

Gout Stop Plus Programme: Closing the Loop

Background

- Gout Stop is a Northland initiative to improve management and outcomes for patients with gout.
- Patients presenting with 2 or more acute flares of gout per year should be issued a gout stop prescription. This provides patients with a 3-month course of medications to firstly treat their acute flare, then provide an appropriate Allopurinol titration regime to begin their longstanding medication regime. The prescription can be found within the PMS by typing 'Gout' into the medication box. There are different regimes according to the patient's eGFR.
- The Gout Stop Plus programme is funded through the Long-Term Conditions fund. It funds Kaiāwhina/virtual nurse follow up of all patients enrolled with a MTH member practice, and prescribed the gout stop prescription. It also funds nurse-led follow up consults (which has specific requirements as per Gout Stop follow up consult checklist) and a maximum of 3 prescriptions if necessary to up-titrate medications until uric acid is at target after the initial Gout Stop Plus programme has been completed.

Epidemiology

- Pacific peoples have the highest prevalence rates of 16% in northland.
- Followed by Māori with prevalence rates of 11.8% in northland.
- Non-Māori prevalence is 8.3%.
- Māori and pacific peoples tend to develop gout at much younger ages.
- Prevalence is increasing due to increased consumption of processed foods.

Aetiology

- Gout is caused by a genetic mutation that means that uric acid cannot be excreted efficiently via the kidney. This results in excess build-up of uric acid in the blood stream.
- Uric acid is a by-product of metabolism. Gout can therefore not be controlled by diet alone.
- It is widely accepted that the genetic mutation responsible for gout conferred an evolutionary advantage to Māori and Pacific peoples as it maintained blood pressure in the face of reduced water intake and lack of sodium in the indigenous diet.

Pathophysiology

- Gout manifests as hot, painful, swollen joints.
- It is caused by build-up of uric acid crystals in the bloodstream. Once the bloodstream reaches saturation levels, the uric acid spills out of the blood and into the joints. Here it crystallises, forming needle-like structures that induce inflammation.

Associated Conditions

- Gout is highly associated with other long term health problems: LV enlargement and heart failure; acceleration of atherosclerosis, increasing risk of heart attacks and strokes; kidney damage and failure; insulin resistance and diabetes.



- 74% patients with gout also have **hypertension**.
- 71% of patients with gout will develop **chronic kidney disease**.
- 26% of patients with gout also have **diabetes**.
- 14% of patients with gout will have a **myocardial infarction**.
- 11% of patients with gout will develop **heart failure**.
- 10% of patients with gout will have a **stroke**.
- It is therefore imperative that you look for and treat other end-organ damage and metabolic disease as well as joint disease when managing patients with gout.

Impact

- Traditional thinking that gout flares are caused by eating/drinking the 'wrong' foodstuffs is outdated and should not be promoted in practice. This leads to feelings of guilt and shame and prevents patients from seeking care.
- Gout flares result in significant loss of economic activity with increased time off work and poor health outcomes for uncontrolled gout.
- Māori and Pacific peoples experience more adverse outcomes due to NSAID and prednisone overuse from under treated gout.

Consult Checklist/Pathway

1. Patient presents to General Practice with 2nd (or more) acute gout flare in 12-month period.
 - a. Discuss and consent for referral to the Gout Stop Programme. Provide an overview of the Gout Stop Programme, and advise that the gout nurse will be in contact within 2 weeks of the referral.
 - b. Gout Stop Prescription issued via PMS (type 'gout' into medication box and gout stop prescription options appear according to eGFR)
 - c. Select appropriate Gout Stop Pack according to patient's most recent eGFR. If no up to date eGFR, utilise an element of pragmatism in decision.
 - d. Check BP, height and weight are up to date – repeat if not done within 12 months.
 - e. Order appropriate bloods/urine: lab request form: Special Requests tab: Gout Stop Blood Panel (eGFR, LFTs, Lipids, HbA1C, uric acid, uACR). Add any extra bloods required as relevant to each case. Ensure patients get bloods done at time of consult to prevent patients being lost to follow up. N.B uric acid levels may be artificially low at the time of the gout flare.
2. Gout Stop Prescription in PMS automatically generates a referral to Mahitahi Gout Stop Nurse who will contact patient within first 2 weeks of starting their medications and continue ongoing support/education/service navigation throughout the 3-month duration of medications.
3. Upon completion of the Gout Stop Pack, the General Practice prescriber issues the patient with a 3-month prescription for long term Allopurinol. This can be done as a repeat medication request and does not necessarily require a consult unless there are indications to do so. Please write a prescription according to the most recent Allopurinol dose. Eg if Gout Stop 1 (eGFR>90) was issued, follow on dose of Allopurinol is 300mg od.
 - a. A prescription for colchicine should also be issued: Colchicine 0.5mg od PRN. Mitte 20 tabs. 2 x repeats.

- b. A lab form for uric acid should also be issued at the same time as the prescription and patient advised to get uric acid checked prior to next prescription due.
 - c. Check that other Gout stop bloods have been done within the previous 3 months. If not, issue 'gout stop' lab form (under special requests in e-orders on PMS)
 - d. Contact patient when repeat prescription is issued to book a funded follow up metabolic health screen with the practice nurse. This must take place prior to issuing the next Allopurinol prescription.
4. Metabolic Health Screen (GOUTC) is completed by a practice nurse within 3 months of patient completing their Gout Stop prescription ie before their next repeat prescription is due (and up to 6 months from starting initial Gout Stop Prescription) (see below for content of follow up metabolic health screen content).

The Gout Stop Follow up Consult Checklist

This consult should be nurse-led. It attracts additional funding of \$100 (GST inclusive) and should be free for the patient. Payment is automatic when GOUTC is entered into the PMS as an invoice code. This consult can be provided as a virtual consult if BP, height, and weight are up to date.

1. **Gout check:** age of onset; how many flares per year; presence of tophi; target uric acid (<0.36mmol/L or <0.30mmol/L if tophi present); current symptoms/niggles.
2. **Heart check:** BP, weight, height,(BMI), lipids, CVDRA (if dashboard indicates it is due)
3. **Kidney check:** uACR (more important than eGFR), eGFR
4. **Diabetes check:** HBA1C
5. **Provide counselling:**
 - a. Education on causes of gout; patient beliefs and understanding about gout.
 - b. Medication: ensure allopurinol is prescribed; advice on how to take; need to take daily; if more than 2 weeks of treatment missed, need to restart at lower dose. Restarting at original dose will precipitate a flare.
 - c. Discuss abnormal blood results and other clinical findings eg a high BP should warrant a discussion about hypertension and its management, including lifestyle/behaviour modification.
 - d. **Gout flare Action Plan:**
 - i. Ensure early treatment available at home in case of gout flare.
 - ii. continue taking Allopurinol even in presence of a gout flare. Flares whilst taking Allopurinol indicate that the dose is not high enough and needs further up titration.
 - iii. Advise patient to present to practice within 2 weeks of an acute flare for review of dose of Allopurinol.
 - e. General advice: keep hydrated (drink water); ensure prescribers are aware of presence of Gout as certain medications may exacerbate/precipitate an attack; general warnings about NSAID overuse.
6. **Onward referrals:**
 - a. Offer HIP/Health coach appointment to support patients to continue long term medications, even when well and to consider what life adjustments they can

make; consider HIP/Health coach referral if clinical checks indicate presence of other metabolic disease eg (pre)diabetes, hypertension; renal impairment to discuss lifestyle/behavioural intervention.

- b. Consider GP/NP/nurse prescriber review as per your clinic pathways if evidence of concurrent diabetes (or pre-diabetes), hypertension; high CVD risk or high uACR
- c. Consider GP/NP consult if contraindication to Allopurinol and requires prescription of an alternative urate-lowering medication; if evidence of hypersensitivity (skin rash most likely); if diagnostic uncertainty; if bloods/clinical checks indicate presence of other metabolic disease eg (pre)diabetes, hypertension, high CVD risk etc AND a prescription is required.

7. Documentation:

- a. Ensure the patient has had a classification of gout and this is highlighted as a long-term condition.
- b. Ensure that the patient has been prescribed Allopurinol and this is highlighted as a long-term medication.
- c. Ensure the patient has been prescribed gout flare medications: prednisone, naproxen or colchicine according to patient profile/preference
- d. Add in recall for Uric acid, HBA1c, eGFR and uACR check at least annually (or sooner as clinically indicated)
- e. Enter invoice code GOUTC

8. Monitoring:

- a. If uric acid is to target ($<0.36\text{mmol/L}$) at time of metabolic health screen, ensure current dose of Allopurinol is continued as a long-term medication.
- b. If uric acid is not to target (ie $>0.36\text{mmol/L}$), uric acid levels must be checked every month and prior to issuing a new prescription of Allopurinol. Allopurinol doses should be increased following every uric acid level not to target. Dose increases should be prescribed as per protocols on health pathways.
- c. N.B. If uric acid levels are still not to target despite multiple dose increases, consider non-adherence to medication as a reason and address prior to prescribing further dose increases.
- d. Ensure uric acid, HBA1c, eGFR, uACR and LFTs are checked annually as a minimum – these can be requested together under the ‘gout stop’ heading in e-orders, under special requests.
- e. Ensure BP is checked annually as a minimum

Professional Resources

[Allopurinol-patient-card-v2.pdf \(communityhealthpathways.org\)](#)

[Update on gout management | He Ako Hiringa](#)

[Improving gout outcomes and achieving equity | He Ako Hiringa](#)

[Welcome to the Gout Guide for health providers](#)

Patient Resources

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Version 2 – Practice Portal - last updated 12 August 2025, 11am



[Support Groups - Arthritis New Zealand](#) – Gout arthritis online support group

[Gout - Arthritis New Zealand](#) – access to free support/advice Monday-Friday

A note on prescribing Allopurinol follow on prescriptions

- **DO NOT STOP ALLOPURINOL EVEN IF NO UP-TO-DATE URIC ACID LEVELS AVAILABLE. CONTINUE AT MOST RECENT DOSE UNTIL URIC ACID LEVELS CAN BE RE-CHECKED.**
- If the dose is to be increased, ensure colchicine 0.5mg od dosing as flare prophylaxis at EVERY up titration
- Allopurinol dose must be increased every month until uric acid levels are to target. Uric acid levels therefore must be checked on a monthly basis in order to do this. Additional funding is available from Mahitahi Hauora PHO in order to complete this activity. Enter invoice code GOUTFU at every monthly dose increase. Funding is available monthly until uric acid levels are to target.
- On average, it takes 6 – 9 months of titration to achieve target uric acid levels.
- Ensure those with renal impairment and patients of East Asian ethnicity have slower titration as quicker dose escalation can increase risk of sensitivity reactions in this patient group.
- The correct dose of Allopurinol is the dose that lowers uric acid levels to $< 0.36\text{mmol/l}$
- Standard maintenance dose of Allopurinol is 100-600mg daily (mean dose is 400mg daily); this may need to be increased to 700-900mg daily in severe cases.
- Ensure the patient also has acute flare medications on hand for prompt treatment (low dose colchicine is preferred medication)
- Rebound flares can occur when regular colchicine prophylaxis is stopped, and patients should be warned of this. Advise patients to continue their Allopurinol at current dose and use colchicine on PRN basis once daily until niggles have settled.
- Colchicine is toxic in high doses and advice should be given around safe storage, limiting numbers of tablets prescribed.