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Learning Objectives

1. Recognize that GCA can first present as stroke or transient ischemic attack (TIA).
2. Be aware that a normal ESR does not exclude the diagnosis of GCA.
3. Understand that the histopathologic diagnosis of GCA can still be attained after days of treatment with high dose steroids.

History

HPI: 71 year old white female transferred from OSH for TIA. The patient developed dysarthria 2 months before admission and was diagnosed with a left posterior frontal lobe infarct by CT, without any subsequent clinical sequelae. She now presents with clumsiness of her left hand that resolved after four hours. No other symptoms reported in the RxOxS.

PMH: Urticarial vasculitis, Hypothyroidism.

MEDS: Prednisone 5mg QOD, Levothyroxine, ASA.

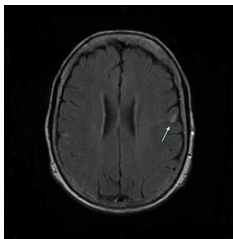
SH: Negative for tobacco, alcohol, illicit drugs.

Physical Exam

- BP 110/60mmHg, P 65, R 16, T 97
- Oriented x 3, normal speech, CN II-XII intact. Strength 5/5, DTR 2+, preserved sensation.

Labs and Studies

CBC and chemistry profile– normal
ESR = 13 mm/hr

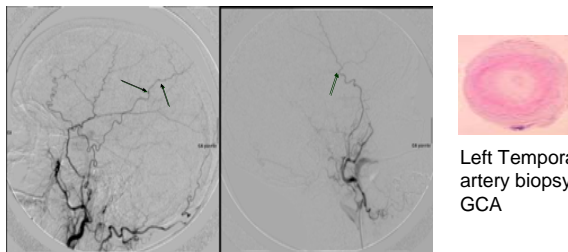
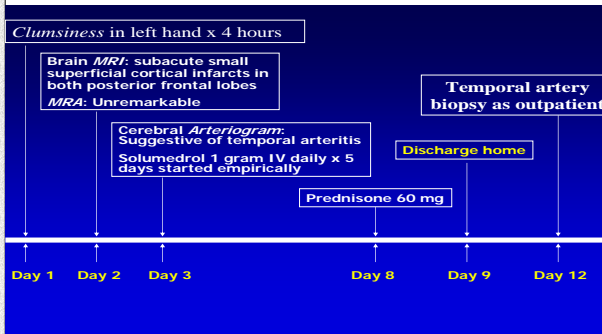


Brain MRI: Subacute small superficial cortical infarcts in both posterior frontal lobes



Intracranial MRA: Unremarkable

Hospital Course



Cerebral Arteriogram: Irregular appearance of the distal left superficial temporal artery (black arrows). Right superficial temporal artery is near occluded (green arrow).

Giant cell (temporal) arteritis

- Systemic inflammatory vasculitis that affects medium- and large-sized arteries.
- Common presenting features: headache, scalp tenderness, proximal myalgia, visual disturbances, fatigue, weight loss and fever. Jaw claudication is less common.
- Stroke and TIA associated with GCA are rare but important to recognize as they may be reversible if diagnosed and treated promptly.
- A high ESR is very characteristic; however an ESR less than 40 mm/hr has been

Conclusions / Take Home Points

- zSds

References

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- Stone JH, Calabrese LH, et al. Vasculitis. A collection of pearls and myths. Rheum Dis Clin North Am. 2001 Nov;27(4):677-728.
- Ghanchi FD, Dutton GN. Current concepts in giant cell (temporal) arteritis. Surv Ophthalmol. 1997 Sep-Oct;42(2):99-123.
- Litwin MS, Henderson DR, Kirkham B. Normal sedimentation rates and giant cell arteritis. Arch Intern Med. 1992 Jan;152(1):209.