E03. A DIAGNOSTIC DILEMMA: A CLINICAL CASE OF EXTRACRANIAL GIANT CELL ARTERITIS

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Background: GCA is the most common of the vasculitides and predominantly affects the cranial branches of arteries arising from the aortic arch. It is managed with long-term glucocorticoid therapy to treat and prevent complications of the disease. However, this represents a rare exception to the common difficulty in diagnosis and treatment lies.

Methods: A 62 year old female with PMR treated with prednisolone 20 mg was admitted to hospital for investigation of persistently raised acute phase markers (CRP 216 mg/l, ESR 136 mm/h). She was systemically well with no organ-specific symptoms and she denied symptoms of active PMR. Investigations excluded infection and there were no clinical stigmata to suggest vasculitis. Temporal artery biopsy was negative. During subsequent review in clinic a significant discrepancy in blood pressure between arms was noted and accompanied by a left subclavian bruit. CT angiogram identified thickening and stenosis of the proximal right and left brachial arteries, right subclavian and middle left subclavian arteries. A PET-CT later requested confirmed diffuse abnormal tracer uptake (grade 3) in the thoraco-abdominal aorta and major superior mediastinal vessels; a diagnosis of extracranial GCA was made.

Results: prednisolone caused marked mood disturbance (depression) and therefore MTX, AZA and LEF were tried to minimize total glucocorticosteroid exposure but were associated with adverse effects. Tocilizumab 8 mg/kg was then commenced and after one
treatment CRP and ESR had normalized, blood pressure equalized between both arms and the bruit disappeared. However, due to side effects of a facial rash and glossitis, the dose was reduced to 4 mg/kg and was administered with hydrocortisone and chlorphenamine cover. The patient continued to respond well and the prednisolone dosage was gradually reduced and eventually stopped 8 months after the initiation of tocilizumab therapy and she continues to do well 3 months later.

**Conclusion:** This case describes an asymptomatic patient with persistently raised acute phase markers who created a diagnostic challenge. Due to the original diagnosis of PMR, GCA was considered but there were no cranial symptoms and she denied limb claudication pain. PET-CT was useful in demonstrating a large vessel vasculitis. A recent systematic review identified 24 patients who had been given tocilizumab for relapsing GCA. The standard dose given was 8 mg/kg every 4 weeks, but there was no reference to lowering this dose once disease became controlled. We describe a case of a patient successfully controlled on a dose of 4 mg/kg with no signs or symptoms of relapse. Hence, this case further demonstrates the success and efficacy of tocilizumab in the treatment of large vessel vasculitis.

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