CORRESPONDENCE

Gout treatment: when a tablet is not enough

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We read with great interest the article by Pérez-Ruiz et al.¹ on the association of environmental dietary factors and polymorphisms of urate transporters with an increased risk of gout (*Environment and genetics in gout: a maze for clinicians?* *Nat. Rev. Rheumatol.* 10, 8–9; 2014). The authors concluded that environmental factors, including comorbidities and medications, are the most important risk factors for developing gout and that probably only a small percentage of the population variance in serum urate concentration is due to genetic factors. However, the authors do not make a strong case for environmental modification interventions, because the influence on serum urate has not been shown to be clinically meaningful.

The effectiveness of the weight loss, for example, in lowering urate levels may be disappointing in some studies in population groups with mean serum urate of less than 7 mg/dl. In these groups weight loss of 5–9.9 kg and more than 10 kg are associated with reductions in plasma urate of 0.3 mg/dl and 0.6 mg/dl respectively.² However, in patients with gout and hyperuricaemia (mean serum urate of 9.50 mg/dl) weight loss of 7.7 kg was associated with a reduction in plasma urate of 1.67 mg/dl and significant reduction in cardiovascular risk.³ Thus, the decrease of urate-related weight loss seems to be associated with the degree of weight loss and with a high initial uricaemia. Although the hypouricaemic effect seemed weaker than that of urate-lowering drugs, other associated health benefits would make weight reduction important in this population.²

Patients with gout frequently have a number of comorbid conditions, which can include renal disease, excessive alcohol intake, obesity, metabolic syndrome, type 2 diabetes mellitus, hypertension, lipid

disorders and cardiovascular disease.⁴ The EULAR⁵ and ACR⁶ guidelines for management of gout suggest addressing these comorbidities. The prevention and treatment of these conditions with dietary and lifestyle interventions can provide a long-term therapeutic benefit superior to mere control of urate.

Compliance of gout patients with therapy is low. Work has shown greater success in achieving the goals of treatment in patients with gout when the strategy combines patient education, lifestyle advice and appropriate use of urate-lowering therapy.^{7,8} Lifestyle interventions not only help to reduce levels of urate but also to improve adherence to treatment and the final achievement of the therapeutic goal.

We agree with the final statement that “attitudes that rely mostly on dietary advice for the treatment of hyperuricaemia should never be responsible for the neglect of other interventions.” However, we also agree with the statement in reverse, treatment with a tablet of hyperuricaemia should never be responsible for the neglect of other interventions on diet and lifestyle in patients with gout. Among all of the rheumatic diseases, gout is by far the one most closely related to the lifestyle of the patient.⁹ The recent lifestyle recommendations applicable to most patients with gout or hyperuricaemia,^{6,10} are not very different from those for the general population for a healthier life, although the success of such measures require a firm attitude of the physician and the active participation and long-term commitment of patients.¹¹ Optimal gout treatment cannot conform to only treat acute episodes, or to reach and maintain serum uric acid less than 6 mg/dl, but must also focus on the prevention of comorbidities and cardiovascular risk. There is much work to be done when writing a prescription for hypouricaemic drugs.

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Competing interests

The authors declare no competing interests.

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