Version 2.0 3rd June 2026

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 commencing high dose glucocorticoids

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Transient/permanent visual loss or double vision?

Yes → **Reject Referral** referrer 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, consider GCA probability score
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) signs or symptoms indicating involvement of the aorta and its proximal branches and for comorbidities relevant to treatment, such as diabetes mellitus, hypertension and bone fracture risk
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
Steroid emergency card and sick day rules

GCA highly unlikely → ↓

Consider alternative diagnosis and steroid wean

GCA possible ↓

Refer for ultrasound scan (see GCA USS SOP)

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