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Perspective

Clinical Insights of Giant Cell Arteritis and Polymyalgia Rheumatica

Marcello Govoni*

Department of Rheumatology, University of Ferrara, Ferrara, Italy

ABOUT THE STUDY

Giant Cell Arteritis (GCA) and Polymyalgia Rheumatica (PMR) are two closely related inflammatory conditions that primarily affect older individuals. GCA is a systemic vasculitis characterized by inflammation of medium and large arteries, primarily involving the branches of the carotid arteries, especially the temporal arteries. PMR, on the other hand, is a clinical syndrome characterized by pain and stiffness in the shoulder and pelvic girdle regions. Both conditions are often encountered together, sharing clinical and pathological features.

Epidemiology

GCA and PMR are predominantly observed in individuals over the age of 50, with the incidence and prevalence increasing with age. The average age of onset for both conditions is around 70 years. GCA affects women more commonly than men, with a female-to-male ratio of 2:1. PMR also exhibits a slight female predominance, with a ratio of 1.5:1. Both conditions primarily occur in individuals of Northern European descent.

Clinical presentation

GCA typically presents with constitutional symptoms, including fatigue, malaise, weight loss, and fever. The hallmark symptom of GCA is severe headache, often described as a throbbing or pulsating pain, usually localized in the temporal region.

Other symptoms may include scalp tenderness, jaw claudication, visual disturbances, and polymyalgia. In contrast, PMR is characterized by bilateral shoulder and pelvic girdle pain and stiffness, which worsens after rest or inactivity. Morning stiffness lasting for more than one hour is a typical feature of PMR.

Diagnosis

The diagnosis of GCA is based on a combination of clinical features, laboratory findings, and temporal artery biopsy. Laboratory investigations commonly reveal elevated acute phase reactants, including Erythrocyte Sedimentation Rate (ESR) and C-Reactive Protein (CRP). Temporal artery biopsy remains the gold standard for confirming the diagnosis, demonstrating characteristic transmural inflammation with multinucleated giant cells. In PMR, the diagnosis is primarily clinical and relies on the characteristic pattern of pain and stiffness in the shoulders and pelvic girdle, along with elevated ESR and CRP levels. Imaging studies such as ultrasound and MRI may aid in the evaluation of GCA and PMR, especially in cases where temporal artery biopsy is inconclusive.

Management

The primary goal of treatment in both GCA and PMR is to control inflammation and prevent complications. Glucocorticoids, particularly prednisone, are the mainstay of therapy for both conditions. In GCA, immediate high-dose glucocorticoids are initiated to prevent vision loss, followed by a slow taper over several months. Treatment for PMR usually starts with a moderate dose of glucocorticoids, which is gradually reduced over time. Methotrexate and other immunosuppressive agents may be considered as steroid-sparing agents in refractory cases or to minimize glucocorticoid-related side effects. Regular monitoring of patients on long-term glucocorticoid therapy is essential to identify and manage potential complications, such as osteoporosis, diabetes, and cardiovascular disease.

Prognosis

With appropriate treatment, the prognosis for both GCA and PMR is generally favorable. Glucocorticoid therapy effectively controls symptoms and reduces the risk of complications, such as vision loss in GCA. However, relapses and complications may occur, emphasizing the importance of close follow-up and monitoring. Long-term glucocorticoid use may lead to significant side effects, and efforts should be made to minimize their duration and dosage.

Conditions predominantly affecting older individuals. GCA involves large-sized and medium-sized arteries, while PMR primarily affects the shoulder and pelvic girdle regions. Prompt recognition and appropriate treatment are essential to prevent complications and improve outcomes. Glucocorticoids remain the mainstay of therapy, although steroid-sparing agents may be considered in certain cases. Long-term monitoring and management of potential complications associated with glucocorticoid therapy are crucial.

Correspondence to: Marcello Govoni, Department of Rheumatology, University of Ferrara, Ferrara, Italy, E-mail: Govonimoc@gmail.com

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