DIAGNOSIS

The diagnosis of giant cell arteritis can often be suggested clinically by the demonstration of the complex of fever, anemia, and high ESR and/or CRP with or without symptoms of polymyalgia rheumatica in a patient >50 years old. The diagnosis can be confirmed by biopsy of the temporal artery but may not be positive in all patients due to patchy histologic findings. Since involvement of the vessel may be segmental, positive yield is increased by obtaining a biopsy segment of 3–5 cm together with serial sectioning of biopsy specimens. Ultrasonography of the temporal artery has been reported to be helpful in diagnosis and has been increasingly used by some physicians. Therapy should not be delayed pending the performance of diagnostic studies. In this regard, it has been reported that temporal artery biopsies may show vasculitis even after ~14 days of glucocorticoid therapy. A dramatic clinical response to a trial of glucocorticoid therapy can further support the diagnosis.

Large-vessel disease may be suggested by symptoms and findings on physical examination such as diminished pulses or bruits. It is confirmed by vascular imaging, most commonly through magnetic resonance or computed tomography. Positron emission tomography has become increasingly investigated, although its role in diagnosis and monitoring remains unclear.

Isolated polymyalgia rheumatica is a clinical diagnosis made by the presence of typical symptoms of stiffness, aching, and pain in the muscles of the hip and shoulder girdle, an increased ESR and/or CRP, the absence of clinical features suggestive of giant cell arteritis, and a prompt therapeutic response to low-dose prednisone. Polymyalgia rheumatica can be associated with a peripheral arthritis that can mimic rheumatoid arthritis **(Chap. 358)**. Rheumatoid factor and anti-cyclic citrullinated peptide (CCP) shoulder be negative. In patients who develop a worsening pattern of peripheral arthritis, the potential for a seronegative rheumatoid arthritis or other inflammatory arthropathy should be considered. Levels of enzymes indicative of muscle damage such as serum creatine kinase are not elevated.

TREATMENT