149 ALL PATIENTS WITH POSSIBLE GIANT CELL ARTERITIS SHOULD BE SEEN BY A RHEUMATOLOGIST BEFORE TEMPORAL ARTERY BIOPSY

Vanessa Quick1, Hetal Bhatt1 and Chi-Hwa Chan1
1Rheumatology, Luton and Dunstable Hospital, Luton, UNITED KINGDOM, 2Ophthalmology, Luton and Dunstable Hospital, Luton, UNITED KINGDOM, and 3Maxillofacial Surgery, Luton and Dunstable Hospital, Luton, UNITED KINGDOM

Background: Over the last few years we have been developing a fast track pathway (FTP) for the diagnosis of giant cell arteritis (GCA) at Luton and Dunstable Hospital (LDH), a medium sized district general hospital. There is increasing evidence that such pathways which include temporal and axillary ultrasound (TAUS) and temporal artery biopsy (TAB) improve diagnostic certainty, improve outcomes and are cost effective.

Methods: Before the introduction of TAUS at LDH, baseline data were collected in a retrospective audit of all patients undergoing TAB in 2015. Blinded to the TAB result and subsequent events, the lead author (a consultant rheumatologist) committed each patient to low, moderate or high probability of GCA on all available evidence in the electronic patient record (EPR) before the biopsy date. The following were also collected: whether the patient was seen by a rheumatologist pre-TAB, the final diagnosis of GCA or not-GCA (clinical diagnosis based on available evidence on the EPR) and the cumulative prednisolone dose (CPD) in low probability cases from the date of secondary care assessment to first follow up with the TAB result.

Results: 27 TABs were performed. 9/27 (33%) were diagnosed with GCA: four had a positive TAB, five were diagnosed clinically, 13/27 (48%) were seen by a rheumatologist, who ordered the TAB. In 62%, the pre-TAB assessment was performed by a non-rheumatologist (11 ambulatory care or medical consultants; two ophthalmologists; one oral surgeon), 77% of patients seen by a rheumatologist pre-TAB had a high or moderate pre-TAB probability of GCA (23% low, 31% moderate, 46% high probability), whilst 64% of those seen by another specialty had low probability of GCA (84% low, 21% moderate, 14% high). 100% patients diagnosed with GCA at follow up had a moderate or high pre-test probability of GCA. Mean CPD in those at low risk of GCA was 513mg (range 0-1,430mg).

Conclusion: Rheumatologists are much better at identifying patients at moderate-high risk of GCA than non-rheumatologists. The TAB and prednisolone given to those at low risk during the period of diagnostic work up might have been avoided if patients had seen a rheumatologist. These results helped us to successfully argue the business case for our new GCA FTP, where we aim to see all potential GCA cases in rheumatologist-lead clinic slots, within two working days of triage. Our FTP includes TAUS. These results also suggest that TAUS results should be interpreted by a rheumatologist; GCA can be excluded in those with low risk of GCA and a negative TAUS, whilst GCA can be diagnosed in patients with moderate-high risk and a positive TAUS. In these two scenarios, published evidence and our 2016 audit data suggest TAB is not needed.

Disclosures: V.Q. has received payments from Roche to attend Advisory Board meetings and provide ultrasound teaching. H.B. and C.C. have declared no conflicts of interest.