

### Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:

<https://reachmd.com/programs/cme/treat-or-refer-who-is-responsible-for-managing-gout/15959/>

Released: 10/24/2023

Valid until: 10/24/2024

Time needed to complete: 1h 02m

### ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

---

Treat or Refer: Who Is Responsible for Managing Gout?

### Announcer:

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

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

### Dr. Botson:

Hello. This is CME on ReachMD, and I'm Dr. John Botson from Anchorage, Alaska. I'm here today with Dr. Abdul Abdellatif, a nephrologist who's going to speak with us some about the nephrology perspectives of gout.

Dr. Abdellatif, do you feel, in your clinic, responsible for managing these patients with gout as a nephrologist versus me as a rheumatologist?

### Dr. Abdellatif:

We have recently, in the past 15 years, shifted the focus that this is really our disease. And the reason I say that is because the kidney's really the main organ that gets the responsibility to eliminate the uric acid from the body. And we know that as the patient's kidney function decreases, either with age or development of chronic kidney disease or other factors related to medications, that the uric acid starts to build up, and those patients who have gout have actually worsening episodes of recurrent gout attacks because of the burden of the uric acid.

Uric acid is not part of the routine chemistry that's ordered in a kidney clinic, but now we actually need to order that test. Number one, to diagnose our patients at an early stage so we can control their disease. Secondary, because we know that gout itself, as it progresses, it can lead to progression of kidney disease in some of the patients at risk.

Now it is important to actually get the patient to a nephrologist sooner than later because most of the patients don't even express their symptoms when they go see the primary care physicians and may self-treat. But unfortunately, some of those medications that the patient may reach for to treat themselves include NSAIDs [nonsteroidal anti-inflammatory drugs] over the counter, and those are toxic to the kidney. We really encourage the primary care physicians, podiatrists, even orthopedic surgeons to actually refer the patients for early evaluation as soon as they're diagnosed with the disease. They do not have to have chronic kidney disease before we see them because our goal is to actually slow down the progression of this chronic disease.

### Dr. Botson:

I appreciate that perspective. You know, as a rheumatologist, one of the things that we kind of talk about with our nephrology colleagues is at what point do you check or ask the patient if they have joint pain, which essentially is what separates hyperuricemia from gout is the patient that actually has an active inflammatory process going on in the joints. Rheumatologists, we kind of look at that right up front with the patients coming in the door, but maybe I've heard the critique that the nephrologists maybe don't feel comfortable with that? Is that something that maybe needs to change?

### Dr. Abdellatif:

I believe so because, you know, patients with chronic kidney disease are considered the most complex, probably the most ill, chronic patients that we see in clinics in general. And because they have so many other comorbidities – the nephrologist may be trying to control the blood pressure, they're trying to control their volume status, electrolyte abnormalities, may have to be participating in controlling their heart failure and even diabetes nowadays – that gout may be the last thing on their mind when the patient comes into their practice.

We do sometimes get patients that have been on either NSAIDs for a long time or colchicine for a long time or maybe are receiving a lot of courses of steroid therapy for a long time before they're even put on the appropriate therapy to lower their uric acid. They're not even on urate-lowering agents. And it's really important to not only put them on the appropriate urate-lowering agents, but also escalating the dose to the appropriate target to make sure their gout is controlled and eventually, if they are not controlled, that there we do have even further options for these patients that include infusion therapies.

**Dr. Botson:**

The bottom line of this is that no one of us, rheumatology or nephrology, is going to be able to manage these patients by themselves. And it's important, I guess, that we keep talking and making sure we're taking the best care of these patients that we can.

So I think that's it for this discussion. Thanks for everyone out there listening and hope to see you again.

**Announcer:**

You have been listening to CME on ReachMD. This activity is provided by Prova Education and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to [ReachMD.com/Prova](https://ReachMD.com/Prova). Thank you for listening.