LETTER TO THE EDITOR

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To
Editor in Chief
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At first I would like to thank to the editor for publishing the time demanding review on Treatment of Gout and Hyperuricemia (April Vol 29, No2,2011 Page 85-95). Both specialist and non- specialist should know the recent update about hyperuricemia and gout .As we are adopting western life style day by day , the incidence of metabolic syndrome including gout may increase in future.

I have gone through the article and have certain observations. The content and illustration of the articles were very nice and informative. A systematic review with Pubmed, embase or Cochrane collaboration for specific duration of time would have been more informative in review process. The article reviewed a number of papers but did not mention the mesh or key wards used for generating the search. The review almost covers everything regarding gout but recent update of treatment was not included. I would like to draw your attention to the new advancement that have taken place in the field of treatment of gout in recent past.

Genetic advances with the identification of the urate anion transportor (URAT-1) and genetic variation in SLC 2A9 as a key regulator of urate homoeostasis, have given us deeper understanding of the pathophysiology of gout, and also allow for more targeted treatments[1,2]. Hopefully, new and emerging therapeutic options will reduce treatment-resistant gout in patients who are unresponsive or unable to take traditional urate lowering therapy. In 1996, rasburicase was developed by recombinant DNA technique from a genetically modified strain of Saccharomyces cerevisiae. Rasburicase is given IV at a dose of 0.20 mg/kg for 5–7 days to treat tumour lysis syndrome (TLS)[3]. Rasburicase is successfully used in gout with renal transplant patients and patients intolerant to allopurinol.[4,5] PEG–uricase is another potentially powerful agent for treating refractory gout in those who are unable to tolerate other treatments. PEG–uricase is effective in resolving tophi[6] and could have a role in 'debulking' tophi in advanced gout before switching to another agent for maintenance treatment[4]. Losartan, an angiotensin II receptor antagonist used for hypertension, and fenofibrate, a fibric acid derivative used in hyperlipidaemia, both have uricosuric actions and reduce Serum uric acid(sUA)[7]. This effect of losartan and fenofibrate on sUA is particularly beneficial, given the frequent co-existence of hypertension and hyperlipidaemia with gout.

Anakinra, an IL-1 receptor antagonist, is a new treatment in development. an open-labelled pilot study have shown subcutaneous injections of anakinra 100 mg daily to be a safe and efficacious treatment of flares.[8] In addition to anakinra, other IL-1 inhibitors are in development such as rilonacept, which is currently undergoing Phase III trials .Novel therapies including febuxotat, Anakirna and PEG- uricase offer hope to patient groups previously difficult to treat.

Traditionally, gout was viewed as a disease of the privileged, but is now increasingly prevalent among the lower socio-economic classes who have high rates of obesity and diabetes. More is known about which life style factors protect or cause gout. However, despite significant advances in understanding and exciting developments of new treatments, the management of gout remains sub-optimal in primary and secondary care. So, treatment of gout is necessary to learn by every physician in this respect.

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