard 8

People with gout should be offered education on the nature of the disease and advice on lifestyle modification, to reduce their risk of gouty arthritis.

Standard 9

People with gout who are prescribed a diuretic ("water tablet") should be reviewed to see if the diuretic can be stopped. This is often possible when the diuretic is prescribed for high blood pressure but may not be possible if it is prescribed for associated heart or kidney problems.

Standard 10

In order to cure their gouty arthritis, people with gout should be offered long term treatment with urate lowering therapies, with a target serum urate consistently below 360µmol/L (6mg/dl)

Standard 11

People with gout should be offered long term follow-up and have their gout monitored, particularly if taking urate lowering therapy.

Standard 12

Referral to a specialist in the management of gout (Rheumatologist) should be offered to those people with gout who, in spite of measures introduced in primary care, continue to experience difficulties or who are resistant to conventional treatment.

The Rationale

- Gout is a painful and disabling inflammatory arthritis whose incidence and prevalence is increasing, especially in the elderly. It is the most common form of inflammatory arthritis in men aged over 40 and affects 1-2% of adults in developed countries.¹⁻³
- Gout leads to a poorer quality of life, increased work days lost and substantially increased healthcare costs.⁸⁻¹¹
- Gout can cause irreversible joint damage resembling osteoarthritis. Progression of gout to a chronic deforming and disabling disease is often a result of treatment failure, intolerance or non-persistence with treatment. This leads to disproportionally higher disability and healthcare costs.²⁸
- Gout is associated with significant medical comorbidities; in particular the metabolic syndrome and cardiovascular disease and therefore the associated comorbidities should be checked and appropriately managed.²⁴

- Gout is one of a few "curable" types of arthritis. Management encompasses two phases, firstly the control of pain and joint inflammation in the acute attack and secondly, when appropriate, the lowering of blood uric acid levels to a target normal level and the resorption of tophaceous deposits.^{20, 21}
- Lifestyle factors may be a significant risk factor for the development of gout in some people.⁵⁻⁷ Therefore, these should be assessed and, if found, the person should be informed and educated so that they understand why they have developed gout and how they can manage their condition.
- There are recognised risk factors for gout. As these may be modifiable, a full medical assessment of the person presenting with gout should be undertaken to identify these risk factors and to commence appropriate management.^{20, 21, 24}
- Less than one third of people with gout are prescribed medications to lower their uric acid level and often those prescribed treatment do not receive an adequate dose.^{2, 22} Concordance with treatment is often poor and people with gout are often provided with insufficient or inaccurate information about their condition and its management.

Putting the Standards into Practice: key interventions

- i A person presenting with a suspected attack of gout should be seen within 48 hours and treated, to result in rapid relief of pain and joint inflammation. They should be given self-management advice and possible treatments could include:
 - non-steroidal anti-inflammatory drugs (NSAIDs)
 - colchicine
 - corticosteroids (intra-articular, intramuscular, oral)
 - simple analgesics
 - ice therapy
 - joint aspiration
- ii On diagnosis, people with gout will be given written information on gout, its causes and selfmanagement. They should also be given clear advice about warning signs that may indicate the development of an attack of gout so that they know when, how and where to obtain help. The key warning signs are:
 - acute severe pain, swelling and often redness of a joint, especially the big toe, but also the ankles and feet, knees, hands and elbows.
 - deposits of sodium urate crystals ("gout" crystals) predominantly affecting the fingers, toes and elbows.
- iii Once diagnosed, all people with gout should be assessed for modifiable lifestyle factors, which may be responsible for or increase the risk of gout developing. This will help them with self-management. Where relevant, advice should include:
 - education on what urate is and how reducing levels in the body can cure the disease
 - weight reduction if overweight or obese
 - adequate hydration
 - assessment and rationalisation of current medication, particularly diuretics (water tablets)



good practice **B**

Good Practice Example - B

A hospital in the South-East runs an annual 2-day update for GPs, which includes the diagnosis and management of crystal arthritis. Following this year's session a large GP practice audited those patients who had a gout diagnosis and were on Allopurinol.

They found that each GP had between 11 and 23 patients on Allopurinol. Over 90% had not had an annual check on serum urate. Each GP had between 1 and 5 patients who had not had a check for 8 years. Those patients identified were recalled and had their serum urate levels checked.

- alcohol consumption advice
- dietary advice
- exercise
- iv Referral to appropriate Allied Health Professionals within the multidisciplinary team should be made, as required, for a baseline assessment, tailored education and information, advice and appropriate intervention, e.g. Podiatry for assessment of joint function, footwear and orthoses; dietetics for dietary and lifestyle advice; occupational therapy if the patient's work or activities of daily living are affected and other therapies as required.
- Once diagnosed, all people with gout should be assessed for associated comorbidities and treated according to national and European guidelines. (e.g. BSR/EULAR.) Conditions screened should include:
 - diabetes
 - high cholesterol
 - high blood pressure
 - heart disease
 - osteoarthritis
- vi In people where urate lowering management is indicated, they should be managed by both pharmacological and non-pharmacological methods in accordance with national and European guidelines. A target serum urate level below 360µmol/L is recommended as the most conservative target for all patients, however lower levels are desirable whenever possible.^{20, 21} Pharmaceutical methods should include:
 - Allopurinol
 - Febuxostat
 - Uricosuric drugs (sulfinpyrazone; benzbromarone)

The dose of these drugs should be individualised to the patient to ensure that the serum uric acid level is reduced and maintained below the critical "saturation point" (360μ mol/L or 6mg/dl) at which crystals can form.²⁰

vii In people prescribed urate lowering treatment for the first time, an attack of gout may occur and they should be reassured that this is a sign that urate lowering therapy is working.

- viii An NSAID or colchicine should be co-prescribed with urate lowering therapy to prevent urate lowering therapy-induced flares of gout and continued until the target serum urate level is achieved.
- ix People resistant to conventional treatment or who have ongoing difficulty managing comorbidities should be considered for referral to a specialist service dealing with the management of gout. The indications may include:
 - failure to respond to conventional management
 - allergy or the inability to take conventional treatments
 - multiple co-morbid conditions (e.g. heart failure, diabetes mellitus, organ transplant, haematological malignancy)
- x Treatments should be individualised to the patient's condition and take into account the persons comorbidity, the person's own preferences and the side effects of treatment.
- xi People should be offered long-term follow-up and monitoring of their gout, including checks on serum urate and monitoring of their co-morbid conditions including annual cardiovascular risk assessment. Those involved in treatment should ensure that:
 - urate and renal function are monitored frequently on initiation of urate lowering therapy
 - annual checks of urate and renal function are made, once urate levels are stable
 - if indicated, cholesterol, blood pressure and sugar levels are monitored
 - the serum urate level is maintained comfortably below the target level of 360µmol/L (6mg/dl)
- xii Healthcare organisations should ensure that there is access to training on the assessment and management of people with gout for all health professionals involved in their support and care.
- xiii Clear pathways of management need to be determined and agreed by local services and healthcare providers so that people with gout receive the appropriate treatment, as defined by the relevant national and European guidelines.
- xiv GPs should be the first point of contact for people with gout and should be aware of all the pathways in primary and secondary care to which they can refer people for in-depth advice and specialist care.



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Allied Health Professional or Practitioner

A member of the care team who is not a medical doctor, but who offers advice and clinical care. For example, a nurse, physiotherapist, occupational therapist, dietician, podiatrist, or pharmacist. These healthcare professionals are registered with, and regulated by, the Health Professions Council.

Analgesics

Drugs that relieve pain.

Chronic disease

A long-term illness for which there is no cure, but where the activity of the disease can be controlled.

Commissioners

Those that establish health needs and priorities of a population then purchase services to meet those needs.

Co-morbidity

Other disease that one person might have.

Guidelines

Official statements that define the parameters of practice.

Interventions

A general term covering treatments, advice, education and other care that a practitioner may give.

Multidisciplinary team

A healthcare team that includes professionals from different disciplines, working together to provide a comprehensive service for people with gout.

Musculoskeletal

referring to the muscles, tendons, ligaments, cartilage, bones, joints and spinal discs.

NICE

The National Institute for Health and Clinical Excellence is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Orthoses (orthotics)

Devices intended to alter or stabilise the mechanical function of a joint or limb. This includes a range of splints, insoles and braces.

Pathway

A person's route or journey through care, which can include a number of different treatments and services.

Podiatrist

A podiatrist is a clinician who specialises in the evaluation and treatment of diseases of the foot. In the UK, a podiatrist should be registered with the Health Professions Council

Primary care

Care services available in the community, for example through a community pharmacist or the care provided by a GP. This is often a person's first point of contact for advice, information and treatment.

Providers

Organisations responsible for delivering care and treatment, such as NHS trusts. Also called healthcare providers or service providers.

Rheumatology

Diagnosis and treatment of diseases and disorders of the joints, muscles, bones and tendons such as arthritis and degenerative joint disease. Rheumatological conditions are a subset of the broader group of musculoskeletal problems.

Secondary care

Care available usually in a hospital setting. People generally need referral from a professional in primary care.

Service user

A person who accesses healthcare services.

Stakeholder

A person, group, organisation or system which affects or can be affected by an organisation's actions.

Standards

A set of expected norms and acceptable outcomes

Treatment

Drugs or other interventions intended to alleviate symptoms

Triage

The process by which appropriate treatments and/or referrals are decided.



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Menarini MSD Novartis

Working Group

Dr Peter Prouse - Chair Consultant Rheumatologist, Basingstoke and North Hampshire NHS Foundation Trust

Dr Kelsey M Jordan Consultant in Rheumatology, Honorary Senior Lecturer and Trustee of the UK Gout Society.

Professor Michael Doherty

Professor of Rheumatology, University of Nottingham

Dr Edward Roddy

Clinical Senior Lecturer and Honorary Consultant Rheumatologist, Arthritis Research UK Primary Care Centre, Primary Care Sciences, Keele University

Dr Christian D Mallen

Senior Lecturer in General Practice, Director, Academic General Practice, Director, Clinical Academic Training, Arthritis Research UK Primary Care Centre, Keele University

Weiya Zhang

Associate Professor and Reader in Musculoskeletal Epidemiology, Academic Rheumatology, Faculty of Medicine and Health Sciences, University of Nottingham

Jacqueline Rachel Forss

Podiatry Lead, Woundcare, East Sussex Healthcare Trust

Dr Elspeth Wise

Salaried General Practitioner, Encompass Healthcare, Washington, Tyne and Wear

Dr Sam Hullah

Deputy Chair of Calleva Medical, Basingstoke

Project Managers

Isobel Gildon Sarah Rich Victoria Skingley

Other Contributions

Professor Ade Adebajo

Consultant Rheumatologist / Clinical Director for Specialised Medicine Barnsley Hospital NHS Foundation Trust and Professor of Musculoskeletal Health Service Research University of Sheffield.

Arthritis Care

Arthritis Research UK

Dr Jeremy Camilleri

Consultant Rheumatologist, University Hospital of Wales, Cardiff

Robert Field

Lead Podiatrist -Rheumatology Services, Community Health Services, Dorset Health Care, NHS University Foundation Trust

Dr Joanna Ledingham

Consultant Rheumatologist, Queen Alexandra Hospital, Portsmouth

Dr Margaret McArthur

COTSS-R R&D Officer, School of Allied Health Professions, University of East Anglia, Norwich

Professor Anthony Redmond

Head of Clinical Biomechanics and Physical Medicine, Leeds Institute of Molecular Medicine, Division of Rheumatic and Musculoskeletal Disease

Luke Pengelly

Service user, Ipswich

Lillian Young Patient, Worcestershire

Unnamed service user Exeter

Standards of Care for people with





Arthritis and Musculoskeletal Alliance

Bride House 18-20 Bride Lane London EC4Y 8EE

Tel: +44 (0) 20 7842 0910 info@arma.uk.net www.arma.uk.net

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