GOUTY ARTHRITIS AND DRUG-INDUCED LIVER INJURY
AN ANALYSIS OF PRESCRIPTION RECORDS OF GOUT

REFERENCES

Disclosure of Interests: None declared

SAT0432
GOUTY ARTHRITIS AND DRUG-INDUCED LIVER INJURY AFTER THE TREATMENT WITH NSAIDS

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Background: In order to relieve the pain during acute gout attacks, most patients take high doses of nonsteroidal anti-inflammatory drugs (NSAIDs), which can provoke the hepatotoxicity, or DILI (drug-induced liver injury).

Objectives: To define the timing of DILI formation after the treatment with NSAIDs and its severity in patients with gouty arthritis (GA).

Methods: 738 patients with GA from our database who meet the criteria of the ACR (1977) were included into the study. NSAIDs-induced liver damage is known to be mainly hepatocellular. The dynamic ALT concentration in blood before the start of NSAIDs and during the treatment has been assessed. Hepatocellular toxicity was determined according to the DILI classification criteria based on the blood ALT level increased ≥ 2 times to the upper limit of norm (42 U/l for men and 35 U/l for women). Inclusion criteria for the study group (n = 88) were: normal ALT before the treatment with NSAIDs, its increase during the treatment and return to the norm after the treatment.

Exclusion criterion was chronic hepatitis of any etiology. The comparison group (n = 650) consisted of patients with normal blood ALT level.

Results: Among 738 patients with GA, 11.9% (n = 88) developed the hepatotoxicity following the NSAIDs therapy. No significant differences in age (54 (44-59.5) and 57 (52-63) years; p> 0.05) and gender (men 93.3% and 87.6%; p > 0.5) between the study and comparison groups were found. In the study group, the duration of NSAIDs administration was 10 (6–14) days, which did not differ from that in the comparison group – 9.5 (7–12) days (p> 0.05).

In patients with DILI, the elevated ALT was observed as follows: 2-3 times in 74 patients (84.1%); 3 to 5 times in 10 (11.4%); more than 5 times in 4 patients (4.5%). So, minimal cytolysis was presented more frequently than more severe forms (p > 0.05).

In the subgroup with the ALT concentration 3-5 times (n = 10), 6 patients received Diclofenac in high doses, 2 patients were treated with Nimesulide, 1 patient with Etodolac and 1 with Dexamethasone during the observation period. The elevation of ALT concentration 5 times was observed in 3 patients taking Diclofenac i/m and Nimesulide per os, simultaneously, and in 1 patient taking Diclofenac in high doses.

Patients with DILI were taking the following medications: Diclofenac 48.9% (n = 43); Nimesulide 18.2% (n = 16); Meloxicam 5.7% (n = 5), the combination of NSAIDs 20.5% (n = 18) without statistical differences (p > 0.05).

The number of patients who abused alcohol in DILI and control groups did not differ significantly – 53.4% and 48.2%, respectively (p>0.05).

Conclusion: In patients with GA, the hepatocellular DILI was observed in 11.9% cases after the treatment with NSAIDs during 10 days (from 6 to 14 days). Among patients with DILI, 84.1% (n = 74) had NSAIDs-induced hepatitis with minimal cytolysis. Mild cytolysis was seen in 10 (11.4%), moderate in 4 patients (4.5%). In our study, no severe or fatal DILI has been noted. No significant differences for particular drugs in the hepatotoxicity incidence have been found (p > 0.05).

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AN ANALYSIS OF PRESCRIPTION RECORDS OF GOUT PATIENTS IN EUROPE: EVIDENCE OF SUBOPTIMAL MANAGEMENT AND CLINICAL INERTIA

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Background: Urate-lowering therapy (ULT) should be prescribed to people with recurrent gout flares and tophi, and offered to people with first-onset gout. Despite effective drugs, gout flares are common. Reasons for this include lack of prescription of ULT, under-dosing of ULT by physicians (clinical inertia), and poor adherence to ULT.

Objectives: To ascertain the quality of gout care delivered by general practitioners (GPs), prescribing patterns for ULT were analysed in 4 west-European countries.

Methods: Data for this retrospective study were obtained from IQVIA’s Real-World Data Longitudinal Prescription databases of GPs from France, Italy, Spain and United Kingdom (UK). The databases contain anonymised patient prescription records, including demographics, dispensing details (pharmacy, prescription date), and medication (name, dose, therapy duration). Data for patients with gout with or without ULT were analysed from June 2015 to June 2016.

Results: Crude prevalence of gout was 0.7% (UK) to 1.1% (France, Italy, and Spain) [Table 1]. Only about half (France, Italy, UK) to 2/3 (Spain) of diagnosed patients were on ULT. Between 19.9% (France) and 56.4% (Spain) of people on ULT had serum urate (sUA) measurements recorded within the year. Only 26.6% (Italy) to 46.6% (France) of patients with a recorded sUA level were at target (<6.0 mg/dL). The most common 1st-line treatment was allopurinol (ALLO), almost always at a dose ≤300 mg/d. Febuxostat (FBX) was prescribed as a 1st-line alternative in France and Italy. Switch to 2nd-line ULT, such as FBX, was uncommon, especially in Spain and UK. Uricosurics in monotherapy were not used. Average time on ULT ranged from 57.3% (Italy) to 72.6% (France) of the assessment year. At least one comorbidity (CM) was present in >78% of patients, the most common being hypertension, dyslipidemia, diabetes, chronic kidney disease, and obesity.

Conclusion: In the study period, management of patients with gout in 4 EU countries was suboptimal. Nearly half of diagnosed patients were not prescribed ULT. sUA levels were not being monitored regularly and mean sUA levels were above target. ALLO as the most common 1st-line ULT was generally prescribed at sub-therapeutic doses. Initiation of 2nd-line therapy was infrequent indicating a status quo and/or other reasons and medication adherence was poor indicating low patient self-management.

Conclusion: RGE successfully suppressed MSU-induced acute inflammation in mouse model. Also, RGT reduced NLRP3 expression in intercellular gout patients. These results suggest that red ginseng can be implicated as a therapeutic agent for gout.