

Refractory giant cell arteritis: the value of clinical symptoms and imaging

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DESCRIPTION

Tocilizumab is a new option in the treatment of giant cell arteritis.¹ Based on normal acute phase reactants in the treatment of giant cell arteritis with tocilizumab, the detection of disease flare may be difficult.

A 72-year-old woman was admitted to hospital with pain and stiffness of the shoulder girdle as well as occipital headache. The C-reactive protein (CRP) was 20.2 mg/L (reference: <2.0 mg/L). The power Doppler ultrasound showed a halo phenomenon of both common carotid arteries. The diagnosis based on the clinical, laboratory findings and ultrasound was giant cell arteritis. According to the clinical standard, a prednisolone therapy with 60 mg/day was initiated.² All symptoms disappeared. After tapering prednisone to 40 mg per day, the patient presented a new onset of pain and stiffness in the shoulder girdle with occipital headache with a normal CRP. A (18)F-fluorodeoxyglucose positron emission tomography-CT (PET-CT) was performed for further evaluation and revealed inflammatory activity of the aorta, supraaortal arteries (see figure 1A) and the arteries of the upper and lower extremity. Consequently, the

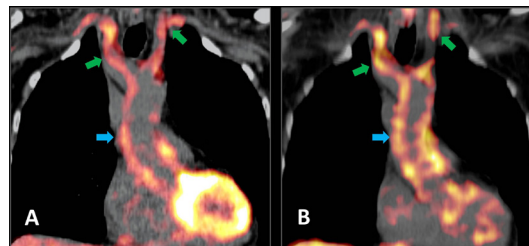


Figure 1 (A) (18)F-fluorodeoxyglucose positron emission tomography-CT (PET-CT) presented inflammatory activity of the aortic wall (blue arrow) and supraaortal arteries (green arrows) indicating a giant cell arteritis resulting in the initiation of an tocilizumab therapy and (B) the (18)F-fluorodeoxyglucose uptake of the aorta and supraaortal arteries in PET-CT in association with anew pain, stiffness in the shoulder girdle and occipital headache under the therapy with tocilizumab revealed a flare of giant cell arteritis.

Learning points

- ▶ Clinical symptoms, in combination with imaging, are markers for the detection of giant cell arteritis flare.
- ▶ CRP is not a marker for the detection of a disease flare.

prednisone dose was increased to 60 mg/day and a therapy with tocilizumab was introduced. Prednisone was tapered in 26-week schema based on the GiACTA Trial.¹ Two months later, the patient revealed anew pain and stiffness in the shoulder girdle associated with occipital headache. The CRP value was normal and the PET-CT showed again typical signs of giant cell arteritis (see figure 1B).

The case report describes a flare of giant cell arteritis, which was detectable by clinical symptoms and PET-CT imaging. In this context, CRP is no indicator for the detection of flare in the treatment with prednisone plus tocilizumab.³ The assessment of clinical symptoms in combination with imaging (eg, PET-CT) seems to be potential markers for the detection of a disease flare. Further studies were required to verify this finding.

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