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.

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- Gout is common in people with CKM conditions and is an independent risk factor for CV 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 conditions:
    - Start urate lowering pharmacotherapy if any of the following:

- Recurrent gout flares – especially > 1 flare 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:
    - ≥ 1 episode of gout with onset of gout at a young age or strong family history of gout (common in Māori and Pacific populations)
    - ≥ 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.
    - ≥ 1 episode of gout and eGFR < 60 mL/min

◦ 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.
    - 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.
    - Acute flares of gout may still occur. If so:
        - Prednisone or colchicine are typically preferred in CKM conditions 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
    - It is important to ensure people with gout should have an up to date CKM risk assessment and optimised management of other CKM conditions to reduce their CV risk.
- **NB:** There continues to be no conclusive evidence supporting urate lowering treatment of asymptomatic hyperuricaemia

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Abbreviations:

CKM
Cardiovascular-Kidney-Metabolic

CV
Cardiovascular

eGFR
Estimated Glomerular Filtration Rate

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