Title	**Management of Patients with suspected Giant Cell (Temporal) Arteritis (GCA)**
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Guidance on the Management of patients with suspected Giant Cell (temporal) Arteritis (GCA)

Symptoms of possible/probable GCA

Age > 50 years, with new/recent:

- Abrupt onset headache (usually unilateral, may be bilateral, in the temporal area, sometimes occipital area)
- Scalp tenderness
- Jaw and tongue claudication
- Visual symptoms (including diplopia)
- Constitutional symptoms
- Polymyalgic symptoms
- Limb claudication

Findings on clinical examination

- Abnormal superficial temporal artery: tender, thickened with reduced or absent pulsation.
- Scalp tenderness.
- Transient or permanent visual loss.
- Visual field defect (if complaining of visual symptoms):
    - Relative afferent papillary defect.
    - Anterior ischaemic optic neuritis.
    - Central retinal artery occlusion.
- Upper cranial nerve palsies.
- Features of large-vessel GCA: vascular bruits and asymmetry of pulses or blood pressure.

Preliminary Investigations

- Blood tests (FBC, UE, LFT, CRP, ESR)*
- Urinalysis^
- Chest-Xray^

*ESR usually >50mm/hr, CRP usually >50mg/L; Can be lower than this in 7-20% of patients with strongly typical symptoms. Normal ESR and CRP almost definitely excludes GCA, look for alternative cause of symptoms.
^Look for infection

Direct Referral for Temporal Artery Biopsy (TAB)

- Where a diagnosis of GCA with ocular involvement is suspected, the patient should be discussed with the Ophthalmologists as a matter of urgency and commence Prednisolone 60mgs daily. Provide the patient with a 4 week course of this dosage of Prednisolone. If retinal involvement is confirmed, continue with Prednisolone dose reduction as suggested below ('ongoing medium-long term management')
- Where a diagnosis of GCA without ocular involvement is suspected, take blood for testing as above:

  I. If ESR >50mm/hr and/or CRP >50mm/hr, start Prednisolone 40mg daily, complete TAB request and histopathology forms, send to the General Surgeons (GeneralSurgery.Malbox@borders.scot.nhs.uk), and 'cc' the Rheumatology inbox (RheumatologyAdvice@borders.scot.nhs.uk)
  II. If ESR and CRP abnormal but < 50mm/hr and 50mm/hr respectively, **but** history/clinical examination is strongly suggestive, start Prednisolone 40mg daily, complete TAB request and histopathology forms, send to the General Surgeons (GeneralSurgery.Malbox@borders.scot.nhs.uk), and 'cc' the Rheumatology inbox (RheumatologyAdvice@borders.scot.nhs.uk)
  III. If ESR and/or CRP abnormal but <50mm/hr and 50mm/hr respectively, **and** uncertainty in history/clinical examination, please email the Rheumatology inbox (RheumatologyAdvice@borders.scot.nhs.uk) for advice

- **Wait for results of ESR and CRP (scenarios I and II) before commencing on Prednisolone or requesting TAB.** If blood tests can only be processed the following working day, or on a Monday, if the patient was assessed the previous Friday; and in anticipation that the patient may develop visual disturbance in the time that it takes to wait for the ESR and CRP result, please provide the patient with an emergency prescription of 60mg daily of Prednisolone for 4 weeks. Instruct the patient to start taking Prednisolone in the event that any change in vision/visual disturbance occurs. Ask the patient to inform you if any change in vision/visual disturbance has occurred, arrange to re-assess the patient urgently, and refer to the Ophthalmologists for urgent outpatient appointment. **If no visual disturbance occurs, the patient should not take any Prednisolone, and no referral for TAB should be made, until the results of the ESR and CRP are known.**
- A TAB should be performed within 2-3 weeks of commencement of Prednisolone.

Immediate short-term Management and Monitoring

- Following commencement of Prednisolone, GP to arrange to see the patient again, within 7 days, to assess response to Prednisolone, and repeat ESR and CRP. Patients with suspected GCA will typically respond rapidly (hours-days) both clinically and biochemically to Prednisolone.
- Where there is biochemical improvement, but no/minimal clinical improvement, please email the Rheumatology Advice inbox (RheumatologyAdvice@borders.scot.nhs.uk) for advice, as an alternative diagnosis may be responsible for the patient's symptoms, and a TAB may not be needed.

Ongoing medium-long term Management and Monitoring

- In patients where there has been an initial and rapid, clinical and biochemical response, continue with Prednisolone and await TAB and result of TAB. TAB results may reveal no sign of vessel wall inflammation due to the possibility of 'skip' lesions, with inflammation affecting some parts of the artery, and not others. In this situation, continue with Prednisolone dose reduction as planned, assuming ongoing clinical and biochemical improvement/response. If TAB positive for inflammation, continue with Prednisolone dose reduction as planned. Monitor ESR and CRP once monthly throughout the course of Prednisolone therapy. Request DEXA to assess requirement for concomitant bone protection.

- Suggested Prednisolone dose reduction:

  I. 40mg daily for 4 weeks, then,
  II. 30mg daily for 4 weeks, then,
  III. 20mg daily for 4 weeks, then,

IV. Reduce by 2.5mg/4 weekly to 10mg daily for 4 weeks, then,
V. Reduce by 1mg/4 weekly until discontinuation

- Suggested Prednisolone dose reduction regime if visual disturbance and retinal involvement/complication(s) confirmed at the Ophthalmology clinic:

I. 60mg daily for 4 weeks, then,
II. 50mg daily for 4 weeks, then,
III. 40mg daily for 4 weeks, then,
IV. 30mg daily for 4 weeks, then,
V. 20mg daily for 4 weeks, then,
VI. Reduce by 2.5mg/4 weekly to 10mg daily for 4 weeks, then,
VII. Reduce by 1mg/4 weekly until discontinuation

- At any point in time during the above dose reduction regime:

I. If there is recurrence of symptoms of GCA, recheck ESR and CRP out with the recommended once monthly frequency of blood monitoring.
II. If there is a rise in either the ESR/CRP, not in keeping with the trend of normality, and if there is no other explanation for such a rise, increase the dose of Prednisolone to the previously used dose where there were no symptoms and a normal ESR and CRP, for 4 weeks (eg from 12.5mg daily to 15mg daily; or from 6mg daily to 7mg daily), before resuming with planned dose reduction. If a further relapse occurs, please email the Rheumatology Advice inbox (RheumatologyAdvice@borders.scot.nhs.uk) for advice, as 2nd line immunosuppressive therapy may be required to achieve optimal control of ongoing inflammation.
III. If there are symptoms of visual upset (regardless of ESR/CRP levels), increase dose of Prednisolone to 60mg daily and refer urgently to Ophthalmology for assessment.
IV. If there are symptoms of recurrence of GCA, but no visual upset **and** no rise in either the ESR/CRP, please email the Rheumatology Advice inbox (RheumatologyAdvice@borders.scot.nhs.uk) for advice.