## Abstract

Gout is one of the commonest inflammatory arthritis encountered in clinical practice. It is characterized by monosodium urate crystal deposition in and around joint space. The incidence and the prevalence has been on the rise for the past decades probably with the rising incidence of metabolic syndrome, obesity and increased alcohol consumption and changing dietary habits.(1–4) It is also one of the most treatment responsive inflammatory arthritis as well. We present a case of acute polyarticular gout presenting with fever, multiple joint involvement, lassitude for 1 week. He had high inflammatory markers and urate crystals in synovial fluid aspiration. Flair was precipitated by recent emergency laparotomy for perforated duodenal ulcer, hospital acquired pneumonia and discontinuation of hypouricemic drugs. He was treated with colchicine and allopurinol with good response to treatment. He developed pressure sores, left lower limb cellulitis and thrombophlebitis during stay with continued disease flair. He made a good recovery and discharged home with colchicine and allopurinol. The diagnosis was delayed in this patient due to lack of awareness and denial of history of arthritis by the patient and lack of documentation with regard to his past medical history. Absence of urate crystals in initial examination of aspirated synovial fluid sample compounded the delay with presence of urate crystals in second sample only.(5,6) It led to prolonged hospital stay and development of multitude of complications with additive arthritis. Improving patient awareness and education is important. And considering gout in the differential diagnosis when patients present with multiple joint symptoms might improve outcome in these patients. Importance of repeated sampling for urate crystals in a patient suspected with gouty arthritis was also stressed upon.