

**Giant Cell Arteritis:**

**Improving Diagnosis and Treating Promptly**

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**Purpose of risk management recommendations**

OMIC regularly analyzes its claims experience to determine loss prevention measures that our insured ophthalmologists can take to reduce the likelihood of professional liability lawsuits. OMIC policyholders are not required to implement these risk management recommendations. Rather, physicians should use their professional judgment in determining the applicability of a given recommendation to their particular patients and practice situation. These loss prevention documents may refer to clinical care guidelines such as the American Academy of Ophthalmology’s *Preferred Practice Patterns*, peer-reviewed articles, or to federal or state laws and regulations. However, our risk management recommendations do not constitute the standard of care nor do they provide legal advice. Consult an attorney if legal advice is desired or needed. Information contained here is not intended to be a modification of the terms and conditions of the OMIC professional and limited office premises liability insurance policy. Please refer to the OMIC policy for these terms and conditions.

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**Introduction**

Allegations of failure to diagnose are common in medical malpractice lawsuits against ophthalmologists. Some ophthalmic conditions, such as giant cell arteritis (GCA), have a short window for diagnosis and treatment. Giant cell arteritis is a relatively rare condition, mostly affecting patients over the age of 50. Ophthalmologists are familiar with the classic signs of GCA – vision changes, headache, jaw pain, fever, and scalp tenderness – yet, if they don’t appreciate the significance of those signs and symptoms or recognize that GCA often does not exhibit “classic” signs and symptoms, they may not follow through to confirm the diagnosis and coordinate treatment. The patient then risks severe bilateral vision loss, and the treating ophthalmologist incurs liability exposure. The high-stakes consequences of GCA, for both patient and provider, call for strengthening the diagnostic and patient management process.

This document explores aspects of the diagnostic process and offers risk management recommendations to help ophthalmologists reach better outcomes relative to GCA.

**Elicit a Thorough and Accurate History**

Prompt diagnosis of GCA depends upon the thoroughness and accuracy of the health history. Obtaining an accurate history can be challenging for several reasons:

* Patients often report their history differently to each healthcare provider, based upon the questions asked, the time spent gathering the information, and many other factors; as a result, another physician sometimes obtains the more thorough history.
* Patients presenting with eye complaints often do not think that it is important or pertinent to tell their ophthalmologist about non-ophthalmic problems they are experiencing, such as jaw pain when chewing, fatigue, or weight loss. Consequently, ophthalmologists may learn only about the patient’s vision complaints and headache, while other physicians may obtain other information, such as the duration or quality of the headache and the existence of jaw pain.
* In addition to vision loss, headache, jaw pain, fever, and scalp tenderness, varied and non-specific constitutional symptoms, such as fatigue, malaise, and weight loss, may develop over time.
* Information can slip through the cracks if the ophthalmologist doesn’t review the notes that staff took during the initial work-up and intake, in which they may have obtained and documented the presence of GCA symptoms. Without this additional information, an ophthalmologist may not consider GCA in the differential diagnosis.

**Risk Management Recommendations**

* Aim for specificity. For example, with a patient complaining of a headache spanning two days and a “curtain” over their vision, the ophthalmologist can gain valuable information by asking more about the precise nature of that “curtain” (e.g., transparent, dark).
* In addition to eliciting accurate information about the patient’s eye complaint, query older patients about constitutional symptoms. A careful review of signs, symptoms, and systems can help distinguish the few patients who could have GCA from the large number of older patients with more common eye problems seen daily in ophthalmic practices. Don’t wait for the patient to offer the information; ask for it.
* Use OMIC’s sample [GCA Checklist](https://www.omic.com/giant-cell-arteritis-toolkit/) to prompt you in obtaining information to build a more thorough history and offer cues to take action.

**Pursue the Diagnosis**

When a patient presents with vision changes, headache, jaw pain, fever, and scalp tenderness, the treating physician should always consider the worst possible diagnoses and develop a plan that rules out those diagnoses. Giant cell arteritis, which could lead to blindness, would be among those diagnoses.

**Risk Management Recommendations**

* Gather information needed to make the diagnosis or rule it out. Knowing what information to seek will guide you in taking the history, performing the exam, ordering studies, and requesting consultations.
	+ Use OMIC’s sample [GCA Checklist](https://www.omic.com/giant-cell-arteritis-toolkit/) to support information gathering.
	+ Ensure that you know where and how to access information in the EHR (e.g., referral requests; studies ordered by the ER and other physicians; notes made by staff).
	+ Remember that gathering information from the patient over the phone has limitations and invites the risk of delayed diagnosis. Obtain a careful history when taking after-hours calls and **document** your discussion. If your staff screens after-hours calls, develop and implement a formal telephone screening protocol to avoid staff practicing outside of their scope. (See: OMIC’s [Telephone Screening of Ophthalmic Problems](https://www.omic.com/telephone-screening-of-ophthalmic-problems-sample-contact-forms-and-screening-guideline/))
* Communicate clearly with the patient and other treating providers.
	+ Patients often do **not** appreciate the potential seriousness of their condition and, therefore, delay seeing the physician.
		- Make sure the patient understands your concerns about the potential for vision loss.
		- Explain to the patient that GCA can progress rapidly and lead to bilateral, irreversible, blindness.
		- Give the patient information on exactly what signs and symptoms to watch for and instruct them to contact you as soon as they notice any changes. (See OMIC’s [GCA Patient Information Sheet](https://www.omic.com/giant-cell-arteritis-toolkit/))
		- **Document** these discussions and the patient’s understanding, especially any patient refusal to follow recommendations.
	+ If the patient is hospitalized, write explicit orders for nurses regarding signs and symptoms you want reported to you at once.
	+ Share your decision-making process and differential diagnosis with others (e.g., ER physicians, consultants, the patient’s primary care physician).
* **Document your decision-making process**. This is crucial for both continuity of care, and to defend your actions should your care be questioned later. While ophthalmologists do not explicitly use a SOAP format in their charting, the model can prompt you to document meaningful information:
	+ **S**ubjective**.** When possible, use the patient’s own words to document the presenting complaint, including onset, severity, duration, how it affects vision, and whether the patient has contacted another healthcare provider about it.
	+ **O**bjective. Document the history, exam, and diagnostic process. Chart all pertinent positive and negative findings. OMIC’s sample [GCA Checklist](https://www.omic.com/giant-cell-arteritis-toolkit/) can help with this.
	+ **A**ssessment. Include your differential diagnoses.
	+ **P**lan. Include further diagnostic work-up, treatment, follow-up plans, and any instructions given to the patient about when to call you and when to return.
* Be aware of some warning signs of a missed diagnosis:
* The diagnosis does not account for all symptoms and findings.
* Your decision-making process did not rule out worst-case scenario.
* The patient is not responding to treatment.
* The patient has a new, evolving, or recurring complaint.
* The patient makes repeat visits or phone calls to you, or calls multiple providers.
* Continue to pursue:
* Obtain records from other providers.
* Read all prior chart notes.
* Account for all symptoms and findings.
* Ask for consultation or referral as needed.

**Review Office Systems to Ensure Better Coordination of Care**

Systems issues include poor or inconsistent communication (between physicians and patients, physicians and staff, and staff and patients); faulty coordination of care; inadequate supervision; problems with information management (EHR); and poor tracking of test results.

**Risk Management Recommendations**

* Keep diagnosis and treatment efforts on track by having a robust office follow-up system. A follow-up system helps you monitor diagnostic procedure results, patient compliance with treatment recommendations, and appointments. Create a tracking system for:
	+ Patients you send for consultations and referrals
	+ Diagnostic tests and procedures performed by other providers
	+ Requests for consultations/referrals from the ER and other providers
	+ Missed or canceled appointments (ideally, schedule patients before they leave the office)

**Conclusion**

The combination of incomplete history, poor coordination of care among providers, and office systems issues is a common theme in GCA claims. Ophthalmologists can take steps to reduce the likelihood of delayed diagnosis of GCA and subsequent claims. Key among these steps is proactively obtaining a more thorough history to improve the likelihood of including GCA in the differential diagnosis when older patients present with vision changes.

**Need confidential risk management assistance?**

OMIC-insured ophthalmologists, optometrists, and practices are invited to contact OMIC’s Risk Management Department at (800) 562-6642, option 4, or at: [riskmanagement@omic.com](http://riskmanagement@omic.com).