British Society for Rheumatology Audit Tool for Giant Cell Arteritis

**Aim:** This audit tool has been designed to help clinicians audit the investigation and management of giant cell arteritis (GCA) according to the 2019 BSR guidelines. It should be performed on an unbiased (e.g. consecutive) sample of patients presenting to a clinic or service.

**Quality standards**

- Following first medical contact in which GCA is suspected, patients should be reviewed by an appropriate specialist within 3 working days.

- Patients in whom GCA is strongly suspected should be treated with high-dose glucocorticoids on the same calendar day (either at least 40mg prednisolone equivalent, or intravenous methylprednisolone).

- Before or immediately after commencing high-dose glucocorticoids for suspected GCA, patients should have had blood sent to the laboratory for full blood count, CRP, and ESR (or plasma viscosity if ESR unavailable).

- Patients commenced on high-dose glucocorticoids for suspected GCA should undergo an additional confirmatory test, such as temporal artery biopsy or vascular imaging (e.g. vascular ultrasound, 3T MRI of cranial artery, or CT/PET).

- Patients with GCA-related visual symptoms (transient/permanent visual loss or diplopia) should be reviewed on the same calendar day by an ophthalmologist.

- Patients commencing high-dose glucocorticoids should have a random venous blood glucose or HbA1c or capillary blood glucose (CBG) checked within the first 2 weeks and any hyperglycaemia be managed appropriately.

- Patients commencing high-dose glucocorticoids for suspected GCA should have consideration of appropriate bone protection according to the applicable local or national guidelines (e.g. calcium and vitamin D, with oral bisphosphonate unless contra-indicated).

- Patients with confirmed GCA should be offered written information about their condition (for example, the Versus Arthritis leaflet on GCA, or locally-agreed equivalent), including advice on sources of further information and support in addition to medical advice from their care providers. Patients should be advised which matters could be dealt with by their GP, and how to contact their specialist if they need to.

- Patients with confirmed GCA should have documentation of a discussion about what symptoms may signal GCA relapse, and what action they should take in the event of a possible relapse, including the appropriate level of urgency for symptoms that may indicate threatened visual loss.
For patients with suspected GCA:

1. What was the interval in working days between initial medical contact and specialist review?
   - 0 - 1 □
   - 2-3 □
   - 4-5 □
   - >5 □

2. What was the interval between first strong suspicion of GCA and first initiation of high-dose glucocorticoid therapy?
   - <24 hrs □
   - 24-48 hours □
   - >48 hours □
   - not strong suspicion □

3. Were FBC, CRP and either ESR or plasma viscosity requested in the 3 weeks prior to, or immediately after initiation of high-dose glucocorticoid therapy?
   - yes □
   - no □

4. What was the initial daily dose of prednis(ol)one therapy for GCA?
   - <40mg □
   - 40-60mg □
   - >60mg □
   - iv therapy □
   - never treated □

5. What additional confirmatory test was performed?
   - ultrasound □
   - biopsy □
   - other appropriate imaging test □
   - no test □

6. If visual symptoms were documented, did the patient undergo urgent ophthalmology review?
   - Yes □
   - No □

   Ophthalmological diagnosis was (Please circle) Anterior ischaemic optic neuropathy, double vision, central retinal artery occlusion, branch retinal artery occlusion, choroidal ischaemia, other

Additional items, for patients with confirmed GCA:

7. Within the first 2 weeks of treatment which of these are documented?
   - random glucose or HbA1c □
   - blood pressure □
   - vitamin D and calcium prescribed □
   - appropriate bone protection therapy □

8. Is there documentation of provision of written information about the condition, including information about sources of further information and support?
   - Yes □
   - No □

9. Is there documentation of a discussion with the patient/carers about symptoms to watch out for and what to do if they experience symptoms suggesting GCA relapse?
   - Yes □
   - No □