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PROGRAM NAME

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Johnson:
This is CME on ReachMD. I'm Dr. Richard Johnson, and we're going to talk today about why managing gout in the nephrology clinic is a challenge. And for this, I would like to introduce a wonderful nephrologist, Dr. Abdul Abdellatif, who has had a lot of experience treating gout in the CKD clinic.

Abdul, tell us a little bit about management of gout in the CKD clinic and some of the challenges you face.

Dr. Abdellatif:
Thank you, Richard, for having me discuss this topic, which is really very important for our patients and our clinicians. We know managing gout in the kidney clinic is very challenging. Unfortunately, in the community we know there's a lot of misunderstanding of management of gout because gout is basically a two-way street. You have the acute gout attack, which that's when the patients present to see their clinicians or their practitioners, and there's the chronic gout that we need to control to prevent, you know, recurrent acute gout attacks. Unfortunately, a lot of patients may be treated with NSAIDS [nonsteroidal anti-inflammatory drugs] or colchicine to control the acute symptoms, but there is misunderstanding that the goal is to lower the uric acid to a target level.

We know that lowering the uric acid to less than 6 is the guideline's target, but we know in our patients with chronic kidney disease, it also might be lowered to a lower level because we know most of those patients, when they present, they may have tophaceous gout. The challenge also is when you use these urate-lowering agents, you may not get to target. The most common urate-lowering agents in the United States that are commonly used are allopurinol and febuxostat. And has been shown in a clinical trial of looking at more than 300 patients that when you use allopurinol, you're only able to get those patients to target in about 21% rate. But when you use febuxostat, you may get about 53% of those patients to target of less than 6. However, we know that even if you get patients to less than 6, it's been shown that these patients may not have resolution of their tophi, because it may take much longer to treat the condition if you continue to use normal urate-lowering therapies, and we know there is also other options for those patients, such as pegloticase, which is an infusion therapy that is given every 2 weeks. And for those patients we've seen significant improvement and much faster control of their chronic tophaceous gout or chronic uncontrolled gout, which is defined by having a uric acid more than 6 or with 2 flares per year of gout or having tophi at the same time. And now also, we know that these medications may affect the kidney or the liver, and sometimes they are limited in some of our patients, but pegloticase has been shown to be safe at any kidney level. Patient with normal kidney function, chronic kidney disease on dialysis, hemodialysis, peritoneal dialysis, or even transplant patients.

Dr. Johnson:
That's very interesting. When you give allopurinol or febuxostat, you know, kind of our goal is to get the serum uric acid under 6, but I believe you've discussed how some of these patients have tophaceous gout. In fact, many patients with chronic kidney disease have tophaceous gout where the goal is even to get the uric acid lower. And it's very hard to, with the standard treatments like allopurinol and febuxostat, to really be able to get the uric acids down low enough to help resolve those tophi.

So pegloticase is a pretty good treatment, right? Because it can drop the uric acid down to, like, 2 or 3 or even lower.

Dr. Abdellatif:

Definitely. I mean, we've seen that the resolution of those tophi when using this therapy is significantly faster than traditional oral urate-lowering therapies.

Dr. Johnson:
Well, thank you very much, Abdul, for the great insights today. This ends our discussion.

Announcer:
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