

Giant Cell Arteritis & Takayasu Arteritis

Diagnostic testing, medical/surgical treatment, relapse management, and monitoring for large-vessel vasculitis.

2021 ACR/VF Guideline
Guideline for GCA and Takayasu Arteritis
Maz M, et al. • Arthritis Care Res 2021;73:1071-1087

GRADE

 Strong Cond. For Cond. Against

All recommendations conditional unless marked Strong. GCs = glucocorticoids; TAK = Takayasu arteritis.

1 GCA — Diagnostic Testing

BIOPSY

Cond.

Unilateral preferred over bilateral temporal artery biopsy; **long-segment** (>1cm) over short (<1cm); within 2 weeks of starting oral GCs.

Cond.

Temporal artery biopsy preferred over ultrasound or MRI for diagnosis.

IMAGING

Cond.

If biopsy negative — **noninvasive large-vessel imaging** + clinical assessment preferred over clinical assessment alone.

Cond.

New diagnosis — obtain noninvasive vascular imaging to evaluate large-vessel involvement.

2 GCA — Initial Treatment

INITIAL GC REGIMEN

Cond.

No vision threat — high-dose oral GCs preferred over IV pulse; daily dosing over alternate-day; high-dose over moderate-dose.

Cond.

Threatened vision loss — IV pulse GCs preferred over high-dose oral GCs.

ADJUNCT THERAPY

Cond.

Oral GCs + **tocilizumab** preferred over GCs alone; add non-GC agent for extracranial large-vessel involvement; aspirin if critical vertebral/carotid involvement.

Cond.

Against statins specifically for GCA treatment.

3 GCA — Relapse, Surgery & Monitoring

RELAPSE MANAGEMENT

Cond.

Relapse on mod-high GCs — add a non-GC immunosuppressive drug.

Cond.

Relapse with cranial ischemia — add non-GC agent + increase GCs preferred over increasing GCs alone; add tocilizumab (over methotrexate) + increase GCs if already on GCs.

SURGERY & MONITORING

Cond.

Surgical intervention — collaborative vascular surgery/rheumatology decision; escalate immunosuppression over surgery for worsening ischemia; high-dose GCs perioperatively if active disease.

Strong

Long-term clinical monitoring recommended in remission.

Cond.

Observe without escalation if inflammatory markers rise alone.

4 TAK — Initial Treatment & Refractory Disease

INITIAL THERAPY

Cond.

Active, severe TAK — high-dose oral GCs preferred over IV pulse; high-dose over low-dose GCs.

Cond.

Combination therapy — non-GC immunosuppressive + GCs preferred over GCs alone; other non-GC agents over tocilizumab as initial therapy.

Cond.

Remission ≥6-12mo — taper off GCs preferred over long-term low-dose GC maintenance.

REFRACTORY & PROGRESSION

Cond.

Refractory to GCs — add TNF inhibitor preferred over tocilizumab; aspirin/antiplatelet if critical cranial/vertebrobasilar involvement.

Cond.

Asymptomatic progression — continue current therapy preferred over escalating/changing regimen (no inflammation on imaging).

5 TAK — Surgical Intervention

Cond.

Decision-making — collaborative vascular surgery/rheumatology decision on type and timing.

Cond.

Against surgery — stable limb claudication without active disease; renovascular HTN/renal artery stenosis; asymptomatic cranial/cervical stenosis — medical management preferred in each.

Cond.

Worsening ischemia — escalate immunosuppression preferred over surgery; delay surgery until disease quiescent if feasible.

Cond.

Perioperative — high-dose GCs perioperatively if active disease.

6 TAK — Monitoring & Vascular Imaging

Strong

Long-term clinical monitoring recommended in remission.

Cond.

Add **inflammation markers** to disease activity assessment; observe without escalation if markers rise alone in remission.

Cond.

Imaging — noninvasive imaging preferred over catheter angiography; regularly scheduled imaging + clinical assessment; treat if new vascular territory inflammation on imaging despite clinical remission.