Giant cell arteritis mimicking spontaneous bilateral vertebral dissections and internal carotid artery fibromuscular dysplasia

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DESCRIPTION

A woman in her 70s presented to the emergency department with a 5-day history of feeling unsteady. Based on CT angiography (CTA) findings, she was diagnosed with left vertebral artery dissection (VAD) involving segments V2 and V3 with underlying fibromuscular dysplasia (FMD). MRI of the brain revealed acute left thalamic ischaemic stroke. Hence, dual antiplatelet therapy (DAPT) with aspirin and clopidogrel was initiated.

Three weeks later, she returned with acute onset left-sided hemiplegia and ataxia. Head CT showed left thalamus subacute infarcts. Head and neck CTA showed interval progression of the left vertebral artery (VA) irregularities, and new multifocal irregularities of the right VA (figure 1), resulting in occlusion at the V2/V3 junction. The anterior circulation redemonstrated mild multifocal occlusion of the bilateral internal carotid arteries (figure 1). MRI revealed acute infarcts involving the left ventral pons and left middle cerebellar peduncle. DAPT was switched to a heparin drip on admission for evaluation.

The patient also reported an episode of abdominal pain and 15-pound weight loss 3 months prior and a week of bitemporal headaches 2 weeks before presentation. She denied fevers, night sweats, vision changes or arthralgias. Neurological examination revealed left-sided hemiparesis. Laboratory tests showed normocytic anaemia (haemoglobin 117 g/L), thrombocytosis (486×10^3/µL), elevated C reactive protein (5 mg/dL) and erythrocyte sedimentation rate (ESR) of 56 mm/hour. Digital subtraction angiography revealed multifocal areas of narrowing involving the basilar artery and bilateral VA segments (figure 2). These vessels showed post-contrast circumferential vessel wall enhancement on vessel wall MRI (figure 3). Abdominal and pelvic CTA indicated soft tissue thickening of the distal abdominal aorta and proximal right common iliac artery (figure 4). The patient met three of the five criteria listed by the American College of Rheumatology 1990 (age ≥50 years, new headache and elevated ESR), and was diagnosed with giant cell arteritis (GCA). 1 The patient received intravenous methylprednisolone 1 g for 5 days, followed by tocilizumab and oral prednisone taper starting at 60 mg. Heparin was discontinued and DAPT was re-initiated with the plan to continue clopidogrel for 30 days. The patient was discharged.
The presence of underlying vasculopathy can be associated with non-traumatic spontaneous VAD, a rare cause of posterior circulation stroke. FMD can present as an underlying cause of VAD, exhibiting the ‘string of beads’ sign on vessel imaging, usually seen in middle-aged individuals. GCA is typically seen in adults older than 50 years and is a rare cause of vertebrobasilar territory stroke. In this case, the rapid progression of our patient’s condition warranted further evaluation. We were able to extract her history of weight loss and temporal headache, and further work-up revealed elevated inflammatory markers and signs of vertebrobasilar artery inflammation. This case of GCA, which initially mimicked the findings of FMD and VAD, highlights the importance of reconsidering the diagnosis when patients develop unexpected clinical courses. GCA should be considered in elderly patients with spontaneous VAD-like presentation.

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