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45. LARGE VESSEL VASCULITIS ASSOCIATED WITH COMMON ILIAC ARTERY ANEURYSM AND LIMB ISCHAEMIA

Megan Rutter1, and Tanya Potter1
1Rheumatology, University Hospital Coventry, Coventry, United Kingdom

Introduction: An 81-year-old gentleman with no prior medical history presented with a 5-month history of gradual onset malaise and reduced appetite. Weight loss of 2 stone was noted. Mild intermittent headache was present. After 3 months, he developed intermittent claudication of the right leg. A diagnosis of giant cell arteritis (GCA) was made. Disease was corticosteroid resistant, on the basis of clinical findings, biochemistry and imaging. Tocilizumab was commenced. Imaging also revealed dissection of the proximal right common iliac artery. The intermittent claudication progressed to acute limb ischaemia, which responded well to conservative treatment with heparin.

Case description: Headache was unilateral, intermittent and lasted a few minutes only, although it was described as severe. There were no visual symptoms, no scalp tenderness and no jaw or tongue claudication. His mobility was severely impacted by intermittent claudication. He was previously playing 3 rounds of golf per week but exercise tolerance reduced to fifty metres. There were no specific risk factors for atherosclerotic disease. He was a retired head teacher and had never smoked. Alcohol intake was 3 units per week. He was not taking any medication. The predominant features in the history were systemic upset and weight loss and the initial focus was on ruling out malignancy. Extensive investigations were performed by the general practitioner (GP). Erythrocyte sedimentation rate (ESR) was 80 and C-reactive protein (CRP) 74. A full blood count and serum biochemistry were otherwise unremarkable. Immunoglobulins were normal with no paraprotein detected. Thyroid stimulating hormone (TSH) was within the normal range. Prostate specific antigen (PSA) was raised at 17.8 but urology investigations revealed no evidence of malignancy.

Computed tomography (CT) of the thorax, abdomen and pelvis showed non-specific inflammation of jejunum & mesenteric fat. Subsequent magnetic resonance imaging (MRI) of the small bowel showed resolution of these changes but noted a chronic focal area of dissection at the proximal right common iliac artery. The GP commenced prednisolone 40mg daily, increased after twelve days to 60mg daily due to partial response. Review in rheumatology clinic two weeks later noted ongoing intermittent claudication. Headache had resolved and weight stabilised. The right temporal artery was difficult to palpate and the right ulnar pulse was absent. Temporal artery ultrasound scan (TA USS) in clinic demonstrated bilateral ongoing active inflammation. Three pulses of 500mg intravenous methylprednisolone were arranged.

Discussion: Whilst ESR had initially increased to 10 and CRP to <3, they subsequently increased to 53 and 45 respectively. Subsequent positron emission tomography with computed tomography (PET-CT) showed diffuse metabolic activity in thoracic aorta, bilateral subclavian, axillary and femoral arteries.

On the basis of bloods, ongoing claudicant symptoms and strongly positive TA-USS and PET-CT, the disease was felt to meet criteria for steroid non-responsiveness. As per NICE guidelines, permission was sought and granted from the local tertiary centre to commence tocilizumab. The patient was noted to have diverticulosis on the basis of imaging but had never been symptomatic. After appropriate patient counselling on the risks of gastrointestinal perforation, a decision was made to proceed with treatment.

The finding of dissection at the proximal right common iliac artery prompted urgent referral to the vascular surgery team. However, whilst awaiting review, the patient developed acute limb ischaemia with pallor, weakness and pain of the right leg. He was admitted and managed...
conservatively with intravenous heparin, followed by subcutaneous heparin and clopidogrel. He responded well to medical therapy and remains under vascular follow up. Notably, the aneurysm was retrospectively noted on CT scan imaging, confirming that it predated corticosteroid treatment.

Key learning points: Whilst aneurysm formation is a recognised complication of giant cell arteritis, they are typically aortic and involvement of lower limb arteries is rare. There is no consensus opinion on optimal surveillance of extra-aortic aneurysms in GCA; decisions should be made on a case by case basis. Tocilizumab is an effective treatment for refractory GCA. The current NICE guideline on its usage is based on the GIACTA study findings.

Conflicts of interest: The authors have declared no conflicts of interest.