

ED GCA Flowchart

Giant Cell Arteritis (GCA) is a relatively rare condition. It can be considered in patients aged ≥ 50 with new temporal headache, *typically* unilateral, which has started within the last three months.

Alternate diagnoses
SAH, ICH
Space occupying lesion
Intracranial infection
Stroke, TIA
Migraine, TTH
Shingles
Trigeminal neuralgia
TMJ dysfunction
Mechanical neck pain

GCA is more likely if:

Female, aged 70 – 80
Morning stiffness
Symptoms present under 6 weeks
Scalp pain, sensitivity or tenderness e.g. discomfort on combing hair
Abnormal superficial temporal artery
- Tender, thickened, or beaded
- Reduced or absent pulsation
Jaw or tongue claudication (pain occurs with chewing or talking, and settles with rest)
Sudden visual change e.g amaurosis fugax, obscurations, diplopia, blurring
Systemic features such as weight loss, fever, fatigue
Polymyalgia or limb claudication
CRP ≥ 10

GCA is less likely if:

Frontal or facial pain
Intermittent or paroxysmal pain
Facial rash
History of migraine
Nausea and/or vomiting
Gradual visual changes
Jaw pain *without* claudication
TMJ clicking
Systemic symptoms or raised inflammatory markers where there is a clear alternate explanation such as infection
Known rheumatoid arthritis

For all patients, ensure alternate diagnoses (box above) have been appropriately considered and excluded. Many diagnoses are more common/likely than GCA, and alternate diagnoses could result in serious harm if missed.

All suspected cases should be discussed with a senior.

When there is reasonable suspicion of GCA, but clinical uncertainty exists, correct use of GCAPS score (see next page) may help. GCA is more likely if GCAPS score ≥ 8 , and less likely if score ≤ 7 .

Probable GCA with visual disturbance present.

- Start prednisolone 60mg daily, aspirin 75mg daily and omeprazole 20mg daily.
- If significant or rapidly progressive visual loss is present (such as loss of all or part of vision), discuss with the ophthalmology SpR on call. For minor disturbance (such as *mild* blurring), advise the patient to call eye casualty as soon as possible to arrange urgent review. Do not delay starting prednisolone and aspirin whilst awaiting ophthalmology review.
- Advise the patient not to drive until cleared to do so by ophthalmology (likely minimum four weeks).
- Make a referral to rheumatology team by sending communicate to "Referral Team General NOC Rheumatology OP." Highlight urgent nature of referral.

Probable GCA with jaw or tongue claudication present, but no visual disturbance.

- Start prednisolone 40mg daily, aspirin 75mg daily and omeprazole 20mg daily.
- Refer to rheumatology team by sending communicate to "Referral Team General NOC Rheumatology OP."

Probable GCA, but with no jaw or tongue claudication or visual features.

- Do not routinely start prednisolone, aspirin or omeprazole.
- Refer to rheumatology team by sending communicate to "Referral Team General NOC Rheumatology OP."

For all patients, provide careful safety netting advice to return to ED if they develop unbearable headache, drowsiness/confusion, or new symptoms. Should visual disturbance develop or worsen during the hours eye casualty is open (see next page), the patient should call eye casualty; out of hours, they should return to ED.

Southend Giant Cell Arteritis Probability Score (GCAPS)

Score	- 3	0	+ 1	+ 2	+ 3
Category 1: Demographics					
- Age (years)		≤ 49	50 – 60	61 – 65	≥ 66
- Sex			Male	Female	
Category 2: Onset (weeks)		> 24	12 – 24	6 – 12	< 6
Category 3: CRP		0 – 5	6 – 10	11 – 25	≥ 25
Category 4: Symptoms					
- Headache		N	Y		
- Polymyalgia		N		Y	
- Constitutional		N	Single		Multiple
- Limb ischaemia		N			Y
Category 5: Signs					
- Eye (AION, CRAO, field loss, RAPD)		N			Y
- Temporal artery abnormality		N	Tenderness	Thickening	No Pulse
- Extra-cranial artery abnormality		N	Tenderness	Bruit	No Pulse
- Cranial Nerve Palsy		N			Y
Category 6: Systemic Conditions					
- Infection	Y				
- Cancer	Y				
- Another systemic rheumatic disease	Y				
- Head and neck pathology	Y				
- Other	Y				

GCAPS can be used **when there is reasonable clinical suspicion of GCA based on the gestalt of an experienced clinician** to risk stratify GCA as more or less likely.

To calculate GCAPS, add together the *highest single score in each of the six categories*.

For example:

- A 67 year old male scores +3 in the demographic category; a 55 year old female scores +2.
- An individual with RAPD and a CNIV palsy scores +3 in the signs category (not +6).
- An individual with sinusitis and rheumatoid arthritis scores –3 in the systemic conditions category (not –6).

A total score ≥ 8 is makes a diagnosis of GCA more likely.

A total score ≤ 7 suggests an alternative diagnosis is more likely.

Clinical judgement should be exercised when using this scoring system – if in doubt, seek senior advice.

Notes:

- GCA is **extremely** unlikely in patients aged under 50, and alternate diagnoses should be strongly considered.
- ESR should not be sent in ED.
- The NOC rheumatology team run GCA clinics several times per week, Tuesday to Friday. Referrals to the team will be triaged, and patients with possible GCA will be seen in the next available clinic. It is important therefore that patients are discharged with sufficient TTO medication to last until this review, and safety netting to return to ED should their condition change or worsen in the interim.
- The primary team in the management of suspected GCA is rheumatology. A referral to ophthalmology should only be made if there is visual disturbance or eye signs.
- The ophthalmology SpR can be contacted via bleep 1225 (available 24 hours a day), or on mobile via switchboard if there is no response to the bleep.
- Eye casualty is open 0830 – 1630 on weekdays, and 0830 – 1530 on weekends and bank holidays. Patients should call 01865 234567, and select option 1 followed by option 1. Their case will be triaged, and they will be allocated an appropriate time for review.

References:

Laskou F, Coath F, Mackie SL, Banerjee S, Aung T, Dasgupta B. A probability score to aid the diagnosis of suspected giant cell arteritis. Clin Exp Rheumatol. 2019 Mar-Apr;37 Suppl 117(2):104-108. Epub 2019 Feb 15. PMID: 30767870