Amman’s case

Andrew’s group

“For a few months now, I just feel exhausted all the time, I don’t know if there is anything that can be done”

* 54 year lady

PMH:

* asthma- well controlled on inhalers (fostair) 2013
* BMI (38)
* essential hypertension on losartan 2002
* previous emergency C-section for preclampsia 1990
* post natal depression 1990

You get a bit more information…

What did you put it down to in your own mind?

* “My father has just come out of hospital and work is really busy at the moment, so I put it down to stress really”

It’s been going on for a while, what’s made you come now?

* “Well I was a bit worried as I feel so achey and sort of…physically terrible too…I can’t even get ready in the mornings. I was worried it might be something else and wanted to make sure I was doing the right things. I have spoken to GPs before...I am sorry if I am wasting your time”

Was there something in particular you were hoping we could do today?

* “just to be examined really and check it out…I was hoping for reassurance more than anything and perhaps some painkillers”

You mentioned painkillers, whereabouts do you feel the pain worst?

* Oh, I've been getting headaches, that has been really sore these past few weeks

Can you tell me a bit more about them?

* It's an ache that sometimes throbs and is always there, paracetamol helps a bit

Does it hurt when you brush your hair or touch it?

* Yes, it does actually…

The rest of the consultation

- No visual disturbance reported
- O/E, tender left sided, palpable temporal artery, vision 6/6 bilaterally with no visual field defect, CNS intact, BP 160/100mmHg

How would you manage this lady?

- Bloods
- Prednisolone…dose?
- Home BP readings
- Review in 72 hours
- Urgent rheumatology referral now? Or wait to see response and bloods?

At her review…

- Bloods showed raised ESR (but only 17)
- Dramatic improvement with prednisolone, therefore urgent rheumatology referral made and PPI cover given, given PIL on GCA

What happened next…

- Clinical diagnosis made by rheumatologists
- Started on calcium and vit D with reducing dose of pred
- DEXA scan requested
- Came to see me a month later with thrush that did not respond to a pessary….

- Fasting glucose was 16 and we are in the process of starting treatment for type II DM, including exercise programme referral for weight loss
- Has been started on alendronic acid (scan showed osteopenia)

Giant cell arteritis

chronic vasculitis characterized by granulomatous inflammation in the walls of medium and large arteries. The extracranial branches of the carotid artery and branches of the ophthalmic artery, such as short ciliary branches, are preferentially involved, although the aorta and its major branches may also be affected

Epidemiology

- a full-time GP is likely to see a new case every 1–2 years
- rare before 50 years of age with a mean age of onset of 70 years of age
- 7 times more common in caucasians

Clinical presentation

- • Suspect giant cell arteritis if the person is aged 50 years or older with at least one of:
- ◦ A new onset localized headache that is usually unilateral, in the temporal area, but is occasionally diffuse or bilateral.
- ◦ A temporal artery abnormality such as tenderness, thickening, or nodularity and pulsation may be reduced or absent.
- • Other symptoms and signs suggestive of giant cell arteritis include:
- ◦ Systemic features (fever, fatigue, anorexia, weight loss, and depression) — affect most people. Fever is usually low grade, but may occasionally be higher.
- ◦ Features of polymyalgia rheumatica (bilateral upper arm stiffness, aching, and tenderness; pelvic girdle pain) — present in about 40% of people with giant cell arteritis.
- ◦ Intermittent jaw claudication — occurs in nearly half of people
- ◦ Visual disturbances — permanent partial or complete loss of vision in one or both eyes occurs in up to 20% of people and is a common early symptom.
- ▪ Typically it is described as a feeling of a shade covering one eye, which can progress to total blindness. The eye is not painful.
- ▪ Double vision and visual field defects may occur.
- ▪ Untreated, the second eye is likely to become affected within 1–2 weeks, although it can be affected within 24 hours.
- ▪ Once visual impairment is established, it is usually permanent.

Management

- • Refer all people for biopsy. A positive result confirms the diagnosis, but a negative result does not always rule it out.
- ◦ If there is visual impairment — arrange an urgent (same day) assessment by an ophthalmologist.
- ◦ If there is no visual impairment — refer for urgent specialist assessment (rheumatology)
- • Start oral corticosteroids immediately
- ▪ For people with visual symptoms — 60 mg as a one-off dose (they should be seen by an ophthalmologist the same day).
- ▪ For people without visual symptoms — 40 to 60 mg daily
- • Consider alternative conditions, especially if there is a poor response to oral corticosteroids after 48 hours.
- • Consider the following tests and send the results to the specialist to help establish the diagnosis:
- ◦ ESR and CRP (often greater than 50 mm/hour, but may be normal at presentation and even during a flare
- ◦ FBC (Normochromic normocytic anaemia and an elevated platelet count are common)
- ◦ Liver function tests (about 1/3 have mildly elevated liver function tests esp Alk phos)

Ongoing management

- shared care with rheumatology
- slowly reduce steroids until lowest dose to control symptoms and normalise ESR (see CKS for tapering doses)
- steriod card
- review after each dose change or 3 monthly until stable
- assess bone protection

Thank you and any questions?