









Proceedings of Outing Gout 3

Mate Kauti; Me haere taatou.

Ki te manawa teenei take.

The Gout: Let's get to the heart of the matter

Co-hosted by:

Ngati Porou Hauora

Counties Manukau DHB Maaori Gout Action Group

Pakirikiri Marae, Tokomaru Bay

Two Outing Gout hui have been hosted by the Counties Manukau DHB Maaori Gout Action Group (MGAG) at Te Manukanuka Marae at Auckland Airport in 2009. The Counties Manukau DHB MGAG wished to go on the road and to hold Outing Gout 3 outside of Auckland. The primary reason for the event being held in Te Tairawhiti is the strategic partnership between MGAG and Ngati Porou Hauora (NPH), who co-hosted the hui with MGAG and Pakirikiri Marae.

Increasingly, MGAG and NPH are focusing on the close (but poorly understood) links between gout, diabetes and heart disease; hence there was a focus on this at Outing Gout 3. Gout is often the first indicator of metabolic disease. Addressing the causes of gout, and improving management, should also lead to improved outcomes in terms of diabetes and heart disease.

Ngāti Porou Hauora

Ngāti Porou Hauora (NPH) was established as an incorporated society in 1994 as the iwi-led health service provider for all people in the Ngāti Porou rohe (tribal area). The rohe extends along 200 kilometres of the East Coast of the North Island, from Potikirua near Hicks Bay in the north to Te Toka-a-Taiau in Gisborne city to the south. Approximately 6,000 people on the Coast and 7,000 in Gisborne city are enrolled with the service, of whom 76% are Māori and the majority is of lower than national average socioeconomic status. As a Māori PHO, the Hauora provides primary health care through eight health centres (Uawa/Tolaga Bay, Tokomaru Bay, Tawhiti/Te Puia Springs, Ruatoria, Tikitiki, Matakaoa/Te Araroa, Puhi Kaiti and Te Whanau a Iwi). NPH also provides hospital services on the Coast from the small hospital in Te Puia Springs, a mental health service, and health promotion and illness prevention services - including Ngāti and Healthy (healthy lifestyles) and Auahi Kauti. Through a gout research collaboration initiated by the late Dr Paratene Ngata (GP in Uawa, with an honorary doctorate from the University of Otago) in 2006/07, NPH and University of Otago have been working on a study of the genetics of gout amongst Ngāti Porou Hauora whānau and communities. Data gathering for this study will be completed in 2011. An early spin-off of this collaboration has been the growing relationship between NPH and the Auckland-based Maaori Gout Action Group (MGAG).

Counties Manukau DHB Maaori Gout Action Group

The magnitude of the impact of gout on Māori and Pacific communities has been identified as a particular concern by the Maaori Gout Action Group[1]. The Group has identified that to achieve modern management of gout, those with gout need to be supported by primary care practitioners who are aware of the need for early intervention with allopurinol, as well as whānau and communities who understand the impact and causes of gout and the lifestyle changes that are needed alongside long-term allopurinol. The Group also supports further research into the impact and causes of gout, particularly for Māori, and to develop strategic alliances to advance the treatment and prevention of gout by those working with co-morbid conditions such as diabetes and cardiovascular disease. The five-strand vision of the MGAG;

1. Enhancing health practitioner management of gout
2. Patient resource development and dissemination
3. Knowledge and awareness-raising campaign
4. Research
5. Strategic partners

Pakirikiri Marae

Pakirikiri Marae in association with Ngāti Porou Hauora hosted the National Māori Out Gout Hui in Tokomaru Bay in March 2011. The marae whānau proudly supported the kaupapa with their unique brand of manaakitanga - from marae accommodation and seaside conference facilities through to tasty and healthy menus throughout the sitting. The whānau fully support the continuing research undertaken by the University of Otago and their colleagues as all were affected either directly or indirectly by this debilitating and painful disease.

Support

The following are warmly thanked for their sponsorship support and donation of prizes:

Arthritis NZ
Bell Tea
Devi-Ann Hall
Gabrielle and John McDevitt
Health Research Council of New Zealand
Pharmac
Roche Diagnostics NZ
University of Otago

[1] Members are Bruce Arroll, Caran Barratt-Boyes, Nicola Dalbeth, Peter Gow, Devi-Ann Hall, Eraina Harbour, Victoria Harris, Francesa Holloway, Karen Lindsay, Tony Merriman, Jane Messer, Hazra Sahid, Gabrielle Sexton, Donna Snell, Lynanne Stanaway, George Vea, Doone Winnard.

Opening Address

Victor Walker (CEO, Te Runanga o Ngāti Porou) opened the hui. Victor gave an educative account of his personal experiences with gout. It has been two years since his last gout attack, his strong message is to take the preventative medication (allopurinol). His first gout attack came after the parents relay at the local school, it felt like crystals of glass in his joint. His immediate question was:
"Doc, how did I get this?"
"It is whakapapa Victor"
"Can't I do anything about this?"
"Yes, you can, with medication. Start on allopurinol, with colchicine in case of any flare ups."

Pere Ngere Ngere (Whanau Ora Manager East Coast, Ngāti Porou Hauora) spoke midway through the hui. He acknowledged the wanaanga here for informing health workers, it was inspirational to hear speakers from diverse backgrounds. He acknowledged Victor, conferring an honorary degree on gout on him. Pere reflected on his return to the Coast and seeing his colleagues not using allopurinol.

Session One: What we can do together to improve gout.

Target audience: The community and healthcare professionals

Peter Gow (Counties Manukau DHB) and Victoria Harris (Arthritis NZ) explained gout. Uric acid comes from the breakdown of cells and the diet. It is excreted in the mimi. When the level of excretion is lower, which can occur naturally or by the use of diuretics (fluid tablets used for heart conditions and treating high blood pressure) uric acid levels increase in the blood. When uric acid levels are high it turns to a solid (crystallises) in the joint and the immune system reacts to it. This causes the joint to be hot and inflamed in the gout attack. Attacks are often in the big toe because it is colder and easier for the uric acid to form a solid. If the level of uric acid is 0.36mmol/L or below then future gout attacks will be prevented.

Peter then described the best medication for keeping uric acid levels down

1. Allopurinol, which stops uric acid being produced in the blood. When starting on allopurinol it is important to use colchicine to deal with any flares. Not appropriate though for people with kidney problems.
2. Probenicid, which helps the kidneys get rid of uric acid in the mimi.

Peter also emphasised the benefit of losing weight, even not much. For example a drop from 100kg to 95kg will help uric acid levels to drop, even by as much as 0.06. Victoria talked about Voltaren, a painkiller often used by gout sufferers for pain during the attacks. It is harmful for the kidneys if used too much, better to use the uric acid lowering medications (allopurinol and probenicid).

Peter answered a question about how long it takes to prevent gout attacks when starting on allopurinol. If the uric acid is high, a drop will be observed within weeks, and should be normal within 3 months. The dose of allopurinol can be gradually increased if necessary. If uric acid levels are less than 0.36 for six months, then the colchicine can be stopped. If the patient stops taking allopurinol then uric acid levels will increase and gout attacks will begin again.

Marama Parore and Roy Hoerara (Pharmac) together presented a Pharmac perspective on gout and co-morbidities. Marama began by describing poor access to drugs in general, for example Māori 2-3 times more likely to be hospitalized by asthma, statins generally not available for poor Māori in the East Coast, South Auckland, and the Far North. Roy's data showed that Māori men are dying 10-14 years younger from cardiovascular disease. In 2004, 41% of deaths were from heart disease. Marama then talked about how women need to let men work out what works in addressing gout, men tend not to listen to messages: "Our people deserve excellence. People are the resource." Roy finished by describing the importance of whānau, wairua, tinanga, hinengoa in prevention strategies.

Tony Merriman (University of Otago) talked about some biological causes of gout. Inherited genes are known to be important in determining who gets gout and who doesn't. In particular, versions of genes which give the ability to excrete less uric acid in the urine, as shown by the Genetics of Gout in Aotearoa study. In the environment in which our ancestors evolved, it was sensible to have higher levels of uric acid in the

blood – uric acid helped keep blood pressure up in times of low salt, it is an aid for the immune system, is an anti-oxidant and protects the nervous system.

Now, our environment is much different. The Genetics of Gout in Aotearoa study has also shown that Māori, Pacific Island and Caucasian people who drink 4 or more sugary drinks a day have more than three times the risk of getting gout. Refined sugar (sucrose), with which drinks are sweetened in New Zealand, is one part fructose and one part glucose. Unlike glucose, the metabolism of fructose is not regulated, with one side-effect being the uncontrolled production of uric acid in the blood. This increases the chances of gout, especially in people who have inherited the ability to excrete less uric acid in the mimi.

Increasing fructose consumption is part of the reason why gout is so frequent now. Gout was rare in Māori people 100 years ago. Now it is very frequent, with a common 'trigger' of gout attacks being seafood. However, Māori ate a lot of seafood traditionally, with very little gout documented. Today we eat about 50 times more sugar than 300 years ago.

The advice to people with gout is to try and reduce sugar consumption and to drink only water, coffee and tea, and to have a moderate consumption of fruit (which contains fructose, but also fibre and other important nutrients). Interestingly, this was recognised over 100 years in ago: in 1893 W. Osler prescribed diets low in sugar as a way to prevent gout. He wrote: "The sugar should be reduced to a minimum. The sweeter fruits should not be taken." Grapes and figs are particularly sweet and should be avoided by people with gout.

Session Two: Continuing medical education, the Coast gout audit, how to manage gout

Target audience: Health professionals

Akin Ojo (GP, Ngāti Porou Hauora) presented the results of an audit of allopurinol prescribing rates within Ngāti Porou Hauora (NPH). He first presented some descriptive data on gout within NPH clients:

237 people with either a diagnosis or clinical symptoms indicative of gout
81% male
97.9% Māori, 2.1% European
54% 51-70 years; 24% 71-90 years; 20% 31-50 years; 2% 10-30 years

Prescription rates from April 2010 – present:

60% colchicine
63% allopurinol
53% non-steroidal anti-inflammatory drugs
10% steroids (prednisone)

Uric acid monitoring:

2008; 79 uric acid tests (33% of patients); 28 (35%) were normal
2009; 135 uric acid tests (56% of patients); 57 (42%) were normal
2010; 102 uric acid tests (43% of patients); 45 (44%) were normal

Akin noted the high consumption of sugary drinks and sports drinks. He considered dehydration to be a factor in gout and recommended one litre of water for every litre of coloured drink.

Mary-Anne Barton and Gina Chaffey-Aupouri (Rural Health Nurses, NPH) spoke on their perspective and approach to managing gout.

Mary-Anne presented a gout plan (below) that focused towards empowering people to take care of their own bodies and health. She also discussed barriers towards patients having regular contact with their GP; petrol, time off work for example.

*G*out
*O*ranges (8-10 freshly squeezed = cause gout attacks)
*U*ric acid (know your level)
*T*reatment

*P*lan menu (eg if the tane gets gout with over 6 mussels, don't give him 10)
*L*ots of water
*A*ttitude and perseverance
*N*ice to your doctor

Gina said that gout was all about pain. Māori suffer a lot of pain because of colonisation; of seabed, of te reo, of health. The pain is so deep that it cannot be explained. The Māori man suffers pain stoically. It is gout, then cardiovascular disease, kidneys, high blood pressure. If we could go back to the basics, the basics of the backyard, that would improve the situation. However the seabed is taken, forests are

taken, therefore hauora is taken. Gina finished by playing a song composed by her daughter, as a wake-up call to all of Ngāti Porou.

Leanne Te Karu (Ngā Kaitiaki o Te Puna Rongoā; President, Māori Pharmacists Association) is the only pharmacist in the country with a brief to specifically address gout. She first highlighted the fact that Māori die disproportionately from heart disease, at 2.3 times the rate of non-Māori and pointed to international literature that suggests that hyperuricemia plays a direct causative role in heart disease. "Māori are prescribed too many non-steroidal anti-inflammatory drugs and not enough for heart disease." Leanne then presented some data on ethnic breakdown of allopurinol prescriptions:

Caucasian	73% of all allopurinol prescriptions
Māori	18%
Pasifika	7%
Asian	2%

Key to Leanne's presentation was description of case studies and their experience with pharmacy. Mrs AT developed gout 23 years ago, with a long history of NSAID use (drugs including voltaren, indomethacin, ibuprofen). She only started allopurinol two years ago. She now has kidney disease. Mr WC thought allopurinol was for his sugar levels, he therefore took allopurinol haphazardly. Mr SC is 44 years old with regular gout for ten years. He has had 180 prednisone tablets in 6 months. He was prescribed allopurinol two years ago during a gout attack, it made the attack worse and he now won't take allopurinol. Furthermore he spreads a negative message about allopurinol.

Leanne highlighted that within Whānau Ora, Tatau Kura Tangata contain the key indicators relating to the socioeconomic determinants of health, risk and protective factors for health, health status, health service utilisation, and the health system. There is no mention of gout in Māori health indicators.

Leanne's message for whānau was to find out who was on NSAIDs longterm, inform them that gout attacks are preventable, and empower them with the knowledge to prevent their gout (with allopurinol).

Gary Sinclair (GP, TaPasefika) presented the PitStop project, a clinical intervention aimed at improving gout outcomes. The current scenario is that GPs tend to see people with acute gout at the end of a worker's shift, get treatment for the acute attack and don't get seen until the next attack. The PitStop project is attempting to address this by presenting to men visiting the GP for an acute attack the possibility of coming in for four free visits (3,6,9,12 months) at a time that suits them. Also PitStop gives a chance for men in 20-40 age group to have a cardiovascular risk assessment. Gary made the point that about half of people with CVD are only diagnosed when they are dead; gout brings people with CVD through the door. The PitStop protocol is:

- Basic measurements (Height, Weight) data
- CVD 5 yr risk assessment
- Quality of life assessment (HAQ-II)
- Blood tests to assess wide range of organs

Current PitStop data:

- As of 1/12/10 128 men were enrolled
- 62% attended first visit, 28% attended third visit
- Average uric acid for first visit was 0.49 mmol/L, 0.43 at third visit
- 42% of GPs completed the HAQ-II at enrolment, 44% at first visit. There was an improvement in HAQ-II score from 9.72 at enrollment to 7.00 at the six-month visit. There was also an improvement in time off work; 56% had had time off work at first visit, 25% at third visit
- There was an increase in proportion of men with a CVD risk assessment from 31% at first visit to 89% at the six-month visit.

There was discussion around the men who did not come into PitStop or who stopped attending. No gout, no pain, not an immediate issue. Key is to become a squeaky wheel, phone at home etc, be insistent that they come in for the next visit.

Peter Gow finished the session by providing a commentary. His specific points were:

1. Don't test uric acid during an acute gout attack – it can be 'falsely' low. Get a point-of-care uric testing machine in the clinic (Reflotron, Roche).
2. The success of Ngāti Porou Hauora in achieving the current allopurinol prescribing rate (63%).
3. Need to change target uric acid in Medtech from 0.42 to 0.36mol/L.
4. The only Māori hauora publication to say that gout is a problem is one from Pharmac. For example, a recent MoH publication on health in Māori over 50 years of age mentioned only one form of arthritis (osteoarthritis).
5. We need to focus on point 4 in our hui feedback to political figures.

Session Three: Gout, the warning bell for the heart and diabetes

Target audience: Health professionals

Doone Winnard (Counties Manukau DHB) presented material from gout prevalence studies and epidemiological data on the relationship with CVD and diabetes. She first pointed out that longitudinal studies were better than cross-sectional studies for investigating causality. Although there is a cross-sectional relationship between higher uric acid levels and CVD, it is less clear whether raised uric acid actually causes CVD or is associated with it, partly as a marker of other conditions like diabetes that contribute to CVD. That's important for thinking about how we approach treatment.
Doone then presented a NZ study that used anonymous linked data to indicate how common conditions like gout, diabetes and CVD are in the population:

- Allopurinol and colchicine prescription data and hospitalisation as markers for gout,
- Diabetes specific medication, relevant lab tests, hospitalisations and outpatient visits for diabetes
- Angina specific medication, outpatients/procedures/hospitalisation as markers for CVD.

The data were:

Approx 115,000 people >20 years in NZ with evidence for gout (23,000 Māori)
Approx 4% of the NZ population > 20 years likely to have gout
10% Māori men, 12% Pacific men, 5% Caucasian men
>30% prevalence in Māori and Pacific men >60 years of age
Of those identified with gout, a total of 40% with diabetes and/or CVD
23% also had CVD
26% also had diabetes
9% with both CVD and diabetes.

The opportunities for intervention:
- Whānau. Engage whānau to support lifestyle changes and medication and to support the patient to see their GP or Practice Nurse for CVD risk assessment.
- Practice Nurse. The Practice Nurse should target gout patients for CVD and diabetes assessments and good control of all three conditions.
- Pharmacy – refer people to their GP for a heart and diabetes check if they are asking about pain relief for their gout, as well as to discuss further management of their gout
- Sport. Engage with sports clubs. Often the chance to detect first gout attacks which may be mistaken for injuries.
- Measurement. Measure uric acid regularly; aim to 'hit the target' and document (graph).

Nicola Dalbeth (University of Auckland) presented a study on diabetes and gout, using the Diabetes Care Support Service register maintained by the Diabetes Projects Trust in Auckland. The Diabetes Projects Trust mines the notes of patients with diabetes (as marked by Medtech) in West and South Auckland.
It is already known that:

1. People with gout have a high rate of metabolic syndrome (89%) and diabetes (25-33%).
2. People with gout and hyperuricemia have a higher risk of metabolic syndrome and diabetes.
3. The higher risk is likely because of insulin resistance leading to increased reuptake of uric acid through the kidneys.
4. Conversely, poor diabetes control is associated with lower serum urate.
5. People with diabetes (type 1 or 2) have a lower risk of gout.

Here, four questions were asked

Q1. What is the prevalence of gout in a large community-based cohort of people with diabetes?
Q2. What are the clinical features associated with gout in such a cohort?
Q3. What is the relationship between serum urate and Hb1Ac in people with diabetes?
Q4. Are patients with gout and diabetes achieving gout treatment targets?

Q1. The prevalence of gout in:

-Type 1 diabetes (n=733) was 1.1%
-Type 2 diabetes (n=14,076) was 16.0%
-Prediabetes (n=3,567) was 14.5%
-Māori type 2 diabetes patients (n=2,377) was 28.5%
-Pacific type 2 diabetes patients (n=2,770) was 23.7%

Q2. Clinical factors associated with an increased risk of gout in type 2 diabetes were:

-Increased age
-Male gender
-Māori/Pacific ethnicity
-Smoking
-Overweight
-Poorer kidney function

Clinical factors associated with a decreased risk of gout in type 2 diabetes were:

-Increased Hb1Ac
-Metformin treatment

Q3. In type 1 diabetes there was no relationship between Hb1Ac and serum urate, however in type 2 diabetes, as Hb1Ac increases serum urate decreases. The reason for this is unclear.

Q4. A subset of 414 gout/diabetes patients were examined. Only 6.7% (28/414) of gout/diabetes patients were achieving target serum urate levels. Only 51% were treated with allopurinol and only 33.6% had had their serum urate tested.
Addressing the relationship between gout and diabetes is important because gout makes management of type 2 diabetes difficult for these reasons:

-Hard to exercise and lose weight owing to arthritis
-Extra diet restrictions
-Medications for acute gout (NSAIDs, prednisone) may contribute to diabetic complications
-Complex foot disease/ulcer risk
-Extra medications

Dr Dalbeth presented a plan for GPs to improve outcomes in patients with diabetes, using the DCSS audit tool to target patients with:

-Documented gout and no serum urate check in the last year
-Documented gout, serum urate >0.36mmol/L, on allopurinol
-Documented gout, serum urate >0.36mmol/L, not on allopurinol
-No documented gout, but serum urate ≥0.60mmol/L

Vicky Cameron (University of Otago) presented Hauora Manawa Heart Health (The Community Heart Study). Life expectancy in Māori has increased over the past 60 years to 69 years of age in males, but still 8 years less than in non-Māori. Heart disease is a major factor, with rates double that in non-Māori.

The aim of the Community Heart Study is to compare levels of diagnosed and previously undiagnosed cardiovascular disease, diabetes, and CVD risk factors in a random community sample of rural Māori (Waiora), urban Māori (Christchurch) and age- and gender-matched non-Māori (Christchurch). A kaupapa Māori methodology was used.

There was a gradient of CVD risk factors (Wairoa Māori>Chch Māori>Chch non-Māori):

	Wairoa Māori	Chch Māori	Chch non-Māori
Type 2 diabetes	11%	4%	2%
Gout	6%	4%	0.4%
MetS	36%	27%	15%
BMI	30	29	26
Obesity	48%	39%	16%
Blood pressure	130/84	128/86	125/83
Serum urate	0.30	0.30	0.28
Serum urate >0.42	25%	10%	5%
Smoking	43%	30%	15%
Alcohol	81%	92%	91%

(There were little differences in lipids (though high in all groups) and physical activity.)

In Wairoa there was 25% previously diagnosed hypertension with a further 22% detected, 14% previously diagnosed dyslipidemia with a further 42% detected, 11% previously diagnosed type 2 diabetes with 52-69% estimated to be insulin resistant. Vicky and her colleagues have collected the two year follow-up data, but have not analysed it yet. It is clear, however, that being in the study has made a positive difference.

This study reported the persistent high rates of cardiovascular risk factors in Māori communities, particularly obesity, hypertension, dyslipidaemia, type 2 diabetes, hyperuricaemia and smoking. The study highlights that rural Māori carry the greatest burden of CVD risk factors that have remained largely the same for the past half-century.

Isaac Warbrick (Massey University) described his research on fitness and body composition as a predictor of insulin sensitivity in Māori. Previous data on fitness and risk of diabetes in Māori was scant. One study had shown that obesity and fitness predicted diabetes risk in young Māori. Here, Isaac studied 31 young Māori men with no diabetes, with 12 retested after 2-3 years. Seventeen non-Māori men were also included as a comparison group. The kaupapa centred on a strong personal relationship with the participants, for example taking them out for kai.
Isaac found that fitness and body composition did predict risk of diabetes (insulin sensitivity) and that this relationship was maintained over time. This relationship was not observed in the non-Māori group.
What are the implications?

-Should the focus for Māori move from healthy weight to fitness?
-Does fitness protect the overweight from diabetes?
-An exercise test may be an alternative way to predict risk of diabetes.

Session Four: Gout, the whanau and the tane

Target audience: The Community

Ihi Heke and Turanga Health Colleagues (Dallas Poe and Denzil Moeke) presented the 'Silicon Coach' used in their research project to analyse gait and relate gait to health. Ihi began by acknowledging the late Dr Paratene Ngata, Ihi is carrying out his legacy by getting his people more active (running up maunga for example). These strategies are used:

1. Traditional games and activities. Waka ama, kapa haka, kia raha. Kia raha was played by Māori soldiers in WWII. Now played in Italy and the US. National championships to be held in Tolaga Bay in September.
2. Indigenising contemporary sport. For example at the University of Otago a new gym is being built that incorporates physical health, hinengaro, wairua. Around the gym there are plants for rongoa and a fitness trail for kaumatua.
3. Food sovereignty. How do we grow, gather and hunt our own? The Ngāti Porou Hauora Mana Tane group for example (see next presentation).
4. Kaupapa Māori based training. For example, ngarutahi (movement of a wave), whereby groups of people do squats in the shape of a wave.
5. Innovation. Using Silicon Coach, which has been used with golf for kaumatua in Tolaga Bay for example.

The Turanga Health team described the Marae-based research project they are doing with about 130 kaumatua. The participants are split into 3 groups:

1. Silicon Coach analysis. (This was demonstrated at the hui, subject walks on a treadmill, is videoed and gait analysed using Silicon Coach software.)
2. Silicon Coach analysis plus use of an Asics Gel Cardio Shoe.
3. Silicon Coach analysis plus use of an Asics Gel Cardio Shoe plus a six-week supervised exercise programme.

People were initially anxious about 'research', but once some started participation snowballed. People came through the door because of the gait project, once there Turanga Health could start discussions on physical activity and nutrition. Regarding physical activity, Ihi reported that older people cannot do required high intensity activity because their joints are already damaged. There is a need to begin with people in their 30s in order to build up muscle strength.

Roger White (Ngāti and Healthy) and the Mana Tane group talked about their mahi. Financially, the group was initially sustained through Ngāti and Healthy, Te Puni Kokiri, Ministry of Health. Now a distinct entity and funded by Tairawhiti DHB.
Eru, group kaumatua, began by emphasising the need for annual check-ups at the GP: "The greatest thing in the world is health, health, health, central to health is you, you need to look after yourself.'

Roger White started four years ago in the Ngāti and Healthy project with a mandate to improve men's health. The chosen route is through good food (not processed) that is grown and gathered, and regular meetings with men. The meetings address health and well-being through hosting speakers (gout, domestic violence, health checks, diabetes).

Rob Thompson has been committed to the kaupapa since it began. His passion is kai the way the old people grew and gathered it. He teaches about gardening (growing, composting, worm farming etc), awareness of natural kai (eg Māori spinach), incorporates tikanga and learns from pakeke. He is developing a green currency. Fruit trees are taonga with no waste from bottling and drying. Gathering from goat, venison, wild-pork, edible weeds, parengo, beekeeping (honey and pollination), tuna, fish, ducks, koura, diving, snapper etc. Incorporate whānau into some aspects (eg preserving, collecting shellfish).

Richard Cooper (Counties Manukau DHB) presented on the men's groups that are operating through Counties Manukau DHB.

-Monthly meetings, with invited specialists in gout, podiatry, diet, endocrinology, opthamology, renal.

-Focus on healthy kai, with links established with Mana Tane from Tairawhiti, knowledge on gardening is shared from Mana Tane to Counties Manukau DHB.

-Linkage with Ihi Heke, kia raha has been learnt and adapted for kaumatua and tamariki.

-Numbers attending groups have steadily increased (2007, 120; 2008, 332; 2009, 967; 2010, 1059).

-Kaupapa includes reducing alcohol consumption, apologies when unable to attend, regular monitoring of blood glucose.

-A women's group has been established.

Richard finished by showing a video of six men talking about their involvement:

1. The first man enjoyed doing activities together. Safety in a group.
2. The second man learnt to moderate fruit intake (1-2 pieces, rather than 1-2kg).
3. The third man had just been prescribed insulin.
4. The fourth man had had his insulin requirements reduced.
5. The fifth man was taking control. He maintained a comprehensive food diary, had lost 9 kg recently, showed us his garden (in pots).
6. The sixth man was proud of his garden: 'Buy a plant, dig a hole and put it in the ground.'

Richard's grandson had the last word: The primary reason why men are interested in health is tamariki and mokopuna.

Karen Lindsay (Counties Manukau DHB) presented a work in progress, done with Richard Cooper and Art Work done by Marcus Winters, regarding the development of a model to explain gout in the body.

-Maui Haututu Defeats Gout (Straddling Both Worlds)

The story centres on Maui Haututu and his arrival in Aotearoa from Hawaiki. In Aotearoa he did not have to collect his own kai. He forgot the kai of Hawaiki. He grew lazy. He got gout. In desperation he eventually sought the kuia Hine Purotu who gave him a kete of knowledge from her burning fingers – go back to the foods of your childhood and take rongoa every day to prevent the gout. He realised that the burning from Hine Purotu was a warning to him and his whānau about gout and the health of his whānau. He no longer got gout, whereupon he returned to Hawaiki and told his whānau about Aotearoa and the kete of knowledge about how to live there.

Other Activities

Outing Gout 3 also offered other gout, heart disease and diabetes education and check-up activities.

- Information and free health checks were offered by Ngāti Porou Hauora nurses, including point of care testing of serum urate levels, with the support of Bronwyn Sheppard of Roche Diagnostics New Zealand.
- Arthritis New Zealand had a strong presence and offered education to the community on the causes and medications for gout.
- Clinical tools to improve gout management and communication between clinicians and patients regarding gout and medications were shared between MGAG and Gary Sinclair and Ngāti Porou Hauora.
- Proceedings were enlivened by fun quizzes and prizes, including one for best dressed on St Patricks Day. MGAG members Gabrielle Sexton and Devi-Ann Hall (pictured on first page) are warmly thanked for organising this. They were a memorable duo.