Temporal arteritis with erythrocyte sedimentation rate <50 mm/h: a clinical reminder

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Abstract: Temporal arteritis, also known as giant cell arteritis (GCA), is a systemic vasculitis that predominantly involves the temporal arteries. It is a medical emergency and should be treated promptly as it can lead to permanent loss of vision. It is very commonly associated with a raised erythrocyte sedimentation rate (ESR), usually >50 mm/h, one of the essential criteria defined by the American College of Rheumatology classification of GCA. Here, we describe the case of a 73-year-old male presenting with a 2-day history of a sudden onset of a severe left-sided headache, which had the signs and symptoms consistent with GCA but he had an ESR of only 27 mm/h. The patient was urgently treated with prednisolone 60 mg per day, and his symptoms dramatically improved within 24 hours of therapy. Temporal artery biopsy results were consistent with an inflammatory response, and withdrawal of treatment led to a relapse of the symptoms. The patient was slowly tapered off the high steroid dose and is now currently managed on a low steroid dose. We should keep a high index of suspicion for GCA in patients presenting with clinical symptoms of GCA even though the ESR is <50 mm/h as stated in the criteria for GCA diagnosis.

Keywords: temporal arteritis, giant cell arteritis, prednisolone, erythrocyte sedimentation rate

Case history

A 73-year-old male presented to the Medical Assessment Unit with sudden onset of a 2-day history of severe left-sided headache. He described the headache as dull and throbbing, predominantly localized in the frontal and temporal areas on the left side radiating down to the left side of the neck. On further examination, mild temporal artery beading could be palpated. In addition, the patient had mild nausea and slight photophobia since the headache began. There were no focal neurological deficits or meningism and no preceding aura. On physical examination, he was afebrile and vital signs were stable; however, he had an exquisitely tender left temporal artery. Fundoscopic examination did not reveal any abnormalities. A complete vascular examination was performed, which did not reveal any upper extremity pulse loss or subclavian, carotid, and axillary bruits. There was no asymmetry of pulses and blood pressure in the extremities. Computed tomography of the head ruled out any space-occupying lesions or hemorrhagic lesions. Lumbar puncture was performed to screen for infection and xanthochromia (both negative). Past medical history included well-controlled chronic obstructive airway disease with good exercise tolerance for independent daily activities.

A full blood count showed a normal white cell count of 9.2×10^9/L with only positive findings of a raised erythrocyte sedimentation rate (ESR) of 27 mm/h (normal range: 1–15 mm/h) and a slightly raised C-reactive protein of 10 mg/L (normal range: <5 mg/L). Chest radiograph and urinalysis did not reveal any abnormalities. The patient was urgently prescribed 60 mg (0.75–1 mg/kg) of prednisolone as per hospital protocol, and during treatment, he had regular follow-up to monitor for complications of high-dose steroid
therapy. He had symptomatic relief within 24 hours of initiation of steroid therapy. According to local hospital protocol, the patient underwent an urgent temporal artery biopsy (TAB) within 4 weeks after the steroid therapy was initiated, and it suggested signs of postinflammatory changes consistent with vasculitic changes and reduplication of internal elastic lamina modified by steroid therapy. These signs were consistent with an inflammatory response, which is responding effectively to steroid therapy. The patient was prescribed bisphosphonates and calcium and vitamin D supplements for bone protection. A proton pump inhibitor was prescribed to provide gastric protection. The patient was followed up in rheumatology and ophthalmology departments as per hospital protocol. He was followed up initially at 0, 1, 3, and 6 weeks, and then at 3, 6, 9, and 12 months in the first year. Additional visits were encouraged if signs of relapse or adverse events were observed. Rapid relapse of symptoms was observed after withdrawing glucocorticosteroids, which excluded vascular and neurological causes for patient symptoms. During treatment, the patient had regular glucose monitoring, blood pressure recordings, visual field testing, and assessment for side effects of corticosteroid therapy. The patient made a complete recovery, and symptoms are now under control with low-dose (1 mg) prednisolone for long-term maintenance treatment. Ethical approval was sought from the Research and Development Department at Wirral University Teaching Hospital. Verbal informed consent was taken from the patient to publish the case study.

Discussion
The prevalence of giant cell arteritis (GCA) in the general population is <1%. GCA is a large-vessel vasculitis, and it usually affects individuals >50 years old. The disease is unlikely to occur in individuals <50 years of age. GCA is surprisingly a frequently occurring condition with a prevalence estimated to be 1 in 500 in individuals >50 years and incidence of 2.2 per 10,000 patient-years in the UK. The mean age for GCA occurrence is 72 years, as GCA is a type of systemic vasculitis whose symptomatology is quite extensive. Thus, the presentation of the disease can be quite variable and diverse. The symptoms could include constitutional symptoms such as tiredness, fever, and weight loss. Fever is usually of low grade; however, high-grade fever of >39°C has been reported in 15% of patients. Other clinical features include abrupt-onset headache, which is usually unilateral affecting the temporal region; however, diffuse and bilateral headaches have been reported; scalp pain or localized scalp tenderness; jaw claudication; nonproductive cough; and visual symptoms such as amaurosis fugax, blurring of vision, or even blindness in severe cases.

Other associated conditions include polymyalgia rheumatica and, in chronic cases, aortic involvement leading to aneurysms and aortic dissection. Aortic disease features are usually a consequence of long-term, low-grade vasculitis and typically not present at the time of diagnosis. Less common complications may include dysarthria, throat pain and tongue infarction, mononeuritis multiplex, sensorineural hearing loss, and, even rarely, mesenteric ischemia. According to the American College of Rheumatology (ACR), diagnosis of GCA should be considered in all patients aged >50 years who have at least three of the five criteria findings (Table 1). The gold standard test to confirm the diagnosis is TAB, which should be performed in all patients suspected of GCA; however, consideration should be given to the urgency of initiation of medical treatment and waiting for biopsy should not delay initiation of high-dose steroid treatment in a suspected case of GCA. The positivity of the biopsy results can be variable and is dependent on numerous factors. These include sampling error due to skip lesions, attaining too small a sample (<2 cm), and different phenotypic disease not associated with cranial arteritis in which case the TAB will be negative even if repeated. Such patients may have GCA but only involving large vessels, including subclavian artery (arm claudication), carotid artery, and the aorta (aneurysms and dissection), but without cranial vessel involvement. These patients will not require TAB; however, they may need systemic imaging to assess isolated large-vessel GCA. Early TAB should be performed preferably within 1–2 weeks of initiating glucocorticoids; however, reports suggest that results may remain positive for 2–6 weeks following initiation of glucocorticosteroids.

Duplex ultrasonography secures a promising role in the future for diagnosis of GCA, particularly large-vessel disease; however, it does not currently replace TAB as the first-line investigation as recommended by the British Society of Rheumatology guidelines. It is user dependent and requires a high level of expertise, which are yet not currently

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<tr>
<th>Table 1</th>
<th>Criteria used to diagnose temporal arteritis</th>
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<tr>
<td><strong>American College of Rheumatology criteria for temporal arteritis</strong></td>
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<td><strong>Age ≥50 years</strong></td>
<td>New onset or new type of localized pain in the head</td>
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<td>Elevated ESR &gt;50 mm/h (by Westergren method)</td>
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<td>Temporal artery tenderness to palpation or decreased pulsation, unrelated to arteriosclerosis of cervical arteries</td>
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<td>Biopsy specimen showing vasculitis characterized by mononuclear infiltration or granulomatous inflammation, usually with multinucleated giant cells</td>
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**Note:** The patient is said to have temporal arteritis if at least three out of five criteria are present. Data from Hunder et al. 15

**Abbreviation:** ESR, erythrocyte sedimentation rate.
widespread in UK. Furthermore, it does not have the added
diagnostic value of histology. In case of large-vessel GCA,
ultrasound is still a sensitive technique, especially for upper
limb vasculitides.

Historically, ESR has been considered one of the most
useful markers to predict the likelihood of having GCA.
A normal ESR makes GCA unlikely; however, ESR does
not rule it out. A meta-analysis of 114 studies showed that
normal ESR values indicate much less likelihood of a positive
diagnosis of GCA (negative likelihood ratio (LR) for abnor-
mal ESR, 0.2; 95% confidence interval [CI], 0.08–0.51),
but physical findings such as temporal artery tenderness
indicated a higher likelihood of GCA (positive LR, 2.6; 95% CI,
1.9–3.7). This meta-analysis revealed that a high level of
ESR was a less important indicator in ruling out GCA as
the underlying cause for the patient’s symptoms, but positive
physical findings, characteristic of GCA, were more likely to
be a strong indicator of a positive diagnosis of GCA. Our case
reported to have positive clinical findings such as temporal
artery tenderness with a mildly raised ESR; however, ESR
was not raised to fulfill the ACR criteria for GCA.

Treatment includes immediate initiation of high-dose
glucocorticosteroids, recommended upon suspicion of
GCA. Visual loss is an early complication of the disease;
hence, once established, it rarely improves, and hence,
the emphasis is on early treatment. Prednisolone 40–60 mg
daily is usually the recommended dose for 4 weeks. The
total duration of high-dose prednisolone is usually governed
clinically by the resolution of symptoms and improvement
in laboratory test abnormalities. The dose is then reduced
by 10 mg every 2 weeks up to 20 mg, then by 2.5 mg every
2–4 weeks up to 10 mg, and then by 1 mg every 1–2 months,
provided there are no further relapses. These patients should
also be coprescribed bone protection (weekly bisphospho-
nates and calcium/vitamin D supplementation). Gastrin-
testinal protection with proton pump inhibitors should also
be used. Considering that these patients are on a high dose
of glucocorticosteroids, they require close monitoring of
adverse events, which can be possible through shared care
with primary care physicians.

**Monitoring and follow-up**

At each visit, the following investigations should be
performed:

- full blood count, ESR, C-reactive protein, urea and elec-
trolytes, and glucose (to look for steroid-induced diabetes);
- every 2 years, chest radiograph to monitor for aortic
aneurysm (more detailed investigations such as MRI and
echocardiography may also be appropriate);
- as patients are on long-term steroid therapy, bone mineral
density scans may be required.

Follow-up schedules can vary according to local hospital
protocols. British Society of Rheumatology recommend close
monitoring at weeks 0, 1, 3, and 6 and then at months 3, 6,
9, and 12 in the first year. Unscheduled visits are advised
in the event of relapse.

Treatment of relapse follows a similar regimen:

- Headache: patients should be restarted on the previous
higher prednisolone dosage.
- Headache and jaw claudication: treatment should be
started with 60 mg prednisolone.
- Visual symptoms: treat with either 60 mg prednisolone
or intravenous methylprednisolone.
- Large-vessel GCA: further investigation such as positron
emission tomography and MRI imaging is recommended
and consider treatments using systemic vasculitis
protocols.

**Predictors of neuro-ophthalmic (cranial) complications**

Recent study evaluating risks of cranial ischemic event
in GCA patients revealed that patients with low systemic
inflammatory response (odds ratio [OR] =0.30, 95% CI,
0.08–1.08), hypertension (OR =7.77, 95% CI, 0.83–72.76),
and a past history of ischemic heart disease (OR =8.65, 95% CI,
0.92–80.95) are associated with a high risk of developing
severe cranial ischemic events. Low-dose aspirin has also
been shown to decrease cranial complications. In resistant
or recurrent GCA, immunosuppressive agents such as metho-
trexate may be used as adjuvant therapy to allow reduction
in glucocorticosteroid use.

A meta-analysis identified different relationships between
clinical features and TAB positivity. A positive TAB
has been associated with cranial complications, including
cerebrovascular strokes. Clinical features that increase
the likelihood of having a positive TAB include jaw claudication:
shows a high positive LR 4.2 (2.8–6.2), diplopia: LR 3.4
(1.3–8.6), temporal artery beading: LR 4.6 (1.1–18.4), and
temporal artery tenderness: LR 2.6 (1.9–3.7).

Features that have been shown to have less likelihood of
a positive TAB include the absence of temporal artery abnor-
mality (beading, tenderness): negative LR 0.53 (0.38–0.75)
and a normal value of ESR: negative LR 0.2 (0.08–0.51).

**Conclusion**

The diagnosis of temporal arteritis requires a high index of
suspicion as it may manifest in a variety of clinical features.
However, a mildly elevated ESR in the presence of positive
characteristic clinical features is increasingly suggestive of GCA and should still trigger initiation of treatment for GCA. Acute medical professionals need to be aware of the criteria of GCA but, in addition, need to be aware of atypical GCA presentations such as low ESR, arm claudication, dysarthria, and phenotypic cases not involving cranial arteries.

**Key learning points**
- Consider diagnosis of temporal arteritis in patients with new onset or new type of localized headache having age ≥50 years.
- Consider diagnosis of temporal arteritis even in patients with ESR <50 mmHg/h but who meet the criteria of temporal arteritis clinically.
- Prompt diagnosis and urgent treatment should be initiated by the acute medical doctors for temporal arteritis.

**Acknowledgment**
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**Disclosure**
The authors report no conflicts of interest in this work.

**References**