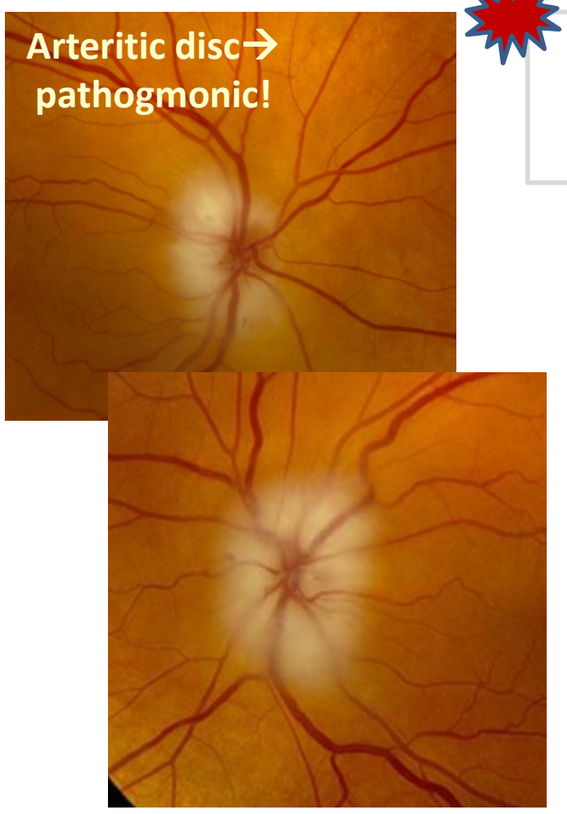
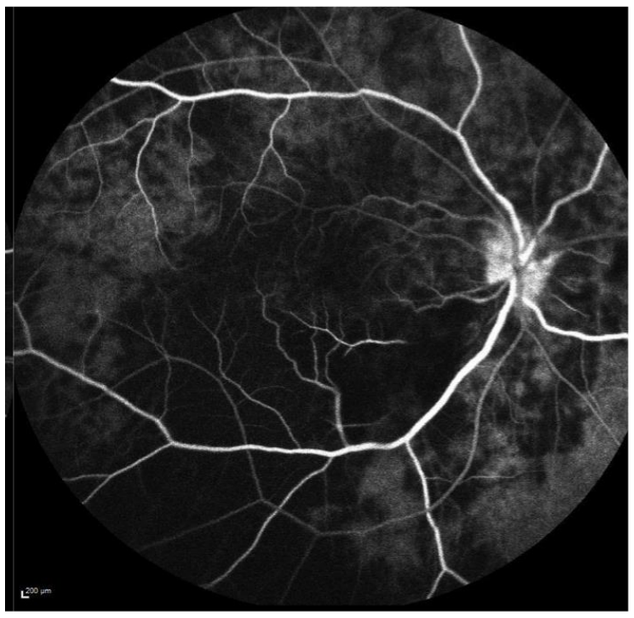
L Alvarez 2019



Acutely pale disc swelling = arteritic AION (GCA) until proven otherwise

Choroidal ischemia/ perfusion delay is often behind transient or persistent visual loss without infarcted disc in GCA



Giant Cell Arteritis

Compatible ocular presentation?

Acute ocular ARTERIAL ischemic signs (ischemic optic neuropathy, amaurosis fugax/ transient visual loss, retinal ischemia) OR new onset non explained visual disturbance OR/ AND new onset diplopia in elderly patient > 50. (* note GCA is very rare in non-caucasians, but not impossible).

Systemic symptoms?
[they are absent in 20%]

Scalp pain or tenderness
Facial pain/ headaches
Jaw claudication (very specific)
Limb claudication
Hip/shoulder girdle pain and stiffness
Lethargy, malaise, fever, weight loss,

Supportive Examination?

Thickened, tender or non-pulsatile TA
Compatible visual signs or symptoms
Ocular motor cranial nerve paresis

High Acute Phase Response?
Send FBC, ESR, CRP **+** U&E, LFT, Glu, INR, (HbA1c)

Most specific predictors for a positive biopsy (low sensitivity but very suggestive if present)
- Jaw claudication
- New onset diplopia (when alongside other symptoms eg amaurosis fugax)
- Abnormal temporal artery on palpation
- Thrombocytosis

Pre-test probability ?

High suspicion

Pathognomonic ocular presentation (arteritic AION) +/- raised inflammatory markers +/- systemic symptoms +/- compatible ocular other

Acute visual symptoms (impending or established visual loss)

- Admit and start steroids STAT *
- Start Aspirin 75mg
- Arrange TAB
- Urgent referral to neuro-ophthalmology +/- rheumatology

No visual symptoms or other acute ischemic symptoms

- Start steroids stat (IV versus oral 40-60 mg OD)
- Arrange TAB
- Urgent referral to rheumatology

Intermediate suspicion

Compatible/possible ocular presentation + /-equivocal significance of inflammatory markers +/ equivocal or absent systemic symptoms

Careful senior assessment of history, symptoms, comorbidities, potential morbidity of steroids, other differential diagnoses? Low index of suspicion! Usefulness of FFA.

Yes ← GCA still suspected? → No

Low suspicion

Consider alternative cause.

Special attention to identification of **Amaurosis fugax/ CRAO-BRAO requiring urgent stroke referral + high dose aspirin**

Other urgent potential causes of **acute optic neuropathy requiring urgent admission?**

STEROIDS in GCA

* Some evidence supports IV versus oral steroids in GCA with acute visual loss in GCA. However if IV cannot be given/ delay unavoidable, start oral stat in the Accident and Emergency department.

Assess risk/ benefit of oral versus IV (oral may be preferable in the very frail, CKD & electrolite imbalance severe cardiac failure)→ low threshold for medical referral.

In high suspicion GCA, first dose of steroids must **not** be delayed. Chest X ray should be organized on starting steroids but never to delay first dose.

Dose of intravenous steroids : 15 mg/kg BW Methylprednisolone (up to 1g per day) for 3 days when acute visual loss / impending visual loss. Alternative: 60 mg oral prednisolone

Steroids for treatment of GCA are maintained (always under rheumatology / neuro-ophthalmology guidance) 40mg or 60mg for 4 weeks - or longer until symptoms resolved- then reduce dose by 10mg every 2 weeks until 20mg, then reduce by 2.5mg every 2 weeks until 10mg, then reduce dose by 0.5-1mg every 2 months until discontinuation (in absence of relapses).

Adjuncts to Steroid Treatment

Prednisolone oral tablets – non-enteric coated – dose as per pathway

Aspirin 75mg OD with steroids to prevent ischemic complications

Proton pump inhibitor (PPI) or H2 antagonist for gastroprotection

Calcium and vitamin D supplement and Biphosphonate (if no contraindication – consider renal function, previous peptic ulcer disease etc.)

Medical assessment

Always document full medical history : cardiac or renal failure, diabetes, other systemic comorbidities?

If present : low threshold for medical review (preferably rheumatology) as inpatient, consider adjusting dose of steroids

Sandwell and West Birmingham NHS Trust
Suspected Giant Cell Arteritis (GCA) Care Pathway - Referral form –

Surname: Forename: Location of Patient:
Eye casualty.....
Date of Birth: Ward.....
Hospital (RXK) or NHS no:
Patient Tel.number:.....

Symptoms: (circle yes / no)
Scalp pain or tenderness yes / no
Jaw claudication yes / no
Visual loss or blurring, diplopia yes / no
Hip/shoulder girdle pain or stiffness yes / no
Lethargy, malaise, anorexia, weight loss yes / no
Fever yes / no
Limb claudication yes / no
Signs: (circle as appropriate)
Temporal artery / branches tender No – R – L – Both
Temporal artery / branches thickened No – R – L – Both
Temporal pulses absent No – R – L – Both
Description of visual symptoms and signs Amaurosis fugax / Ischemic optic neuropathy/ Other (specify) R – L – Both
……

Investigations:
ESR (mm/h).....
CRP (mg/L).....
GFR ml/min^2.....
Plts x10^9/L.....
INR……

Comorbidities: **(circle) Diabetes Osteoporosis CKD Ischaemic heart disease**

other **(please state)**.....

Drug Treatment **(circle) Aspirin Warfarin/Rivaroxaban/Clexane etc. Bisphosphonate**

PPI or H2 antagonist Calcium/vitamin D

other **(please state)**.....

ACTION BY REFERRER:

Dose of Prednisolone commenced?..... Date: ...../...../.....

TA Biopsy performed/ scheduled? yes/no Date: ...../...../.....

Print Name:..... Contact tel./bleep.....

Signature:..... Date: ...../...../.....

FAX REFERRAL TO *0121 507 5451 (City)* ***OR*** *0121 507 3696 (Sandwell)*
PLEASE CALL *0121 507 5793 (City)* ***OR*** *0121 507 3470 (Sandwell)* ***TO CONFIRM RECEIPT***
Contact Rheumatology SpR at City / Sandwell Hospital or Consultant on-call via Switch if queries