Results: A total of 125 gout patients were included, of whom 91 underwent both DECT scans of knees and feet. In bivariate analysis, age (p=0.03), symptom duration (p<0.003), subcutaneous tophi (p=0.004), hypertension (p=0.02), diabetes mellitus (p=0.05), and chronic heart failure (p=0.03) were associated with the total DECT volume of MSU crystal deposition. In multivariate analysis, factors associated with DECT MSU volumes ≥1 cm3 were gout duration (OR for each 10-year increase 3.15 [1.60;7.63]), diabetes mellitus (OR 4.75 [1.58;15.63]), and chronic heart failure (OR 7.82 [2.29;31.38]). The model performance was good with an AUC of 0.816.

Conclusion: Specific comorbidities, particularly chronic heart failure, diabetes mellitus, and hypertension, are more strongly associated with increased MSU crystal deposition in knees and feet than gout duration, regardless of serum urate level.

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THU0438 INADEQUATE CARE FOR PATIENTS HOSPITALISED WITH GOUT: EVIDENCE THAT EULAR GUIDANCE IS NOT UTILISED

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Background: Hospitalisations due to gout have increased over the last decade, in direct contrast to declining admissions for other inflammatory arthropathies including RA [1]. Gout is a treatable condition with recently published EULAR guidelines [2, 3]. Admissions could be avoided with effective use of urate-lowering therapies (ULT).

Objectives: We hypothesised that the majority of patients attending hospital with acute gout attacks would not be on ULT. Furthermore, we hypothesised that the majority of patients would not be provided with a plan for ULT commencement and/or uptitracion on discharge, leaving them at risk of further hospitalisations.

Methods: We retrospectively analysed electronic health records for all patients presenting acutely with a primary admission diagnosis of gout (ICD-10 code: M10) at two hospitals in London, UK, from January – December 2017. Analyses of in-hospital gout management were performed for these patients, including to ascertain the number and proportion of patients who: i) had a known history of gout; ii) were receiving ULT at time of admission; and iii) were provided with a discharge plan for ULT commencement and/or uptitracion. We further determined whether the patient was provided with patient-assessed pain in the 1st and 2nd flare was reduced to similar degrees in the anakinra and triamcinolone groups. Secondary endpoints were in favor of anakinra across flares 1 to 4.

Results: Over a 12-month period, there were 234 emergency attendances for gout in 225 individuals. 80% were male, with a mean age of 58 years. 70/234 (30%) attended as in-patients. Of the 311 patients who had attended a hospital admission for gout (mean length of stay: 2 days; range: 0-31 days), 211 patients had routinely captured clinical data available for further analysis. 90/211 (43%) patients had prior diagnoses of gout, of whom 38% were on ULT at presentation (32 allopurinol, 2 febuxostat). 38% of patients were discharged with a plan for ULT commencement and/or uptitracion. 20 patients re-presented to hospital with acute gout within 12 months (17/20 were not receiving ULT).

Conclusion: Most patients hospitalised with gout were not receiving ULT, even those with a prior history of gout attacks. Few were provided with a ULT plan, leaving them at risk of re-admission to hospital. Hospital admissions are unpleasant for patients and incur a high economic burden for health services; if they are to be prevented, there must be a concerted effort to implement and follow gout management guidelines to ensure patients receive ULT at appropriate doses.

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