Suspected GCA

New headache

Age > 50yrs

Temporal artery tenderness thickening or loss of pulse

Scalp tenderness

Jaw or tongue claudication

Visual symptoms

PMR symptoms

Raised ESR or CRP

Visual Symptoms

Diplopia, sustained or transient loss of vision, 3rd nerve palsy

Commence 60mg prednisolone and refer for **same day** ophthalmology assessment

Monday- Saturday 8am-6pm ring eye casualty: 0300 4223578

Outside of the above hours contact the oncall ophthalmology registrar via switch board

Confirmed GCA with eye involvement

Opthalmology will arrange:

500mg IV methylprednisolone for 3 days followed by 60mg oral prednisolone + PPI +/- bone protection

Arrange TA USS within 24 hrs *

Arrange TA Biopsy

If, following ophthalmology review, no eye involvement but suspected GCA then commence:

60mg prednisolone if jaw claudication

40mg prednisolone if no jaw claudication

Request TA USS

No Visual Symptoms

Referrer to immediately commence prednisolone

40mg if no jaw claudication

60mg if jaw claudication

Refer to acute medical take for further assessment, Rheumatology does not accept direct referrals

GP to refer via Cinnapsis

ED to eRefer to SDEC or AEC

If after assessment GCA is felt to be the most likely explanation for symptoms then acute care team to:

Continue prednisolone as above + PPI +/- bone protection

Request TA USS *

eRefer to Rheum for Follow up and continue steroids until seen

*TA USS can be requested by requesting an USS Skull on ICE/ EPR and specifying TA USS in clinical details **AND** emailing ghn-tr.vascularlabreferrals@nhs.net

EARLY RECOGNITION

Over 50 years old?

- Headache
- Jaw/tongue claudication (pain worsens on chewing), occasionally limb claudication
- Scalp tenderness
- Raised CRP or ESR (age adjusted ESR)
- Constitutional symptoms (fatigue, weight loss)
- Visual symptoms (loss of vision or diplopia, either transient or sustained)
- Temporal artery abnormalities (prominent artery/tender to palpation/absent pulse)

If over 50 and the above symptoms/ signs are present even in the absence of headache…

THINK GIANT CELL ARTERITIS

General Principles:

GCA is almost never seen in the under-50 age group. Symptoms can be acute or subacute. Over 90% of patients with GCA will describe constitutional symptoms, in particular fatigue. Malignancy must be excluded if marked weight loss is present or when concerning symptoms are detailed on systemic enquiry or examination. Although headache is present in two thirds of patients with GCA, it may be transient and is not always localised to the temporal regions. Jaw pain/ claudication is the most specific symptom of GCA and may be associated with an increased risk of neuro-ophthalmic complications. GCA is considered a medical emergency as visual loss may be irreversible within hours. Strongest risk factors for visual loss are increasing age, jaw claudication and visual symptoms.

Clinical Assessment:

1. Full clinical history including detailed systemic enquiry.
2. Cardiovascular examination to include peripheral pulses.
3. Temporal artery palpation
4. Cranial nerve examination (including ophthalmoscopy if available) but please do not delay referral of all patients with visual symptoms to ophthalmology for full assessment.
5. Full examination to exclude mimics (infection, malignancy or cervical spine pathology).

Baseline Investigations:

- CRP and ESR/PV, FBC, U&Es, LFTs.
- Please consider if additional investigations are required when considering alternative differential diagnoses.

URGENT REFERRAL

Following acute medical assessment, all cases of suspected GCA must be referred to either Ophthalmology or Rheumatology team, depending on the presence/ absence of visual symptoms.

GCA with visual symptoms:

Patients presenting with a history of new visual loss (transient or permanent) or double vision should be evaluated as soon as possible on the same calendar day by an ophthalmologist. Please contact the ophthalmology team as per below instructions.

GCA without visual symptoms:

1. Commence treatment summarised below

2. ALL patients should have a Temporal Artery USS requested on the day of presentation.

3. ALL electronic requests (ie via ICE or Sunrise EPR) as 'USS Skull' for TA USS but MUST be accompanied by an email to inform the vascular lab that the test has been requested: ghn-tr.vascularlabreferrals@nhs.net

4. Patients do not need to be referred for Temporal Artery Biopsy at this point.

5. ALL patients to be referred for rheumatology assessment by e-referral to either:

- **https://web.glos.nhs.uk/eReferRheumatologyGrh/**
- **https://web.glos.nhs.uk/eReferRheumatologyCgh/**

6. Please advise the patient that they should be seen by a rheumatologist within 7 working days, please advise them to contact Rheumatology bookings office on: 0300 4225987 if appointment not received within 5 working days.

IMMEDIATE MANAGEMENT

GCA with visual symptoms:

Refer ALL cases for urgent ophthalmological assessment +/- admission for IV methylprednisolone (IVMP). Please contact the eye casualty helpline 8-6PM Monday to Saturday 0300 4223578. Outside of this time contact the ophthalmology surgical trainee on call via switchboard.

GCA without visual symptoms:

With jaw claudication: Prednisolone 60mg daily.
Without jaw claudication: Prednisolone 40mg daily

This should usually be prescribed alongside protein pump inhibitors for gastro-intestinal protection and consideration for bone protection. When starting prednisolone it is important that the first dose is given stat in the department if not already started by the GP to avoid any delay and risk of visual complications. Please ensure have two weeks minimum supply until seen by rheumatology. Please inform the patient that if they develop visual symptoms they must seek urgent medical advice.