CKM Guidance

Cardiovascular-Kidney-Metabolic Disease

Preventing Adverse Outcomes in Cardiovascular Kidney Metabolic Conditions

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Please make sure to periodically check for updated content.

Instructions:

The guidance is separated into the multiple sections.

Clicking on the yellow highlighted text will take you to the relevant section of the guidance on the guidance web site

Clicking on a pink highlighted abbreviation will take you to the relevant abbreviation within the abbreviations section of this document.

Clicking on a blue link will open relevant external guidance in a new window for more detailed information.

Contents:

9. Management of gout

Abbreviations

9. Management of gout

- Gout is common in people with CKM disease and is an independent risk factor for <u>CV</u> and renal disease. Effective treatment of gout is important in preventing gout flares and reducing CV and renal sequelae.
- Detailed guidance on managing gout can be found here including ensuring the correct diagnosis and management of acute gout flares. The guidance below is a brief synopsis of the management of gout relevant to CKM disease:
 - Start urate lowering pharmacotherapy if any of the following:
 - Recurrent gout flares especially ≥ 2 flares per year

- Gouty tophi or chronic gouty arthritis
- Evidence of joint damage due to gout
- Urate lowering pharmacotherapy should also be considered if ANY of the following:
 - \blacksquare \ge 1 episode of gout with onset of gout at a young age or strong family history of gout
 - ≥ 1 episode of gout and serum urate > 0.6 mmol/L
 - ≥ 1 episode of gout and impending significant weight loss e.g. bariatric surgery, total diet replacement strategies etc.
- Allopurinol is first line agent aiming for serum urate levels < 0.36 mmol/L or < 0.3 mmol/L if tophi.
 - Initial dosing ONLY is based on renal function:
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 - eGFR > 60 mL/min 100 mg allopurinol daily
 - eGFR 30 60 mL/min 50 mg allopurinol daily
 - eGFR < 30 mL/min 50 mg allopurinol on alternate days
 - Consider HLA-B*5801 screening in high-risk Asian populations before starting allopurinol to reduce risk of severe hypersensitivity reactions
 - All people of Chinese or Thai descent
 - All Korean people with eGFR < 60 mL/min
 - Ask people to stop allopurinol and to contact the practice if they develop a skin rash
 - Increase dose of allopurinol by 50 100 mg every 4 weeks until urate to target
 - Typically recommended cover colchicine when starting allopurinol to prevent gout flares.
 - Consider reducing dose in renal impairment and beware of drug to drug interactions
 - Discuss adverse effects, particularly GI adverse effects and to stop if significant effects occur
 - Ensure safe storage and to keep out of the reach of others as overdose can be fatal as no reversal agent

- Consider requesting child-proof packaging on prescription if appropriate
- Continue colchicine for 3-6 months after target serum urate is achieved
- Once at target, measure serum urate 6 12 monthly to ensure still to target
- Reassure that once target urate reached it may take > 12 months for gout flares to stop and years for tophi to dissolve
- Consider probenecid or febuxostat if intolerant of allopurinol or failure of allopurinol despite ensuring adherence. More information on probenecid and febuxostat can be found here
- Gout is almost always caused by genetic variants and is typically more severe with a younger age of
 onset in Māori and Pacific Peoples. Recommended lifestyle interventions may be helpful, particularly if
 dietary triggers, but should not delay starting urate lowering pharmacotherapy or dominate the
 consultation.
 - Weight loss if overweight
 - Drinking 2 litres of water per day if no concerns over fluid overload
 - Avoiding excess alcohol
 - Reducing high sugar food and drinks
 - Eating regular meals as gout can be triggered by both fasting and overeating
 - Avoid foods that have previously triggered their gout flares (if any).
 - Once urate levels are to target, previous dietary triggers are often well tolerated.
- o Acute flares of gout may still occur. If so:
 - Prednisone or colchicine are typically preferred in CKM disease with normal precautions
 - Consider back pocket prescription in case a further gout flare occur
 - Ensure serum urate to target but beware that urate levels may be normal in 50% of acute flares
- People with gout should have their cardiovascular risk factors managed aggressively. If other features
 of CKM then assessment of cardiovascular risk factors should be performed at least annually to ensure
 all to target
- **NB:** There continues to be no conclusive evidence supporting urate lowering treatment of asymptomatic hyperuricaemia
- The guidance in this section is aligned with the new evidence-based new national Health Pathway for gout

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Abbreviations:

СКМ

Cardiovascular-Kidney-Metabolic

\mathbf{CV}

Cardiovascular

eGFR

Estimated Glomerular Filtration Rate

↑ Back to contents

↑ Back to top