

although oligo- and polyarticular gout flares can develop over time. The metatarsophalangeal joint of the first toe is involved in 70–90% of cases (podagra), followed by tarsal joints, ankles, and knees. Finger, wrist, and elbow joints can also be involved, although more often in elderly patients or in advanced disease. The gout flares often begin at night to early morning, constituting one of the most painful conditions experienced by humans. The affected joints rapidly become warm, red, tender, and substantially swollen with a clinical appearance that often mimics that of cellulitis (pseudocellulitis). Typical flares tend to subside spontaneously within 1–2 weeks, and most patients have intervals of varying length with no residual symptoms until the next episode (intercritical gout). Triggers of gout flares include purine-rich food, alcohol, diuretic use, initial introduction of urate-lowering therapy, local trauma, and medical illnesses such as congestive heart failure and respiratory hypoxic conditions ([Fig. 372-1](#)).

Usually after years of gout flares without treatment, chronic gouty arthritis can develop, often associated with ongoing synovitis, subcutaneous tophi, deformity, and bony destruction. Less commonly, chronic gouty arthritis will be the only manifestation, and more rarely, gout can manifest only as tophi. Women represent only 5–20% of all patients with gout. Most women with gout are postmenopausal and elderly; tend to have osteoarthritis, hypertension, or mild renal insufficiency; and usually are receiving diuretics. Premenopausal gout is rare, although kindreds of precocious gout in young women caused by decreased renal urate clearance and renal insufficiency have been described.

■ DIAGNOSIS

Laboratory Diagnosis Even if characteristic clinical features strongly suggest gout, the presumptive diagnosis ideally should be confirmed by needle aspiration of involved joints or tophaceous deposits. Acute septic arthritis, other crystal-associated arthropathies, palindromic rheumatism, and psoriatic arthritis can mimic clinical presentations of gout. During acute gout flares, needle-shaped MSU crystals typically are present both intracellularly and extracellularly ([Fig. 372-2](#)). Under compensated polarized light,