Giant cell arteritis (GCA) is a medical emergency requiring prompt assessment and immediate steroid treatment in order to prevent irreversible visual loss.

**Suspected Giant Cell Arteritis**

Commence oral steroid therapy:
- Visual symptoms or jaw claudication: prednisolone 60 mg PO daily
- Headache and/or scalp tenderness and no jaw claudication: prednisolone 40 mg PO daily

Prescribe aspirin 75 mg PO od and gastroprotection if no contraindications

FBC, U&E, LFT, CRP and ESR within 24 hours (do not wait for the result)

**Visual Symptoms**

Immediate referral to Eye Casualty:
Contact the on-call Ophthalmology registrar on bleep 787 or via switchboard out-of-hours

Active visual symptoms:
Give intravenous methylprednisolone 500 mg – 1 g daily for 3 days (may require admission) followed by 60 mg oral prednisolone daily with gastroprotection

Arrange TAB by Ophthalmology and refer urgently to Rheumatology

**No Active Visual Symptoms**

Urgent referral to Rheumatology to be seen within 7 days:
ERS if in primary care
Email bht.rheumatology@nhs.net if in secondary care. For advice contact Rheumatology registrar on bleep 905 / 907 or Rheumatology consultant via secretaries 01296 316664

Temporal artery ultrasound (USS):
This needs to occur within 7 days of steroid initiation. Put in an urgent request on ICE and ring Radiology secretaries 01296 316917.

**Temporal Artery Ultrasound**
- Chase the outcome of the TA USS if performed

Arrange temporal artery biopsy (TAB) if indicated:
- In order to increase the chances of a positive result, TAB should be performed within 7 days of starting steroids but can remain positive for up to 6 weeks
- Complete TAB referral form and fax to Plastics and Vascular booking team on 01296 316955
- Take screening swabs for MRSA in clinic

Ensure baseline investigations performed:
- Full blood count, urea and electrolytes, liver function tests, CRP and ESR
- Chest radiograph
- Urinalysis
- Any investigations required to exclude mimicking conditions

Prescribe bone protection and ensure aspirin and gastroprotection have been initiated

Follow up
- Give patient a steroid weaning regimen
- Arrange clinic follow up for 4 weeks
*GCA symptoms:*
- Aged ≥50 years
- New onset headache (usually unilateral and temporal but can be diffuse or bilateral)
- Tender, thickened or beaded temporal artery or reduced temporal artery pulsation
- Scalp pain/tenderness or difficulty with combing hair
- Jaw or tongue claudication
- Visual symptoms (amaurosis fugax, reduced visual acuity, diplopia, blurring of vision)
- Elevated ESR and/or CRP
- Large vessel vasculitis suspected if prominent systemic symptoms, persistently elevated inflammatory markers despite steroid therapy and limb claudication

**Differential Diagnosis**
- Herpes zoster
- Migraine
- Serious intracranial pathology e.g. infiltrative base of skull/retro-orbital lesions
- Other causes of acute vision loss e.g. transient ischaemic attack
- Cluster headaches
- Cervical spondylosis
- Other upper cervical spine disease
- Sinus disease
- Temporomandibular joint pain
- Ear disease
- Other systemic vasculitides or connective tissue disease

References:
Dasgupta et al. BSR and BHPR guidelines for the management of giant cell arteritis, *Rheumatology*, 2010;49(8):1594-1597
Monti C et al. The proposed role of ultrasound in the management of giant cell arteritis in routine clinical practice, *Rheumatology*, 2018;57:112-119

See also
Guideline 222 Adult and Paediatrics Injectables Guide
Guideline 299FM Guideline for Prescribing Non-Steroidal Anti-inflammatory Drugs (NSAIDs) in Adults
Guideline 402FM Osteoporosis: Primary Fracture Prevention Guidelines in Men and Women Over the Age of 50 with Risk Factors

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