Correction: 2022 American College of Rheumatology/EULAR classification criteria for giant cell arteritis


The correction was made to figure one in the line: LABORATORY, IMAGING, AND BIOPSY CRITERIA, in the subrow labelled Maximum ESR ≥ 50 mm/hour or maximum CRP ≥ 10 mg/liter². This correction has not been made in print.

Figure 1
2022 AMERICAN COLLEGE OF RHEUMATOLOGY / EULAR CLASSIFICATION CRITERIA FOR GIANT CELL ARTERITIS

CONSIDERATIONS WHEN APPLYING THESE CRITERIA
- These classification criteria should be applied to classify the patient as having giant cell arteritis when a diagnosis of medium-vessel or large-vessel vasculitis has been made
- Alternate diagnoses mimicking vasculitis should be excluded prior to applying the criteria

ABSOLUTE REQUIREMENT
Age ≥ 50 years at time of diagnosis

ADDITIONAL CLINICAL CRITERIA
- Morning stiffness in shoulders/neck +2
- Sudden visual loss +3
- Jaw or tongue claudication +2
- New temporal headache +2
- Scalp tenderness +2
- Abnormal examination of the temporal artery +2

LABORATORY, IMAGING, AND BIOPSY CRITERIA
- Maximum ESR ≥ 50 mm/hour or maximum CRP ≥ 10 mg/liter² +3
- Positive temporal artery biopsy or halo sign on temporal artery ultrasound +5
- Bilateral axillary involvement +2
- FDG–PET activity throughout aorta +2

Sum the scores for 10 items, if present. A score of ≥ 6 points is needed for the classification of GIANT CELL ARTERITIS.

1. Examination of the temporal artery showing absent or diminished pulse, tenderness, or hard 'cork-like' appearance.
2. Maximum erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) values prior to initiation of treatment for vasculitis.
3. Presence of other definite vasculitis on temporal artery biopsy or halo sign on temporal artery ultrasound. There are no specific histopathologic criteria to define definite vasculitis or temporal artery biopsy. Presence of giant cells, mononuclear leukocyte infiltration, and fragmentation of the internal elastic lamina were independently associated with histopathologic interpretation of definite vasculitis in the DCVAS cohort⁵. Halo sign is defined by the presence of an homogeneous, hypoechoic, wall thickening on ultrasound⁶.
4. Bilateral axillary involvement is defined as luminal damage (stenosis, occlusion, or aneurysm) on angiography (computed tomography magnetic resonance, or catheter-based) or ultrasound, halo sign on ultrasound, or fluorodeoxyglucose uptake on positron emission tomography.
5. Abnormal fluorodeoxyglucose (FDG) uptake in the arterial wall (e.g. greater than liver uptake by visual inspection) throughout the descending thoracic and abdominal aorta or focal or normal emission tomography (PET).

© Author(s) (or their employer(s)) 2023. No commercial re-use. See rights and permissions. Published by BMJ.