James Paget University Hospitals NHS Foundation Trust

Referral of Suspected Temporal (Giant Cell) Arteritis Trust Guideline

A Clinical Guideline recommended for use

In:	Ophthalmology & Rheumatology
By*:*	All Staff in Ophthalmology & Rheumatology
For:	Patients with suspected temporal (giant cell) arteritis
Key words:	Suspected, temporal, arteritis, giant cell
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V5	Mr TK Butler & Dr D Makkuni	May 2023	Reviewed with no changes.
V4	Mr TK Butler & Dr D Makkuni	April 2020	Reviewed with no changes.
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V2	Mr TK Butler & Dr D Makkuni	October 2013	No changes, review date extended. Document in new format
V1	Mr TK Butler & Dr D Makkuni	November 2009	To originate document

1. Objective/s

These guidelines are intended to help in the diagnosis, initial management and referral of patients in whom this diagnosis is suspected.
These guidelines are intended for GPs, primary care healthcare professionals and those in secondary care to whom such patients present.

2. Rationale

The diagnosis of temporal (giant cell) arteritis can be challenging. There is considerable morbidity associated with this diagnosis, and a risk of sudden visual loss in some patients.

3. Broad recommendations

Patients over 50 years of age with any of the following symptoms should prompt a clinical suspicion of temporal (giant cell) arteritis:

1. New headache – usually temporal or occipital
2. Scalp tenderness – often over temple
3. Jaw claudication – pain on chewing, relieved by rest
4. Raised inflammatory markers (ESR; CRP)

Such patients without visual symptoms should be referred primarily to **Rheumatology.**
Referrals should be faxed urgently to the Rheumatology team.

Patients who have any of the following **visual** symptoms with or without the above features should be referred urgently to **Ophthalmology**:

1. Sudden painless loss of vision
2. Transient visual obscurations – fleeting loss, or Amaurosis Fugax
3. Diplopia

All patients, in whom this diagnosis is suspected, should be started on systemic steroid treatment immediately, with onward urgent referral as above. Prednisolone is suggested at 40mg od if no visual symptoms, 60–80mg od in the presence of visual symptoms.

If the diagnosis is in doubt, discuss with the Rheumatology team.

Patients with suspected temporal arteritis should have a temporal artery biopsy whenever possible. This will be arranged following the above referral. The biopsy **must not** delay the implementation of steroid treatment once the clinical diagnosis is made. [Note that patients may need to suspend any anticoagulant treatment prior to temporal artery biopsy].

4. Clinical audit standards

To ensure that this document is compliant with the above standards, the following monitoring processes will be undertaken:

Not Applicable

5. Summary of development and consultation process undertaken before registration and dissemination

The authors listed above drafted this document on behalf of Mr TK Butler, Consultant Ophthalmologist who has agreed the final content. During its development it has been circulated for comment to:

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6. Distribution list/ dissemination method

James Paget University Hospital Intranet

7. References

1. British Society of Rheumatology & British Health Professionals in Rheumatology: guidelines on the management of giant cell arteritis. Available at: www.pmr-gca-northeast.org.uk/assets/pmr_resource_8.doc
2. Seo P, Stone PH. Large vessel vasculitis. Review. Arthritis & Rheumatism 2004; 51(1):128-139