A case of vision loss in a patient with Giant Cell Arteritis

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A missed case of Giant Cell Arteritis – Awareness for the PCP

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Abstract

GCA BASICS

• GCA is a systemic vasculitis with a predilection to supra-aortic arteries, particularly the branches of the external carotid artery. (5)
• It is seen overwhelmingly in individuals over 50 years of age and incidence increases with age. (5) The highest incidence of GCA is seen in persons of Northern European ancestry. (6)
• The clinical presentation of GCA may include cranial symptoms including headache, temporal or scalp tenderness and jaw or tongue claudication. Extra-cranial manifestations may include unexplained fever, malaise, weight loss, fatigue. (7)
• Vision loss in GCA is caused by anterior ischemic optic neuropathy (5) with images from our case patient seen to the right (Figure 1).

Case Description

An 80 year old Caucasian female with a history of Coronary Artery Disease, Hypertension and Right Supraspinatus Tear presented to her PCP office with a 1 week history of aching left sided neck pain with radiation to posterior scalp. She denied any associated symptoms. She was ambulatory and functioning independently.

• Neck pain was initially diagnosed as cervical spondylosis, the patient received osteopathic manipulation and was discharged with a physical therapy referral.
• Two weeks later she was seen by a different provider in the same practice in the ED with partial vision loss in her right eye. ESR was found to be elevated at 47mm/hr. She was started on Prednisone 60mg PO daily and underwent Temporal Artery Biopsy (TAB) which confirmed the diagnosis of Giant Cell Arteritis.
• 4 months following her initial vision loss she reported no improvement in vision despite adherence to therapy. 6 months after the diagnosis of GCA she was admitted for severe sepsis and lower GI bleeding secondary to terminal ileitis. She had poor functional recovery following discharge and died under hospice care 7 months later.

Discussion

• A recent meta-analysis estimates the mean time from presentation to diagnosis of GCA at 9 weeks. (3) This case demonstrates a similar pattern and highlights the challenge and importance of achieving a prompt diagnosis.
• Existing literature suggests that few of the classic symptoms and physical signs are predictive of biopsy-confirmed GCA. (7)
• The American College of Rheumatology published Classification Criteria for GCA in 1990, however comprehensive management guidelines are still under development. Existing European and British guidelines endorse maintaining a high degree of clinical suspicion to prompt urgent referral for TAB and specialist evaluation. To improve clinical outcomes through rapid diagnosis, studies of high-risk referral pathways have demonstrated reduced rates of permanent vision loss compared to conventional care. Nonetheless, increased primary care awareness is necessary for consideration of this less common but potentially catastrophic diagnosis.

Photos

Figure 1. Fundoscopy images demonstrating marked optic disc edema of left eye secondary to Ischemic Optic Neuropathy.

Background

WHY THIS CASE?

• Giant Cell Arteritis (GCA) is the most common large vessel vasculitis (1) and carries the risk of lifelong-changing morbidity manifested as permanent vision loss or other neurological deficit. Despite these well-undertstood complications, fancy tests that are more specific than the usual work-up are available without dramatically changing the overall management. Our case demonstrates the importance of being aware of the clinical course of this disease.

• Giant Cell Arteritis (GCA) is the most common large vessel vasculitis associated with GCA, patients are likely to be in the ambulatory setting. This case report aims to provide an example of a delay in diagnosis of GCA and improve awareness of the diagnostic challenges facing primary healthcare providers.