Pathway for investigation and initial management of patients with suspected GCA

Clinical Symptoms

Age of onset > 50 yrs (GCA rarely occurs below this age)

- NEW localised headache
- Scalp tenderness
- Jaw/tongue claudication
- Visual changes or double vision
- Systemic illness (fever, anorexia, weight loss etc.)
- Limb claudication
- Signs
- Cranial nerve palsies
- Temporal artery tenderness, nodularity or reduced pulsation
- Cranial nerve palsies

If clinical history is entirely typical and inflammatory markers are normal, GCA cannot be excluded; such patients should still be treated and referred

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Blood tests: FBC, CRP, ESR, U&E, bone profile, LFT before or immediately after commending high dose glucocorticoids

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Transient/permanent visual loss or double vision?

Yes → **Reject Referral**
GP to refer ophthalmology for same day assessment

No ↓

Commence prednisolone (40-60 mg) daily and PPI
Urgent rheumatology referral

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Rheumatology assessment within 3 working days
History and examination
Height/weight/BP
Bloods: FBC, CRP, ESR, glucose, U&E, LFT, bone profile, HbA1C, glucose
Consider serum protein electrophoresis and urine Bence-Jones protein/serum light free chains if ESR elevated out of proportion to CRP
Screen for serious infection (if appropriate)
Consider referral for glaucoma screening if risk factors (known glaucoma or glaucoma risk factors)
FRAX and consider screening tests for osteoporosis risk (e.g. TSH, vitamin D)
Patient education and advice line number
MHRA steroid emergency card

GCA highly unlikely → Consider alternative diagnosis and steroid wean

GCA likely ↓

Refer ophthalmology for TA biopsy

TAB negative → Consider alternative diagnosis and steroid wean

TAB positive ↓

Follow-up within two weeks
Individual steroid tapering schedule
Consider calcium/vitamin D
Consider bisphosphonate – see policy for protocol for oral bisphosphonates

Relapse →

Check inflammatory markers
Headache – return to previous higher prednisolone dose
Jaw/tongue claudication – consider high dose prednisolone (40-60mg)
Visual disturbance – refer ophthalmology for same day assessment
Large vessel symptoms – consider imaging, consider increasing steroid dose

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Follow-up 2-8 weeks in first 6 months, 12 weeks second 6 months, 12-24 weeks during second year or more frequent if relapse
Refer MFT if fulfils NICE TA518 for tocilizumab
Consider glucocorticoid sparing agent such as MTX if high risk of glucocorticoid toxicity or relapse