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Editorial

Remission in Gout: The Key to Patient Satisfaction?

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Thomas Sydenham (1624–1689) described gout flare pain as a feeling of "dislocated bones," sometimes akin to the "gnawing of a dog, and sometimes a weight"[1]. These strong words are not unusual: The majority of gout patients rate their flare pain as severe or very severe, with gout ranking among the top 2 health conditions for its negative effect on patients' quality of life[2]. Despite the excruciating pain that patients with gout intermittently suffer, physicians continue to do a poor job of preventing gout flares. Even among patients with severe or very severe symptoms, only 57% of patients with gout are prescribed urate-lowering therapy (ULT)[3]. Among those who have been prescribed a urate-lowering drug, noncompliance may be as high as 61%[4].

Multiple factors contribute to these unfortunate statistics. The burden of gout care falls most heavily upon overworked primary care physicians (PCP), who, within an average visit of 15 or 20 minutes, must prioritize the many comorbid conditions common to gout patients, including high blood pressure, chronic kidney disease, high cholesterol, diabetes mellitus, and coronary artery disease[5,6]. Guidelines for gout treatment are dissonant: rheumatology societies recommend ULT in most cases, whereas American College of Physician guidelines take a more lackadaisical approach[7,8]. Inadequate patient and provider education further leads PCP and their gout patients away from optimal treatment[9]. These factors contribute to a large disease burden for patients, who, in the face of poor gout control, have more outpatient visits, emergency room visits, and inpatient stays than matched patients without gout, with subsequent increased healthcare utilization and costs[10]. Education and persistence about urate lowering works: In one study, Doherty, *et al* reported that training research nurses to deliver guideline-based gout care resulted in improved adherence to ULT, better achievement of target urate, and better patient quality of life, as well as corresponding decreases in tophi and cost of care, compared to usual care by general practitioners over a 2-year period[11].

Understanding what is important to our patients and improving our ability to support them on their own terms could increase treatment adherence and gout clinical outcomes. In this context, the study by Taylor, *et al* in the current issue of *The Journal of Rheumatology*[12] helps bridge the gap between what matters most to patients (cessation of flares) and what matters most to physicians (targeted urate lowering with compliance to medication). The study's authors set out to understand how gout flare frequency affected patient perception regarding the state of their own disease, defined as remission, low disease activity (LDA), and Patient Acceptable Symptom State (PASS).

Evaluating 512 patients across 17 countries, Taylor, *et al*[12] asked patients how they perceived their own condition. Overall, patients agreed that they were in remission if they had no flares in either the past 6 or 12 months. In contrast, patients considered that 2 or more flares in the past 6 or 12 months were equivalent to high disease activity, aligning well with the American College of Rheumatology guidelines on when to institute ULT in patients with gout[8]. Of note, the authors found no difference in patient perception regarding remission if they had had no flares in 6 or 12 months, possibly helping to reduce time of monitoring patients for gout remission in future studies.

In the "gray zone" between remission and high activity, the authors' results further advance our understanding of what constitutes acceptable gout disease activity from the patient's perspective. With each additional flare over the past 6 months, patients were 15% less likely to rate their disease as being in LDA/PASS, while in the prior 12 months, each flare was associated with 5% lower odds of self-categorizing as being in LDA/PASS. Patients thus seemed to remember recent flares more vividly and judge their recent disease as being worse; a similar flare more than 6

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months earlier did not trigger a similar concern for severity. The psychology of pain recollection is an underinvestigated area and may differ according to the type and context of the pain. In one study, patients rated their pain during a cardiac event as worse 6 months after the event than they did during the event itself[13]. Whether the ability of gout patients to "forget" the pain of older episodes contributes to poor treatment compliance is an area worthy of investigation.

An important next step is to understand how patients who consider their gout to be in remission think about the benefits of ULT. What do they think about a treatment with a "silent" effect (i.e., lack of flares), and how does that thinking connect with their current and future gout control? By understanding how patients perceive their gout and what compels patients to seek good treatment and control, we may be able to help drive patient-centered care and improve adherence to therapy.

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