Te Whatu Ora
Health New Zealand

Suspected Giant Cell Arteritis (GCA) Pathway: Bay of Plenty

Only consider GCA in patients aged >50 who have a new headache. Reminder: Female:Male ratio = 2-3:1. GCA is uncommon in the non-white population.

Do they have features of GCA?
- Recent onset of temple headache (days to weeks)
- Any visual disturbance
- Jaw claudication[¤]
- Scalp tenderness
- Recent/Current Polymyalgia rheumatica[¥]
- Systemic features (fever, sweats, weight loss)
- Hard, beaded, tender or pulseless temporal arteries

No → Consider alternative causes of headache[§]

Yes ↓

Examine for complications:
- Cranial and peripheral nerve abnormalities
- Heart sounds
- Volume and symmetry between radial pulses

Test:
- Urgent (same day) FBC, U&E, LFT, CRP, ESR

***ENSURE TO INCLUDE "?GCA" IN CLINICAL DETAILS**

Normal ESR* → Consider alternative causes of headache[§]

Raised ESR / CRP ↓

If GCA felt to be likely, are visual symptoms present?

No ↓

Discuss with Rheumatologist on call via telephone acutely. If not available / out of hours, commence prednisolone **if likely**[ᵒᵒ] and discuss next working day (do not refer using e-referrals without discussing first with the rheumatologist).

Yes → Contact Duty Ophthalmologist acutely (same day)

↓

Rheumatology will subsequently risk stratify the patient and decide on further investigation(s) and management. The tool (*opposite*) will help risk stratify the patient and can also aid the referrer in determining the probability of GCA.

Further investigations may include temporal artery ultrasound +/- temporal artery biopsy and ideally need to be performed as soon as possible from prednisolone commencement. Currently, there is no temporal artery ultrasound or biopsy service available at Tauranga Hospital. Rheumatology may refer to Waikato/Whakatane if a temporal artery ultrasound is required. Rheumatology may refer to Whakatane if a temporal artery biopsy is required. Please note, the referrer cannot refer directly for these investigations (all requests go via Rheumatology). When making the e-referral, please document the name of Rheumatologist with whom you have discussed.

Notes

[¤]Jaw claudication = no jaw pain at rest or on the first few bites, but pain gradually builds as they eat or talk, then eases after they stop.

[¥]Polymyalgia rheumatica = pain and stiffness (no weakness) in the shoulders and hips that is worst in the morning and improves with activity.

*ESR upper limit of normal =
age in years / 2 (men)
(age in years+10) / 2 (women)

[§]Common GCA mimics:
- Shingles
- Sinusitis
- Ear infection or other problem
- Dental problem, including abscess
- Temporomandibular joint dysfunction
- Cervical spine disorders
- Other headaches – tension, migraine
- Intracranial haemorrhage
- Raised intracranial pressure

[ᵒᵒ]Prednisolone dose:
40mg: standard dose
60mg: if jaw claudication or visual symptoms

Table I. GCA probability score [GCAPS] proforma.

Weightage	-3	0	+1	+2	+3
Demographics					
Age (years)		≤49	50-60	61-65	≥66
Sex			M	F	
Duration					
Onset of symptoms		>24 weeks	12-24 weeks	6-12 weeks	<6 weeks
Laboratory					
CRP		0-5 mg/L	6-10 mg/L	11-25 mg/L	≥25 mg/L
Symptoms					
Headache		N	Y		
Polymyalgic		N		Y	
Constitutional		N	Single		Combination
Ischaemic		N			Y
Signs					
Visual (AION, CRAO, Field loss, RAPD)		N			Y
TA abnormality		N	Tenderness	Thickening	Pulse loss
Extra-cranial artery abnormality		N	Thickening	Bruit	Pulse loss
Cranial nerve paisy		N			Y
Alternative					
Infection	Y				
Cancer	Y				
Systemic Rheumatic diseases	Y				
Head and neck pathology	Y				
Other	Y				
Total score					

Low Risk: <9
Medium Risk: 9-12
High Risk: >12