PATIENT FACT SHEET

Giant Cell Arteritis

CONDITION DESCRIPTION

Giant cell arteritis (GCA) is a type of vasculitis, or inflammation of blood vessels. It occurs in adults over 50. In some people, GCA occurs along with polymyalgia rheumatica (PMR), a joint pain condition.

GCA is also called temporal arteritis. In GCA, arteries around the scalp and head inflame. Often, the temporal artery, a small blood vessel under the skin at the temples, swells and thickens. People with GCA may have persisting headaches, fatigue, fevers and flu-like symptoms.

About half of GCA patients also have symptoms of PMR, and about 5-15% of PMR patients will be diagnosed with GCA at some point. GCA affects women more often than men, and Caucasians more often than non- Caucasians. Its cause is unknown

SIGNS/ SYMPTOMS

New, persistent headache is a common sign of GCA. Headaches are often at the temples, but may occur around the head. Other symptoms are fatigue, fevers, flu-like symptoms, weight loss, loss of appetite and pain when chewing. Less common signs are face, throat or tongue pain.

A rheumatologist should diagnose and treat GCA. It can spread to vessels that supply blood to the eyes and affect eyesight. People may notice temporary blurring, double vision or blindness. Permanent, sudden loss of eyesight is a rare complication that can be prevented with prompt GCA treatment.

People with PMR should report new headaches, vision changes or jaw pain to their rheumatologist right away to be screened for GCA. To diagnose GCA, patients may have an erythrocyte sedimentation ("sed") rate blood test to look for signs of inflammation, followed by an ultrasound scan or biopsy of the temporal artery.

COMMON TREATMENTS

GCA treatment should start immediately after diagnosis to prevent vision loss. Doctors may start treatment before biopsy results are in if GCA is strongly suspected. First-line treatment usually is 40-60mg per day of prednisone (Deltasone, Orasone), a corticosteroid. Headaches and other symptoms often ease quickly with treatment, and the sed rate drops to normal.

After about a month of high-dose corticosteroids, the dose is tapered. The rheumatologist will time the dose decrease based on how well the patient's headaches or sed rate improves, or if these symptoms come back. For most patients, prednisone dose is reduced to 5-10mg per day over a few months. Patients often taper completely off prednisone after one to two years. GCA rarely returns after treatment.

High-dose prednisone has serious side effects, so patients should discuss these with their rheumatologist. In May 2017, tocilizumab (Actemra) was approved for the treatment of GCA.

CARE/ MANAGEMENT TIPS

Patients may manage steroid side effects, like bone loss, by getting a bone density test, and taking supplements of vitamin D and calcium. This can help prevent osteoporosis and bone fractures.

Patients may also use prescription bisphosphonates like risedronate (Actonel), alendronate (Fosamax), ibandronate (Boniva) or zoledronic acid (Reclast) to help protect their bones.

Other steroid side effects include jittery moods, weight gain and poor sleep. These should improve as the drug dose is tapered. Steroids also raise the risk of muscle weakness, cataracts and skin bruising, so patients should see their doctor often to watch for and treat these problems. Most steroid side effects are temporary and can be managed.

Updated March 2017 by James Udell, MD, and reviewed by the American College of Rheumatology Communications and Marketing Committee. This information is provided for general education only. Individuals should consult a qualified health care provider for professional medical advice, diagnosis and treatment of a medical or health condition.