



Goodfellow Gems are chosen by Goodfellow Director, Bruce Arroll to be either practice changing or thought provoking. You are being mailed these as you are a member of the Goodfellow learning community.

7 points for clinical diagnosis of gout without joint fluid analysis

A systematic review of the diagnosis of acute gout¹ was published recently, containing an earlier study from primary care² with similar findings.

A clinical score was derived from the odds ratios – highest to lowest correlation:

	Clinical score
Serum uric acid > 0.36 mmol/l * (5.88 mg/dL)	3.5
First MTP joint involvement	2.5
Male gender	2.0
Previous patient-reported arthritis attack	2.0
Hypertension or ≥ 1 CV diseases	1.5
Joint redness	1.0
Onset within one day	<u>0.5</u>
Maximum score	13.0

*N.B. uric acid may be low during an acute attack so a blood test 4 or more weeks after an acute attack should be used.

A score of 8 or more meant gout was confirmed in 80% of cases. In New Zealand, a patient of Māori or Pacific ethnicity would have a higher chance of having gout when presenting with unilateral joint pain, given their very high prevalence of gout. By age 65, more than 1 in 4 Māori and Pacific men will be on allopurinol for gout.³

References:

1. Diagnosis of gout: A systematic review in support of an American College of Physicians clinical practice guideline. *Ann intern med* (2017). [Click here](#)
2. A diagnostic rule for acute gouty arthritis in primary care without joint fluid analysis. *Arch Intern Med* (2010). [Click here](#)

National prevalence of gout derived from administrative health data in Aotearoa New Zealand. Rheumatology (Oxford) (2012) [Click here](#)

[Register for next Goodfellow webinar](#): 7.30pm on 20 Mar 2018, Associate Professor Gerry Devlin and Dr Fraser Hamilton discuss the new Consensus Statement on Cardiovascular Disease Risk Assessment and Management for Primary Care.

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