

Gout Diagnosis Criteria

GOUT DIAGNOSIS CRITERIA

This form is based on the ACR/EULAR Gout Classification Criteria.

PATIENT INFORMATION

Name: _____ Age: _____

Gender:

☐ Male ☐ Female ☐ Other

Date of Evaluation: _____ dd / mm / yyyy

ENTRY CRITERION

Only check for other criteria if meeting this criterion.

At least one episode of swelling, pain, or tenderness in a peripheral joint or bursa.

☐ Yes ☐ No

SUFFICIENT CRITERION

If yes, it can classify as gout without applying the other following criteria.

Presence of MSU crystals in a symptomatic joint or bursa (i.e., in synovial fluid) or tophus.

☐ Yes ☐ No

CRITERIA

Use if Sufficient Criterion is not met. Score above or equal to 8 is required to be classified as gout.

I. CLINICAL

1. Pattern of joint/bursa involvement during symptomatic episode(s) ever:

- ☐ 0: Joint(s) or bursa(e) other than ankle, midfoot or 1st MTP (or their involvement only as part of a polyarticular presentation)
☐ 1: Ankle OR midfoot (as part of monoarticular or oligoarticular episode without MTP1 involvement)
☐ 2: MTP1 (as part of monoarticular or oligoarticular episode)

2. Characteristics of symptomatic episode(s) ever:

☐ 0: No characteristics ☐ 1: One characteristic ☐ 2: Two characteristics ☐ 3: Three characteristics

3. Time-course of episode(s) ever:

☐ 0: No typical episodes ☐ 1: One typical episode ☐ 2: Recurrent typical episodes

4. Clinical evidence of tophus:

☐ 0: Absent ☐ 4: Present

II. LAB

1. Serum urate:

- ☐ -4:
☐ 0: 4-
☐ 2: 6-
☐ 3: 8-
☐ 4: $\geq 10\text{mg/dL}$ — [$\geq 0.60\text{mM}$]

2. Synovial fluid analysis of a symptomatic (ever) joint or bursa:

- ☐ 0: Not done ☐ -2: MSU negative

III. IMAGING

1. Imaging evidence of urate deposition in symptomatic (ever) joint or bursa:

- ☐ 0: Absent OR not done ☐ 4: Present (either modality)

2. Imaging evidence of gout-related joint damage:

- ☐ 0: Absent OR not done ☐ 4: Present

RESULTS

Total Score: _____

Classify as gout?

- ☐ Yes ☐ No

Additional Notes:

HEALTH PROFESSIONAL'S INFORMATION AND CONTACT DETAILS

Name: _____ License Number: _____

Phone Number: _____ Email: _____

Name of Practice: _____