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275 TABLE 1: Results of the 2017-8 GCA-FTP compared to the two previous years

GCA pathway model	Traditional Model	GCA FTP Year 1	GCA FTP Year 2
Pathway details	No TAUS service or rapid access to rheumatology opinion, unrestricted secondary care access to TAB	Pathway in development: patients seen ad-hoc for rheumatology assessment and TAUS, TAB requests limited to rheumatology and ophthalmology only. TAB requested in all appropriate cases unless contraindicated, to allow performance of TAUS to be compared to TAB	2 designated FTP slots per week for rheumatology assessment and TAUS. Only patients with moderate-high clinical probability GCA and negative/indeterminate TAUS referred for TAB
Audit period	1/1/2015 -31/12/15, 12 months	1/1/2016-31/3/2017, 15 months	1/4/2017-31/3/2018, 12 months
Total patients referred with possible GCA	Unknown	63 (50.4/year)	70/year
Not GCA	Unknown	33 (26.4/year)	52/year
% GCA patients with secure diagnosis GCA (total, adjusted to 12 months)	44.4% (4/year)	63.3% (19, 15.2/year)	83.3% (15/year)
% GCA patients with insecure diagnosis GCA (total, adjusted to 12 months)	55.6% (5/year)	36.7% (11, 8.8/year)	16.6% (3/year)
TAB performed (total, adjusted to 12 months)	27/year	84.1% (53, 42.4/year)	42.8% (30/year)
TAUS performed and TAB avoided *	Not applicable	Not applicable	35.7% (25/year)
TAB could have been avoided if timely GCA-FTP slot had been available **	Not applicable	Not applicable	12.8% (9/year)
GCA excluded on clinical grounds alone	Unknown	11.1% (7, 5.6/year)	5.7% (4/year)
TAUS performed then large vessel imaging performed instead of TAB***	Not applicable	4.8% (3, 2.4/year)	12.8% (9/year)
% referred patients seen in designated GCA-FTP appointments****	0	0	84.7%
Mean number of days on prednisolone before TAUS	Not applicable	10.6 (median 7, range 0-81)	4.4 (median 2, range 0-54)

*Low clinical probability of GCA according to rheumatologist
+TAUS negative, or mod/high clinical probability of GCA + TAUS positive
**Low clinical probability of GCA according to rheumatologist + negative TAB performed before negative TAUS as no timely FTP slots available (referring clinician approved to book TAB if no timely FTP slots, as mean time to TAB at LDH is 2.75 days).
***Clinical presentation + TAUS findings in keeping with large vessel GCA rather than cranial GCA
****Other patients seen ad-hoc outside clinic time, in cancellation slots, or as over-books. Unfilled GCA-FTP slots filled with other rheumatology patients if still empty at 12pm the previous day.

275 PAUL BACON AWARD: RHEUMATOLOGY-LED FAST TRACK PATHWAYS FOR GIANT CELL ARTERITIS IMPROVE THE SECURITY OF THE DIAGNOSIS AND REDUCE THE NEED FOR TEMPORAL ARTERY BIOPSY

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Background: In the second year of the Luton and Dunstable rheumatology department giant cell arteritis (GCA) fast-track pathway (FTP), two designated GCA-FTP appointments per week were created. No specific referral criteria were required, except concern that the patient had GCA. Clinical assessment and temporal and axillary ultrasound (TAUS) were performed by a consultant rheumatologist with >100 TAUS scan experience (VQ). An Esaote Mylab7 ultrasound machine was used; 6-15MHz probe for axillary and 22MHz probe for temporal arteries. If > 2 referrals were received in a week, they were seen ad-hoc by a consultant rheumatologist, aiming to see all patients within 4 days of referral. Only patients with a moderate-high clinical probability of GCA and negative/indeterminate TAUS were referred for temporal artery biopsy (TAB).
Methods: The following were collected for all patients referred to the GCA-FTP from 1/4/2017-31/3/2018 (year 2): final diagnosis of biopsy/imaging positive-GCA (secure diagnosis), clinical-GCA (insecure diagnosis) or not-GCA, using the electronic patient record to 1/9/2018; imaging used to make the diagnosis; percentage of referred patients seen in GCA-FTP appointments and number of days on prednisolone before TAUS. Where available, data were compared to our previous GCA audits.
Results: In year 2 of our GCA-FTP 83.3% of GCA patients had TAB/imaging positive-GCA compared to 63.3% in year 1 and only 44.4% in the year before our FTP was started. There was a 41.3% reduction in TAB rate compared to year 1. However, a further 12.8% of TABs could have been avoided if a timely GCA-FTP appointment had been available. Although more patients were seen in year 2, numbers with secure diagnosis of GCA remained the same. However, GCA was excluded on clinical grounds alone in only 5.7% of patients, suggesting referrals were appropriate.
Conclusion: Improvement in security of the diagnosis year-on-year was likely due to a combination of factors including shorter time on prednisolone, improved ultrasonographer skill and increasing confidence to withdraw prednisolone in insecure cases. We confirmed that GCA-FTPs significantly reduce the rate of TAB, freeing up resources to develop the service. Further improvements could be anticipated with more FTP slots per week and a year-round ultrasound service.
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