**Prednisone treatment for Giant Cell Arteritis (‘temporal arteritis’)**

**Induction therapy:**

Oral prednisolone 40-60mg/day (no less than 0.75mg/kg/day)

\* If visual loss in one eye, start at Prednisone 60mg/d to protect contralateral eye

**Initial taper:**

10mg every 2 weeks to 20mg/day

Clinical improvement and reduction in CRP after 4 weeks

**Remains in remission:**

* Taper prednisolone 2.5mg every 2 – 4 weeks until 10mg
* Then taper 1mg every 1 – 2 months till discontinued, provided there are no relapses.

**Flare management:**

* Increase daily dose to pre-relapse dose or by 5-10mg
* Taper more slowly within 4-8 weeks to pre-relapse dose
* If ischaemic complications – repeat induction therapy

Clinically stable at 20mg/day

Disease activity present

**Suggested monitoring:**

* 2-4 weeks – clinical symptoms and CRP to guide steroid taper.
* Up to 60% of patients with GCA will have symptoms of PMR.
* Suggested follow up schedule: Weeks 0, 1,3, 6 and Months 3, and every 3 months thereafter for the first year. Extra unscheduled visits in event of a flare, etc.
* Screen for hypertension, impaired fasting glycaemia or impaired glucose tolerance and dyslipidaemia. Actively manage cardiovascular risk factors.
* Bone mineral density for osteoporosis prevention.
* CXR every 2 years to look for aortic aneurysm (echocardiography / MRI (MRA) if suspected large vessel involvement which occurs in up to 20% (incidence of 30.5/1000 person-years). \*
* Methotrexate 7.5-15mg a week can be added for: recurrent relapses +/- prolonged steroid therapy with adverse side effects. \*

\* If refractory to steroid therapy or suspected large vessel involvement, refer back to specialist.

**References:**

Hunder GG, et al. ACR 1990 Classification Criteria. Arth Rheum 1990;33(8):1122-28.

DasguptaB, et al. BSR guidelines for management of GCA. Rheumatology (Oxford) 2010;49(8):1594-7.

Buttgereit F, et al. PMR and GCA a systematic review. JAMA 2016;315(22):2442-58.