Editorial

Remission in Gout: The Key to Patient Satisfaction?

Michael Toprover¹ and Michael H. Pillinger¹

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 life². 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 treatment⁹. 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 costs¹⁰. 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 period¹¹.

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 gout⁸. 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

¹M. Toprover, MD, Clinical Instructor in Medicine, M.H. Pillinger, MD, Professor of Medicine and Biochemistry and Molecular Pharmacology, Division of Rheumatology, Department of Medicine, New York University Grossman School of Medicine, and Rheumatology Section, Department of Medicine, New York Harbor Health Care System New York Campus, Department of Veterans Affairs, New York, New York, USA.

MHP reports that he has served as a consultant to Swedish Orphan Biovitrum and Horizon Therapeutics, and holds investigator-initiated grants for unrelated investigations from Hikma Pharmaceuticals and Horizon Therapeutics.

Address correspondence to Dr. M.H. Pillinger, NYU Langone Orthopedic Hospital, 301 E 17th Street, New York, NY 10003, USA.
Email: michael.pillinger@nyulangone.org.

See Flare thresholds in gout, page 293

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 itself¹³. 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.

REFERENCES

1. Dorwart BB. Thomas Sydenham (1624-1689), on gout: 1717. *J Clin Rheumatol* 2004;10:227.
2. Singh JA, Edwards NL. Patient perceptions of gout management goals: a cross-sectional internet survey. *J Clin Rheumatol* 2019 Jan 4 (Epub ahead of print).
3. Singh JA, Shah N, Edwards NL. A cross-sectional internet-based patient survey of the management strategies for gout. *BMC Complement Altern Med* 2016;16:90.
4. Scheepers L, Burden AM, Arts IC, Spaetgens B, Souverein P, de Vries F, et al. Medication adherence among gout patients initiated allopurinol: a retrospective cohort study in the Clinical Practice Research Datalink (CPRD). *Rheumatology* 2018;57:1641-50.
5. Keenan RT, O'Brien WR, Lee KH, Crittenden DB, Fisher MC, Goldfarb DS, et al. Prevalence of contraindications and prescription of pharmacologic therapies for gout. *Am J Med* 2011;124:155-63.
6. Mechanic D, McAlpine DD, Rosenthal M. Are patients' office visits with physicians getting shorter? *N Engl J Med* 2001;344:198-204.
7. Qaseem A, Harris RP, Forciea MA. Management of acute and recurrent gout: a clinical practice guideline from the American College of Physicians. *Ann Intern Med* 2017;166:58-68.
8. Khanna D, Fitzgerald JD, Khanna PP, Bae S, Singh MK, Neogi T, et al. 2012 American College of Rheumatology guidelines for management of gout. Part 1: systematic nonpharmacologic and pharmacologic therapeutic approaches to hyperuricemia. *Arthritis Care Res* 2012;64:1431-46.
9. Ogdie AR, Hoch S, Dunham J, Von Feldt JM. A roadmap for education to improve the quality of care in gout. *Curr Opin Rheumatol* 2010;22:173-80.
10. Lee YY, Tang CH, Chen JH, Kuo LN, Ko Y. Evaluation of healthcare costs and utilization for patients with gout: a population-based matched cohort study. *Curr Med Res Opin* 2018;34:735-40.
11. Doherty M, Jenkins W, Richardson H, Sarmanova A, Abhishek A, Ashton D, et al. Efficacy and cost-effectiveness of nurse-led care involving education and engagement of patients and a treat-to-target urate-lowering strategy versus usual care for gout: a randomised controlled trial. *Lancet* 2018;392:1403-12.
12. Taylor W, Dalbeth N, Saag KG, Singh JA, Rahn EJ, Mudano AS, et al. Flare rate thresholds for patient assessment of gout disease activity states. *J Rheumatol* 2021;48:293-8.
13. Everts B, Karlson B, Währborg P, Abdon N, Herlitz J, Hedner T. Pain recollection after chest pain of cardiac origin. *Cardiology* 1999;92:115-20.