Week 4 Collaboration Cafe

Mr Roland Berger is a 51-year-old male with complaints of a second gout attack within the last eight months. His past medical history reflects diabetes mellitus type 2 (DM) and gout. He has no allergies to medication. His current medication list is Metformin (Glucophage), a 500 mg tablet by mouth twice daily, and Indomethacin (Indocin), a 50mg tablet by mouth TID for acute gout pain. Mr. Berger is a non-smoker and drinks an alcoholic beverage once a month. He is presenting to the clinic today with acute pain related to a gout flair-up, and his physical exam revealed a reddened, edematous, and painful big right toe. Mr. Berger's labs revealed a 10mg/dl uric acid level.

According to the current clinical practice guidelines (CPG) for the treatment of gout, uric lowering therapy (ULT) is recommended for patients with serum uric acid concentrations greater than 9mg/dl (FitzGerald et al., 2020). Allopurinol (Zyloprim)is the recommended medication for gout treatment. The daily dosage recommendation is from 300-800 mg/day (FitzGerald et al., 2020).

The patient did lab work supporting a gout flair, as he is in acute pain with a pain scale of 8 out of 10, and he presented with a red, swollen right great toe. The patient has a history of a flair-up eight months prior and felt the same way this time. In this scenario, the patient is the advocate, and his chief complaint was a gout flair. This led the provider to focus on the lab work needed to validate that claim on top of a physical assessment validating the diagnosis. The treatment should be Zyloprim (allopurinol) 100 mg by mouth daily, and the patient will need follow-up lab work in 3 weeks based on the CPGs (FitzGerald et al., 2020). Patients with serum uric acid concentrations greater than 9mg/dl are at increased risk of experiencing gout progression (FitzGerald et al., 2020). The recommendation is that allopurinol be the first-line