**Suspected GCA:**

**Calculate GCA Pre-Test Probability Score (PTPS) using table below**

**GCA Referral Pathway Flowchart**

**GCAPS <9 =Not for GCA** **Pathway**

* Strongly consider alternative diagnosis
* If rheumatology input still necessary then discuss via on-call phone if urgent, otherwise place A+G request

**PTPS ≥9 = For GCA** **Pathway**

* Take bloods for CRP, Plasma Viscosity, FBC, U&Es, LFTs *immediately*, where possible.
* Treatment should **NOT** be delayed by venepuncture, BUT, taking bloods >48hours after steroid started impacts result and management severely.

Visual symptoms?

1. Start prednisolone *(as above depending on symptoms*). Please also consider steroid weight adjustment in patients outside normal BMI1.

2. Start PPI, calcium+vit D supplement

3. Phone rheumatologist on call2 via switchboard urgently

4. Once discussed, send proforma via RMS referral

GP to initiate prednisolone 40mg

GP to initiate prednisolone 60mg daily

Jaw or tongue claudication?

Yes

No

No

Yes

Ophthalmology review of those with visual symptoms by eye casualty. SAME DAY via emailing Emergency Eye clinic referral form to rch-tr.EmergencyEyeClinic@nhs.net

Eye casualty will then refer to rheumatology if necessary

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | -3 | 0 | 1 | 2 | 3 | Score(Highest only) |
| Age |  | <50 | 50-60 | 60-65 | >65 |  |
| Sex |  |  | M | F |  |  |
| Onset (Weeks) |  | >24 | 13-24w | 6-12w | <6w |  |
| CRP  |  |  | 6-10 | 11-25 | >25 |  |
| New head /scalp pain |  |  | Y |  |  |  |
| Constitutional |  |  | single |  | combination |  |
| PMR |  |  |  | Y |  |  |
| Ischaemic symptoms |  |  |  |  | Y |  |
| Ophthalmology findings |  |  |  |  | Y |  |
| Temporal artery exam |  |  | tenderness | thickening | lost pulse |  |
| Cranial Nerve palsy (III,IV,VI) |  |  |  |  | Y |  |
| Alt diagnosis as/more likely than GCA or atypical ethnic group | Y |  |  |  |  |  |
| TOTAL SCORE: |  |  |  |

**CRP:** Use greatest value after onset of symptoms but before steroids started.

**GCA Referral Pathway** Date:

**GCA Pre-Test Probability Score (PTPS)**

Name:

NHS number:

DOB:

**Constitutional:** One or more of; fever, night sweats, weight loss

**PMR:** Symptoms of >30 minutes morning stiffness shoulder/hip girdle muscles, or any past use of steroids for PMR diagnosis.

**Ischaemic:** Acute blurring of vision confined to one eye only, diplopia, amaurosis fugax, jaw/tongue pain when chewing.

**Ophthalmology findings**: Acute ischaemic optic neuritis, central retinal artery occlusion, visual field defect, relative afferent pupillary defect. This section can be omitted in a primary care setting and scored as 0.

**Likely alternative diagnosis or atypical ethnic group:** Score yes if non-white, or any of the following are more likely, or as likely, as GCA to account for current symptoms and signs; active infection, active cancer, other rheumatological condition, other head or neck pathology.

|  |  |
| --- | --- |
| **Total Score ≥13** | High risk of GCA (>80%) Appropriate for GCA fast-track pathway. See flowchart below. |
| **Total score 9-12** | Intermediate risk of GCA (25%) Appropriate for GCA fast-track pathway, but alternative causes should still be considered/explored. See flowchart below. |
| **Total score <9 and no valid CRP sample** | Await bloods and review diagnosis prior to referral. Withhold steroids prior to blood results, unless ischaemic symptoms present |
| **Total score <9 with valid CRP sample** | Not for GCA pathway, consider alternative causes of headache and if neurology referral would be more appropriate. If rheumatology advice still needed send advice and guidance request.  |

**Additional Information/Further Reading**

* 1For the vast majority of patients the above steroid starting doses should suffice, for those at extremes of BMI (e.g. >100kg or <50kg), a weight based dosing of 0.7mg/kg in place of 60mg prednisolone and 0.5mg/kg in place of 40mg prednisolone can be employed.
* 2Rheumatology on call is from 9am-5pm weekdays. Out of hours, or in the event we are unable to answer immediately voicemails can be left to give details to call back but responsibility to discuss remains with the referrer.
* There have been no confirmed cases to date of GCA in patients with PTPS<9
* Almost all GCA patients with cranial disease are over 60
* GCA is very rare in non-white patients
* Only 4% GCA patients have normal CRP and Plasma Viscosity (most of these will have focal ischaemic symptoms)

**Patient Pathway**

Once referred to rheumatology we will normally arrange an urgent temporal artery biopsy procedure through vascular surgery or ophthalmology and review in clinic 3-4 weeks later. Some cases may be discharged back to GP at this point if we feel GCA has been ruled out.

If GCA is diagnosed/not ruled out then we will normally follow the steroid reduction regime as detailed below and consider if long term bone protection is necessary.

In cases who relapse during prednisolone reduction, particularly if >10mg prednisolone, we will consider adding steroid sparing agents such as methotrexate or leflunomide to augment the next attempt at steroid dose reduction. In severe cases a biologic agent called ‘Tocilizumab’is sometimes used (pending regional approval.)

**Steroid Reduction**

|  |  |
| --- | --- |
| Dose of prednisolone (mg) | Dose reduction |
| Initial dose (normally 40-60) | Reduce by 10mg after 4 weeks provided GCA symptoms have resolved, and inflammatory markers have normalised |
| >20 (excluding initial dose)  | If remains in clinical remission, then continue to reduce by 10mg every 2 weeks until a dose of 20mg has been reached |
| 12.5-20 | If in clinical remission, reduce by 2.5mg every 2 weeks. |
| 1-10 | If in clinical remission, reduce by 1mg per month until stopped. |

In patients with significant steroid toxicity a faster steroid reduction regime and earlier use of steroid sparing agents may be required.

**Relapse**

If headache or PMR symptoms recur on dose reduction, then return to previously effective dose of prednisolone and inform rheumatology.

If ischaemic symptoms develop (either new or recurrent) then commence high dose prednisolone and manage as per a new case.

**Patient information**

Versus Arthritis, GCA patient information.

https://www.versusarthritis.org/about-arthritis/conditions/giant-cell-arteritis-gca/

**References**

Mackie S, Dejaco S, Appenzeller Set al. British Society for Rheumatology guideline on diagnosis and treatment of giant cell arteritis, Rheumatology, Volume 59, Issue 3, March 2020, Pages e1–e23, <https://doi.org/10.1093/rheumatology/kez672>

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