

The 2020 British Society for Rheumatology guideline on diagnosis and treatment of giant cell arteritis: highlights for patients

This summary was written by:

- Dr Sarah Mackie, University of Leeds / Leeds Teaching Hospitals NHS Trust
- Keith Slater, PMRGCAuk
- Lorna Neill, PMR-GCA Scotland

Here is a short summary of the new British Society for Rheumatology guideline on giant cell arteritis.

The authors of the guideline, a group of leading medical experts on the condition together with patient representatives, divided their report into two sections: **general principles** and **key recommendations**.

The **general principles** are statements that the authors of the guideline mostly agreed on, but they are not necessarily supported by research evidence.

The **key recommendations** are based on the published research evidence. Only two of these recommendations are “strong” – the others are “conditional” meaning there is some evidence to support them, but more research must be done to confirm the findings.

The two strong recommendations are:

1. if GCA is suspected you should have a temporal artery ultrasound scan or a temporal artery biopsy, or both, for confirmation.
2. if you relapse during treatment or if there is concern about the side effects of steroids, your consultant should consider adding tocilizumab to your steroid treatment. (Note that the prescribing of tocilizumab is limited in some countries, including the UK NHS, by funding restrictions.)

The full guideline can be accessed here: <https://doi.org/10.1093/rheumatology/kez672>

General principles

1. If a doctor strongly suspects that you have GCA, they should start you on high-dose steroid treatment, usually prednisolone tablets, at once.
2. Before you start steroids, the doctor will assess you and record your symptoms and you should have a blood test for inflammation markers. It is ok to take the first dose of steroids while waiting for the results of the blood tests.
3. After you have been started on steroids, a specialist at the hospital should be able to see you quickly – ideally within 24 hours, but this is not yet possible everywhere.

4. The specialist who sees you will usually be a rheumatologist. If you have lost vision or experienced double vision, you will need to see an ophthalmologist (eye doctor) as soon as possible, preferably that day.
5. When deciding on treatment, your doctor will take into account how severely the GCA has affected you, and whether you have other medical conditions that may be important for deciding on steroid dosing. Prescriptions for medicines which protect against osteoporosis (bone density loss) and possibly also for stomach protection may be added.
6. As your treatment goes on, you should be consulted about all treatment decisions and your own personal priorities should be taken into account. It is important your specialist communicates clearly with your GP especially if you have other health problems.
7. You should be provided with information about GCA, treatment of GCA, possible side effects of treatment, diet, physical activity and stopping smoking if that is relevant to you.
8. You should be given contact details for patient groups or charities which you may wish to approach for help and support.
9. You should be told what symptoms to look out for that might suggest relapse of GCA, and what to do if this happens.

Key recommendations (*= strong recommendation)

Diagnostic tests

1. *If you are treated for GCA, your doctor should request a test to confirm the diagnosis. This could be a temporal artery biopsy, or temporal artery ultrasound, or both of these.
2. If your doctor suspects that your aorta (the big artery in your chest) or its branches might be affected by GCA, they might request another scan. This could be an ultrasound, MRI, CT or PET scan.

Treatment of GCA

3. Usually, if you have GCA you will be started on prednisolone, a steroid medicine, at a dose of 40 to 60mg daily.
4. If you have loss of vision from GCA, you might be given up to 3 doses of steroids via a drip.
5. Your doctor will try to reduce your steroids and give you a reduction schedule called a taper. The aim will be to stop them after 12 to 18 months, but if your GCA relapses during this taper, it will take longer to stop the steroids. You might be advised to taper your steroid dose faster than this if your doctor is worried about steroid side-effects or if you are also taking another medicine to help taper the steroids faster.
6. There should be close and regular follow-up during your treatment, typically every 2-8 weeks during the first 6 months, every 12 weeks during the second 6 months and every 12-24 weeks during the second year.
7. You should take your steroids all at once in the morning. Don't skip days or split the dose.
8. We do not know whether slow-release prednisolone is effective in GCA.

9. As well as steroid treatment, your doctor might add in a drug called methotrexate if they are worried about steroid side-effects or if you have relapsed. Methotrexate can be given either as tablets or by injection. Clinical trials have not been done on leflunomide, azathioprine or mycophenolate in people with GCA so it is not known for sure whether they are effective although they also are used by some rheumatologists.
10. *As well as steroid treatment, your doctor might add in a drug called tocilizumab if they are worried about steroid side-effects or if you have relapsed. Tocilizumab can only be given by injection.
11. Generally, you would not be started on aspirin or other blood thinners just for GCA.
12. Generally, you would not be started on statins or other cholesterol-lowering agents just for GCA.

The following principles of GC (steroid) dose tapering are suggested:

- Continue with initial dose until **symptoms and laboratory abnormalities resolve** (at least 3–4 weeks).
- Daily dose is then reduced by 10mg every 2 weeks to 20 mg daily.
- Daily dose is then reduced by 2.5mg every 2–4 weeks to 10 mg daily.
- Daily dose is then reduced by 1mg every 1–2 months **provided there is no relapse**.

Relapse treatment:

- Return of headache should be treated with the previous higher dose of steroids.
- Pain and stiffness in the jaw when eating or chewing requires consideration of 40-60mg prednisolone.
- Eye symptoms related to GCA need the use of either 60mg prednisolone or intravenous steroids.
- Symptoms of large-vessel disease should prompt further investigation with MRI, CT or PET scans and the use of higher doses of steroids with or without additional immunosuppressives. Large-vessel disease may present with constitutional symptoms (weight loss, fever, night sweats, anaemia), polymyalgia, raised inflammatory markers, limb claudication or abdominal and back pain due to aortitis.