Παρουσίαση κλινικού περιστατικού

Τζαναβάρη Κατερίνα
Ειδικευόμενη Ρευματολογίας
Γ.Ν.Θ.Άγιος Παύλος

Ιστορικό

Ασθενής , θήλυ, 59 ετών προσέρχεται αιτιώμενη

- πρωινές εφιδρώσεις από 2μήνου
- αδυναμία, καταβολή
- ήπια υποτροπιάζοντα επεισόδια κεφαλαλγίας

Α/α : υποθυρεοειδισμός

κωνοειδή εκτομή τραχήλου

Ιστορικό

Προσκομίζει εργαστηριακό έλεγχο με :

- αυξημένους δείκτες φλεγμονής
  (ΤΚΕ: 80, CRP : 7,9 (<0,5)]
- Αναιμία υπόχρωμη μικροκυτταρική
  (Ht : 30, Hb: 9,5)
- Θρομβοκυττάρωση (PLT : 540.000)

Από ιδιώτη παθολόγο παραπέμφθηκε σε αιματολόγο και υπεβλήθη σε CT ΘΑΚΟ :

- Κατιούσα θωρακική αορτή και κοιλιακή αορτή με **πάχυνση του τοιχώματος έως 4 mm** – θέτουν την υπόνοια αρχόμενης πιθανής οξείας αρτηριίτιδας.

P
A
G.H. AGIOS PAVLOS
WW: 154
WL: 35
SW: 8.00 mm
IE: 0.00
150 mm
MPAKALI 247859\F
Ex: 2478
C+
WW: 251
WL: 52

G.H. AGIOS PAVLOS
MX 16-slice
SW: 7.00 mm
IE: 0.00
WW: 400
WL: 40
MPAKALI 247\85Y\F
Ex: 2478
Se: 9/Im: 34
Se: 9/Im: 33
Se: 9/Im: 39
A
P
L
R

Εισαγωγή 6/2/2017 για διερεύνηση πιθανής αρτηριίτιδας

Κλινικά

- αναφερόμενες άτυπες κεφαλαλγίες χωρίς συμπτώματα από τους οφθαλμούς
- αδυναμία, κόπωση

Αντικειμενικά ευρήματα

- ψηλαφητές κροταφικές αρτηρίες,
- φυσιολογικές περιφερικές σφύξεις, χωρίς φυσήματα
- εμπύρετο (-)

Εργαστηριακός έλεγχος

- Αναιμία (Ht : 31,4, Hb: 9,5,
  MCV 79,3, MCH: 24, MCHC: 30,3)
- PLT : 539.000
- ΤΚΕ : 76, CRP : 7,9 (<0,5)
- RA test : 4 (<30)
- Urea : 16 , Cr : 0,7
- SGOT: 12, SGPT: 13, ALP: 92, γ-GT: 22
- PTH: 50 (15-68) , Βιτ. D3: 6,25 (20-60)
- TSH : 1,76 (0,35-4,94)
- ANA : 1/80 (+), 1/160 (-)
- c-ANCA: (-), p-ANCA: (-)

- Α/α θώρακος : κφ

- U/S καρδιάς :
  Μέτρια περικαρδιακή συλλογή (περίπου 1,3 cm στο τοίχωμα LV), φυσιολογικές διαστάσεις ανιούσας-κατιούσας αορτής, ομαλές ροές στην κατιούσα θωρακική αορτή, φυσιολογική συσταλτικότητα ΑΡ κοιλίας, Ao τρίπτυχη, MR/TR μικρού βαθμού διαφυγή

- DEXA

ΟΜΣΣ	Ο1: -2	ΔΕ ισχίο αυχ: -2,5
	Ο2: -2	συν: -1,6
	Ο3: -1,3	ΑΡ ισχίο αυχ: -2,9
	Ο4: -1,6	συν: -1,5

Διαφορική διάγνωση

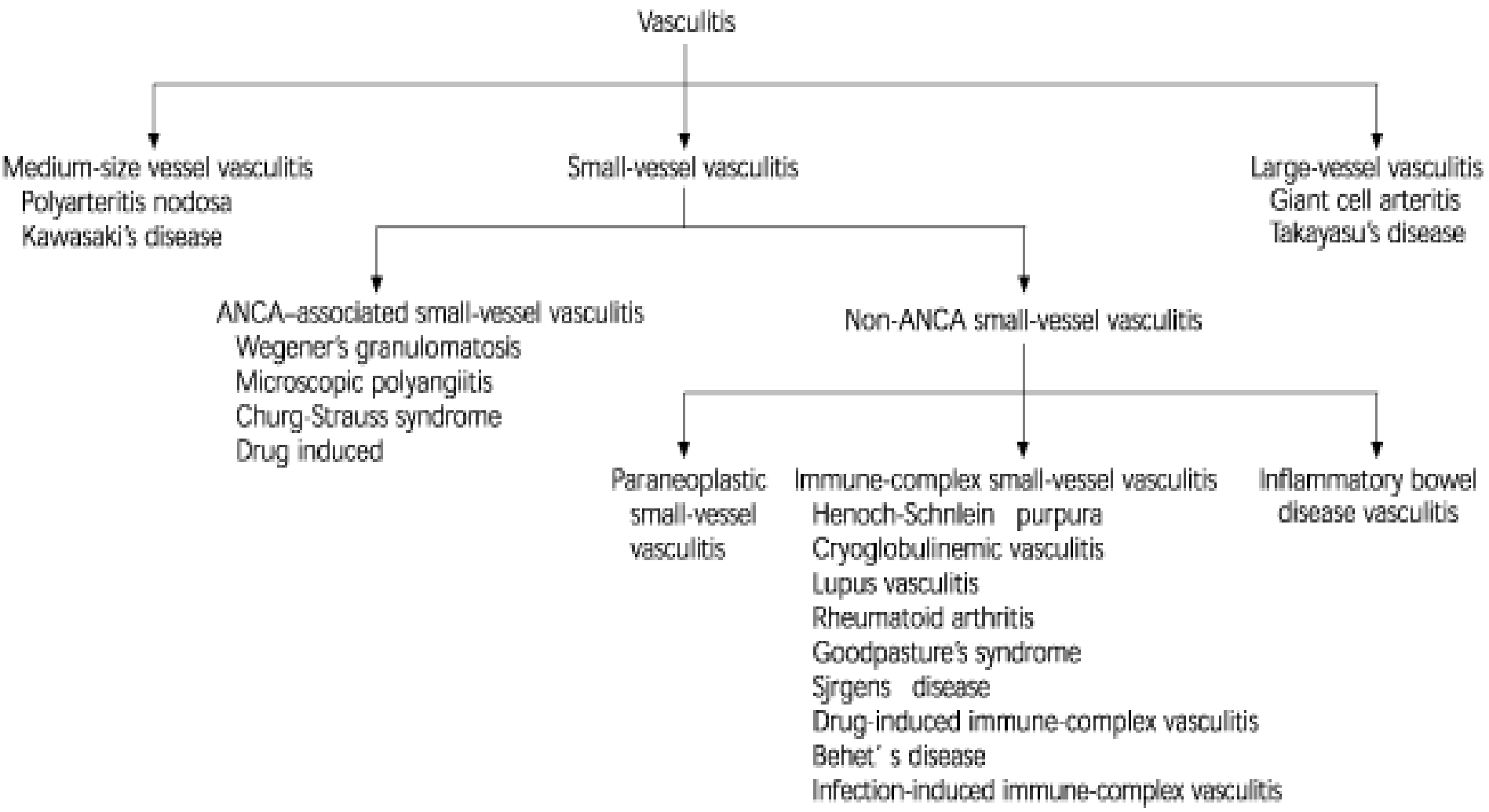
- **Φλεγμονώδεις**
- *Vasculitis*
  - Giant cell arteritis (temporal arteritis)
  - Takayasu arteritis
  - Rheumatoid arthritis
  - Systemic lupus erythematosis
  - HLA-B27 associated spondyloarthropathies (AS, Reiter)
  - Other vasculitides
    - ANCA-associated vasculitides
      - Wegener's arteritis
      - Polyarteritis nodosum
      - Microscopic polyangiitis
    - Behçet's disease
    - Cogan syndrome
    - Relapsing polychondritis
  - Sarcoidosis
- *Isolated Aortitis*
  - Isolated idiopathic (thoracic) aortitis
  - Chronic periaortitis
    - -Idiopathic retroperitoneal fibrosis (Ormond's disease)
    - -Inflammatory abdominal aortic aneurysm
    - -Perianeurysmal aortitis
    - -Idiopathic isolated abdominal periaortitis

- **Λοιμώδεις**
- Bacterial (Salmonella spp. , Staphylococcus spp., Streptococcus pneumoniae, Other)
- Syphilis
- Mycobacterial (i.e., M. tuberculosis)
- Other

- <u>Βιοψία κροταφικής αρτηρίας</u>

=> διάσπαση του έσω ελαστικού πετάλου και διάχυτες πυκνές φλεγμονώδεις διηθήσεις από πολυμορφοπύρηνα, λεμφοκύτταρα, ιστιοκύτταρα και πολυπύρηνα γιγαντοκύτταρα

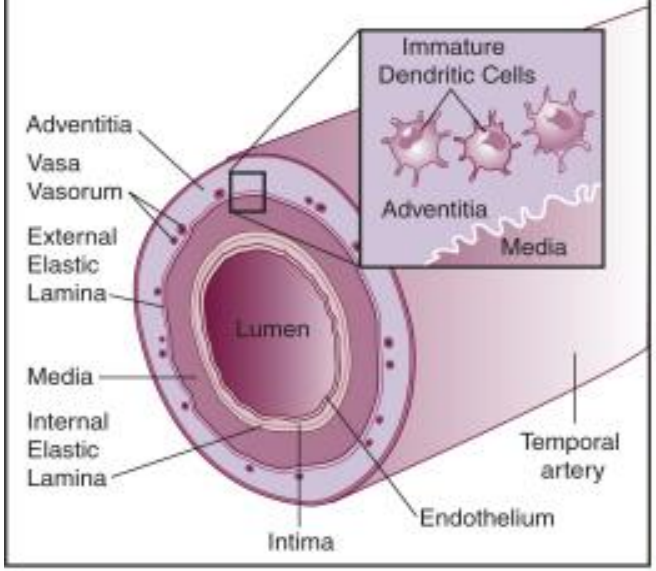
- => ευρήματα γιγαντοκυτταρικής αρτηριίτιδας


Vasculitis
Medium-size vessel vasculitis
Polyarteritis nodosa
Kawasaki's disease
Small-vessel vasculitis
Large-vessel vasculitis
Giant cell arteritis
Takayasu's disease
ANCA–associated small-vessel vasculitis
Wegener's granulomatosis
Microscopic polyangiitis
Churg-Strauss syndrome
Drug induced
Non-ANCA small-vessel vasculitis
Paraneoplastic small-vessel vasculitis
Immune-complex small-vessel vasculitis
Henoch-Schnlein purpura
Cryoglobulinemic vasculitis
Lupus vasculitis
Rheumatoid arthritis
Goodpasture's syndrome
Sjrgens disease
Drug-induced immune-complex vasculitis
Behet' s disease
Infection-induced immune-complex vasculitis
Inflammatory bowel disease vasculitis

ΓΙΓΑΝΤΟΚΥΤΤΑΡΙΚΗ ΑΡΤΗΡΙΙΤΙΔΑ (ΚΡΟΤΑΦΙΚΗ ΑΡΤΗΡΙΙΤΙΔΑ)

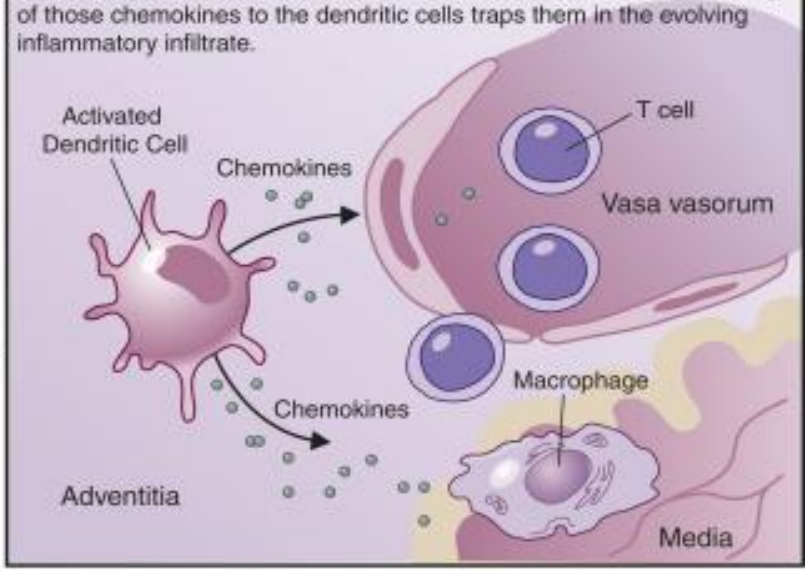
- Είναι μια συστηματική φλεγμονώδης αγγειίτιδα, αγνώστου αιτολογίας, που εμφανίζεται συνήθως σε ηλικιωμένα άτομα, με ποικίλες συστημικές, νευρολογικές και οφθαλμολογικές επιπλοκές.
- Προσβάλει την κροταφική αρτηρία, αλλά και κάθε μεσαίου μεγέθους αρτηρία της κεφαλής και του αυχένα.
- Η απώλεια της όρασης είναι η πιο σημαντική αιτία νοσηρότητας. Μόνιμη βλάβη της οπτικής οξύτητας μπορεί να προκληθεί στο 20 % των ασθενών, σπάνια αμφοτερόπλευρη τύφλωση.

In **healthy medium-sized arteries,** immature, nonactivated dendritic cells reside in the adventitia near the adventitia-media border. When immature dendritic cells present antigen to T cells, the T cells are inhibited, which may be important in maintaining immune tolerance.

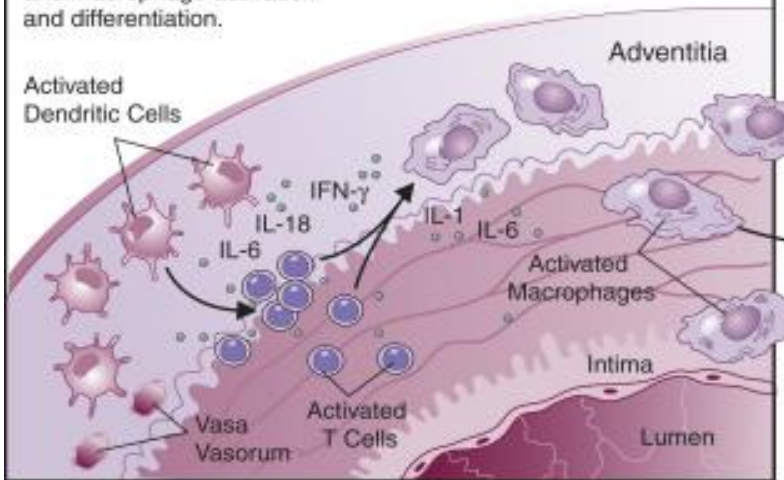


In **temporal arteritis,** a triggering antigens (e.g., an infectious agent, drug, toxin, or autoantigen) activates dendritic cells resident in the arterial wall.

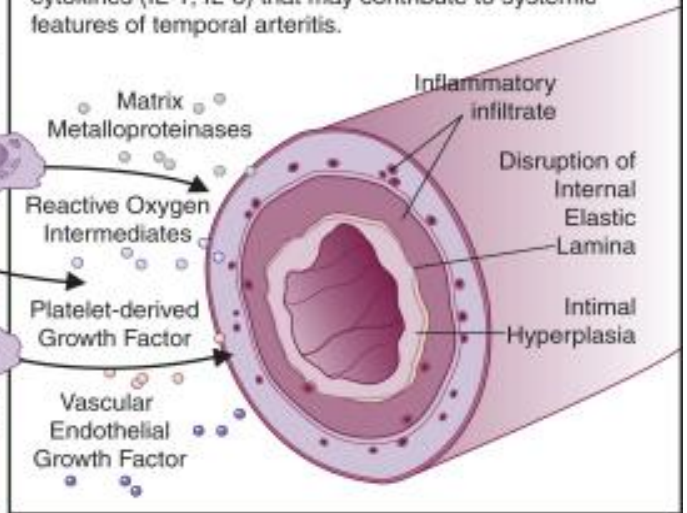
The activated dendritic cells release chemokines that attract T cells from the vasa vasorum and macrophages into the arterial wall. Binding of those chemokines to the dendritic cells traps them in the evolving inflammatory infiltrate.



The activated dendritic cells express receptors and release inflammatory cytokines (interleukin [IL] 6, IL-18) that promote activation of T cells and vascular inflammation. IL-18 up-regulates the release of interferon (IFN) γ from T cells. IFN-γ released from activated T cells promotes inflammation, granuloma formation, and macrophage activation and differentiation.



Activated macrophages produce a variety of mediators that lead to progressive vascular inflammation, endothelial damage, disruption of the internal elastic lamina, and intimal hyperplasia. Macrophages also release cytokines (IL-1, IL-6) that may contribute to systemic features of temporal arteritis.



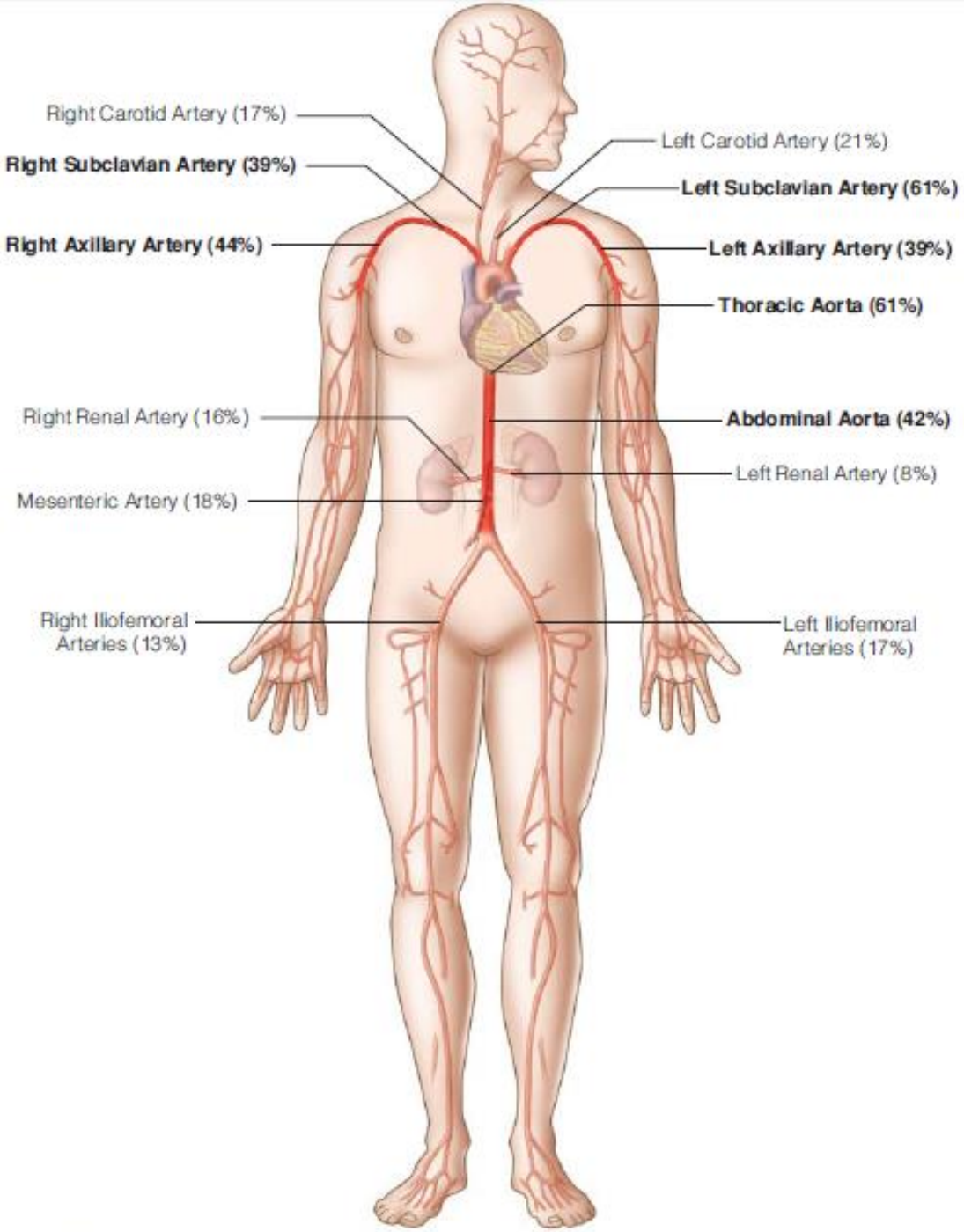
ΣΥΜΜΕΤΟΧΗ ΑΓΓΕΙΩΝ

- Κροταφικές αρτηρίες
- Κοινές έσω και έξω καρωτίδες, συνήθως εξωκράνια
- Ενδο-οφθαλμικοί κλάδοι, ιδίως η οπίσθια αρτηρία του ακτινωτού σώματος και οι οφθαλμικές αρτηρίες
- Σπονδυλικές αρτηρίες
- Υποκλείδιες, μασχαλιαίες και οπίσθιες βραχιόνιες αρτηρίες
- Ανιούσα αορτή, στεφανιαίες αρτηρίες

53%

- Κατιούσα αορτή, μεσεντέριες, νεφρικές, λαγόνιες και μηριαίες αρτηρίες
- Πνευμονικές αρτηρίες

Απώλεια της όρασης οφείλεται σε ισχαιμία του πρόσθιου οπτικού νεύρου, το οποίο αιματώνεται κυρίως από τις οπίσθιες ακτινωτές αρτηρίες



Frequency of arterial involvement in giant cell arteritis.[2]

TABLE 2

EULAR-ACR classification criteria for polymyalgia rheumatica*

Giant cell arteritis (GCA)	Polymyalgia rheumatica (PMR)
– Age over 50 years	– Morning stiffness >45 minutes (2 points)
– New onset of localized headache	– Rheumatic factor and/or anti-CCP-antibodies negative (2 points)
– Abnormality of temporal artery (temporal artery tenderness, reduced pulsation)	– Pelvic girdle pain or reduced hip mobility (1 point)
– Raised ESR (≥ 50 mm/1st hour)	– No other painful joint (1 point)
– Abnormal arterial biopsy (vasculitis with predominantly mononuclear cell infiltration or granulomatous inflammation or evidence of giant cells)	– Ultrasound: inflammatory changes in both shoulders (including subdeltoid bursitis) (1 point)
	– Ultrasound: inflammatory changes in at least one shoulder and hip joint (1 point)

*Classification as PMR requires 4 points (10); for giant cell arteritis (GCA), three criteria for the classification of GCA must be fulfilled.

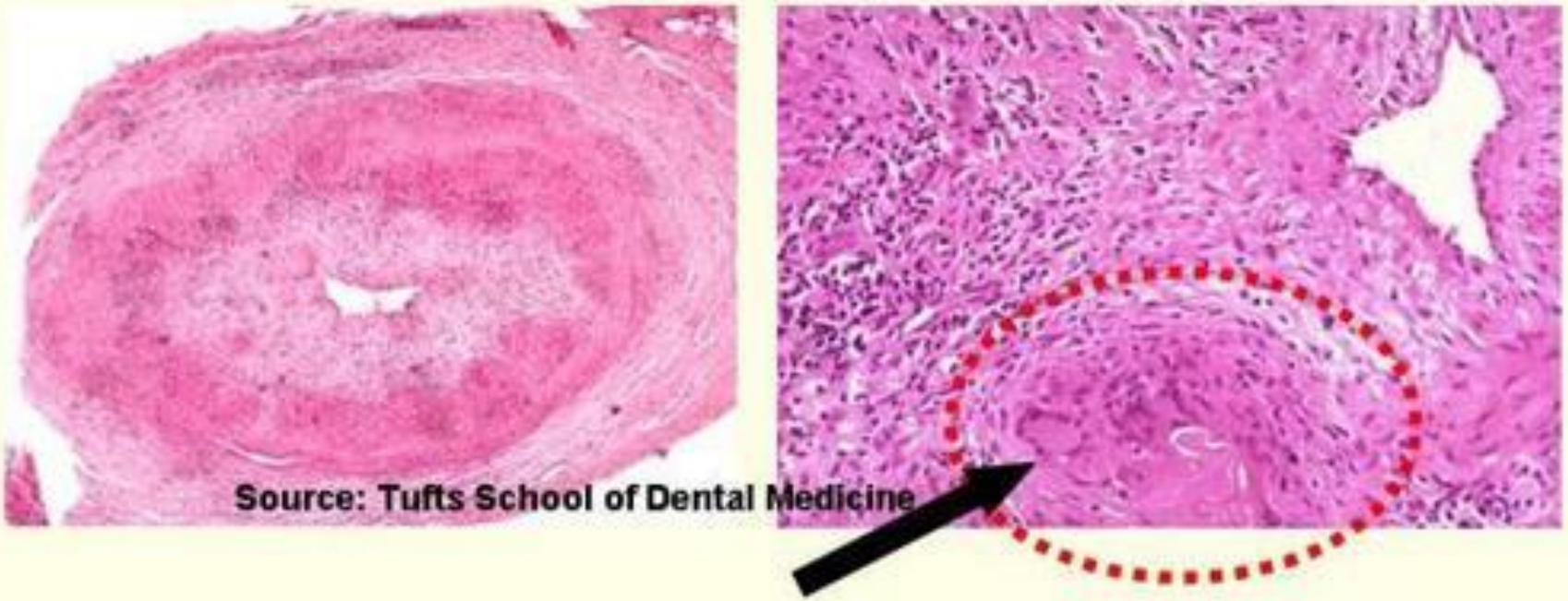
Modified from (14). EULAR, European League Against Rheumatism; ACR, American College of Rheumatology; ESR, erythrocyte sedimentation rate; CCP, anti-cyclic citrullinated peptide antibodies

TABLE 1

Symptoms in giant cell arteritis*

Category	Symptoms
Symptoms due to involvement of cranial vessels	Headache Jaw claudication (pain on chewing) Scalp tenderness Loss of vision Abnormalities of the temporal artery (pain, nodules, absence of pulse)
Symptoms due to involvement of great vessels (aorta and branches of aorta)	Claudication of extremities (especially arm)
Symptoms due to systemic inflammation	Fever, night sweats, weight loss
Polymyalgia rheumatica	Mainly proximal myalgia and stiffness of the neck and shoulder and pelvic girdles

Temporal Arteritis



Giant cells (arrow) within a granuloma (circle)
of granulomatous inflammation

Takayasu αρτηριίτιδα ("Άσφυγμη νόσος")

Μη ειδική κοκκιωματώδης φλεγμονώδης αγγειίτιδα , αγνώστου αιτιτολογίας, που προσβάλλει μεγάλα αγγεία και εμφανίζεται συνήθως σε άτομα κάτω 40 ετών , συνήθως σε γυναίκες.

Αρχική οξεία φλεγμονώδης /συστηματική φάση (40-50%)

- εμπύρετο, κακουχία, απώλεια βάρους, ευαισθησία στην ψηλάφηση των αρτηριών που πάσχουν

Αποφρακτική φάση (50-60%)

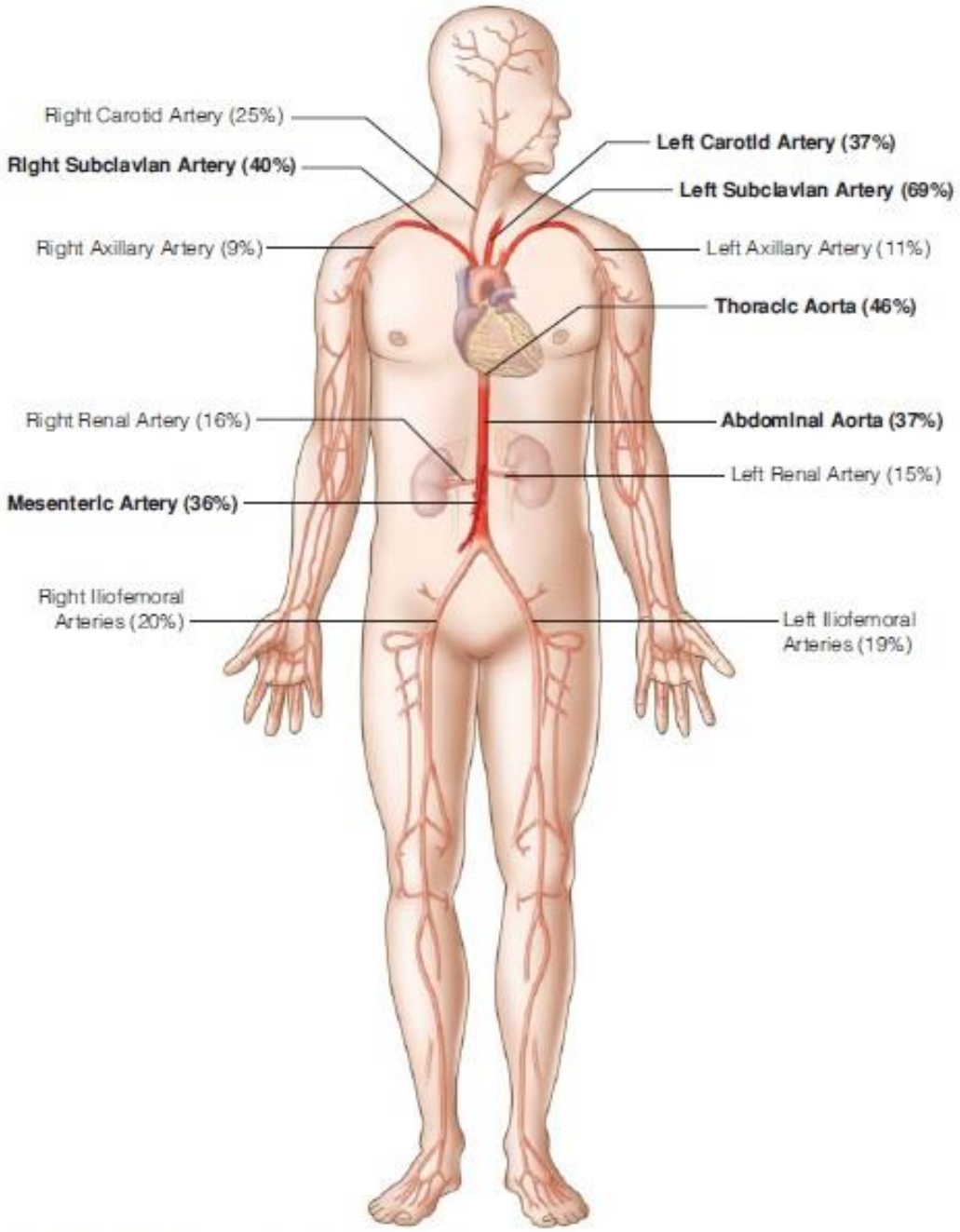
- εγκατεστημένη απόφραξη ή ανευρύσματα

Table 6 Clinical Presentation in TA Patients by Symptom*	
Clinical Manifestation	%
Systemic symptoms	66
Vascular symptoms	97
Absent or decreased pulses	88
Asymmetrical BP arms	81
Bruits	77
Hypertension	43
Ocular	36
CNS (stroke, TIA, visual changes)	63
Cardiac	57

Takayasu arteritis ACR criteria

1. Age at disease onset <40 years: Development of symptoms or findings related to Takayasu arteritis <40 years of age
2. Claudication of extremities: Development and worsening of fatigue and discomfort in muscles of ≥1 extremity while in use, especially the upper extremities
3. Decreased brachial artery pulse: Decreased pulsation of one or both brachial arteries
4. Blood pressure difference >10 mm Hg: Difference of >10 mm Hg in systolic blood pressure between arms
5. Bruit over subclavian arteries or aorta: Bruit audible on auscultation over one or both subclavian arteries or abdominal aorta
6. Arteriogram abnormality: Arteriographic narrowing or occlusion of the entire aorta, its primary branches, or large arteries in the proximal upper or lower extremities not due to arteriosclerosis, fibromuscular dysplasia, or similar causes; changes usually focal or segmental

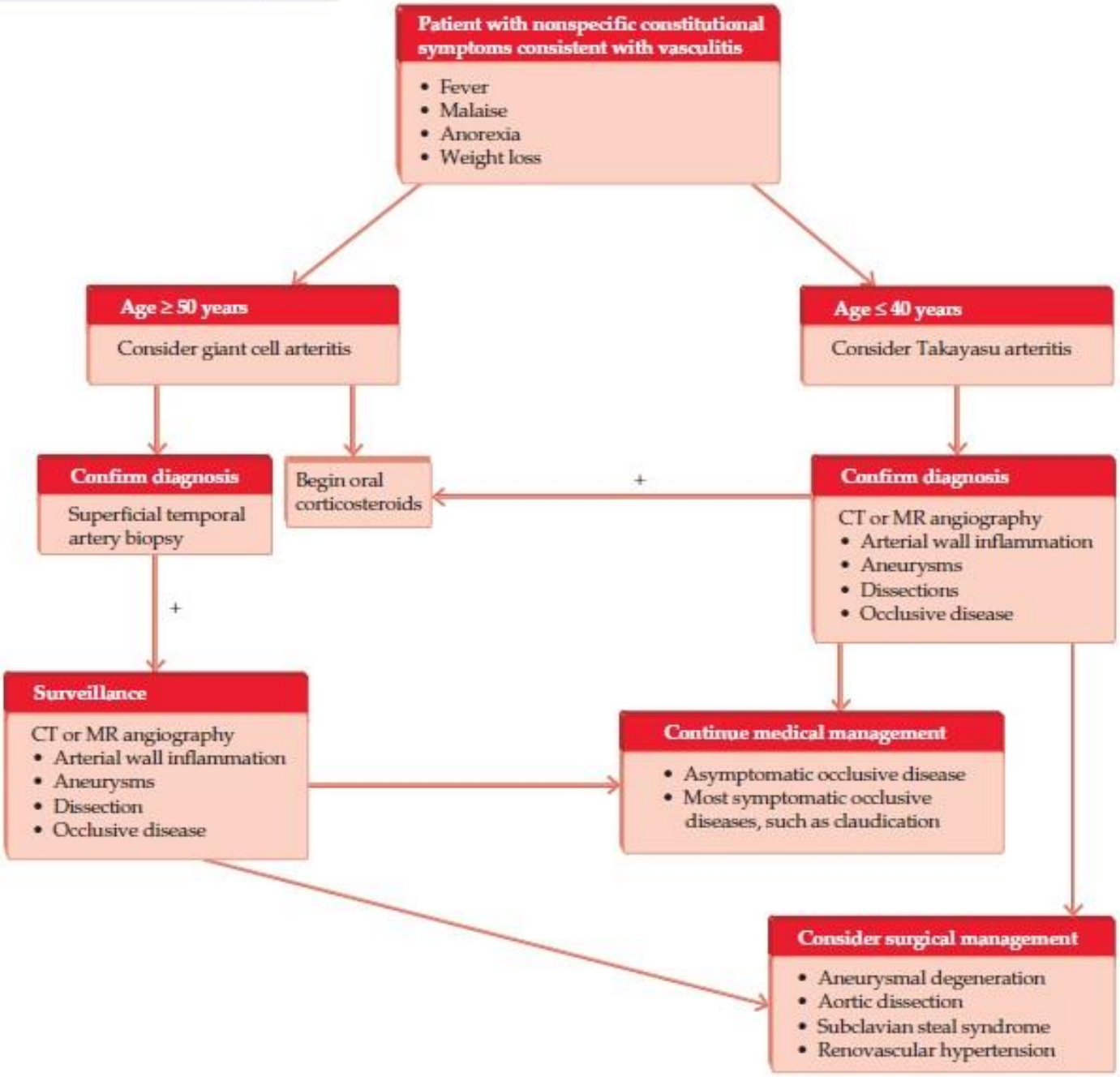
The presence of >3 criteria is consistent with a diagnosis of Takayasu arteritis, with a sensitivity of 91% and specificity of 98%



Frequency of arterial involvement in Takayasu arteritis.[2]

Γιγαντοκυτταρική αρτηριίτιδα	Αρτηριίτιδα Takayasu
Πιο συχνή στη Δύση	Πιο συχνή στην Ινδία
Ηλικία > 50 ετών	Σε νέους < 40 ετών
Οξεία έναρξη	Χρόνια πορεία
Προσβάλλει κυρίως κλάδους της έξω καρωτίδας, ιδίως την κροταφική αρτηρία	Κυρίως την αορτή και τους κυρίως κλάδους
Επιπλοκές : πρόσθια ισχαιμική οπτική νευροπάθεια, πάρεση κρανιακών νεύρων, σπάνια ισχαιμία μεγάλων αγγείων	: αμφιβληστροπάθεια, υπέρταση, αορτική παλινδρόμηση, σοβαρή ισχαιμία στα άκρα
Διάγνωση : βιοψία κροταφικής αρτηρίας	Κυρίως με αγγειογραφικά ευρήματα

Approach to the Patient with Giant Cell and Takayasu Arteritis



Θεραπεία

Κορτικοστεροειδή

- Πρεδνιζολόνη per os 40-60 mg/day
- Σε οξείες οφθαλμολογικές, νευρολογικές διαταραχές :
  - iv 0,25-1 gr/day μεθυλ-πρεδνιζολόνης για 3 ημέρες
- θεραπεία εφόδου για 2-4 εβδ. ή μέχρι να υποχωρήσουν τα σημεία και να ομαλοποιηθούν οι δείκτες φλεγμονής
- Tapering με ελάττωση 10% της δόσης κάθε 2 εβδ

  Σύμφωνα με τις οδηγίες του Royal College of Physicians 2010
  - Ελάττωση 10mg κάθε 2 εβδομάδες έως 20 mg
  - Μετά 2.5mg κάθε 2-4 εβδομάδες έως 10 mg
  - Μετά 1mg κάθε 1-2 μήνες, με την προϋπόθεση ότι δεν έχει υποτροπή
- Υποτροπές παρατηρούνται σε δοσολογία 5-10 mg/d

Θεραπεία

- **Ανοσοκατασταλτικά**
  - Μεθοτρεξάτη 15-25 mg/w
  - Κυκλοφωσφοσφαμίδη σε μηνιαίες ώσεις
  - Αζαθειοπρίνη 1,5-2,5 mg/kg/d
- **Anti-TNF** : infliximab, etarnecept
- **Anti-IL 6** : tocilizumab
- **Αντιαιμοπεταλιακά** (ασπιρίνη)
  - Ελαττώνουν την συχνότητα οφθαλμολογικών επιπλοκών, ισχαιμικών επεισοδίων

Combined Treatment of Giant-Cell Arteritis with Methotrexate and Prednisone

A Randomized, Double-Blind, Placebo-Controlled Trial

Juan A. Jover, MD, PhD; César Hernández-García, MD, PhD; Inmaculada C. Morado, MD; Emilio Vargas, MD, PhD; Antonio Bañares, MD, PhD; and Benjamín Fernández-Gutiérrez, MD, PhD

Background: Corticosteroids remain the comerstone of therapy for giant-cell arteritis, but relapse during dose tapering and corticosteroid-related adverse events often complicate management of this condition. Although several approaches, including combined therapy with cytotoxic agents, have been suggested to overcome these problems, no study has clearly shown benefits of alternate treatments.

Objective: To analyze the safety and efficacy of combined therapy with corticosteroids and methotrexate in giant-cell arteritis.

Design: Randomized, double-blind, placebo-controlled trial.

Setting: University-based clinic.

Patients: 42 patients with new-onset giant-cell arteritis accord

Results: Compared with combined prednisone and placebo therapy, treatment with prednisone and methotrexate reduced the proportion of patients who experienced at least one relapse (45% vs. 84.2%; $P = 0.02$) and the proportion of patients who experienced multiple relapses ($P = 0.004$). The mean cumulative dose of prednisone was 4187 ± 1529 mg in the methotrexate group and 5489.5 ± 1396 mg in the placebo group (mean difference, 1302 mg [95% CI, 350 to 2253 mg]; $P = 0.009$). Overall, the rate and severity of adverse events were similar between groups. Treatment was discontinued in 3 patients in the methotrexate group who experienced definite drug-related adverse events. In sensitivity analysis that included patients lost to follow-up, differences between groups in number of relapses and cumulative dose of

Conclusions: Treatment with methotrexate plus corticosteroid is a safe alternative to corticosteroid therapy alone in patients with giant-cell arteritis and is more effective in controlling disease.

A Multicenter, Randomized, Double-Blind, Placebo-Controlled Trial of Adjuvant Methotrexate Treatment for Giant Cell Arteritis

Gary S. Hoffman,[1] Maria C. Cid,[2] David B. Hellmann,[3] Loic Guillevin,[4] John H. Stone,[3] John Schousboe,[5] Pascal Cohen,[4] Leonard H. Calabrese,[1] Howard Dickler,[6] Peter A. Merkel,[7] Paul Fortin,[8] John A. Flynn,[3] Geri A. Locker,[1] Kirk A. Easley,[1] Eric Schned,[5] Gene G. Hunder,[9] Michael C. Sneller,[6] Carol Tuggle,[1] Howard Swanson,[10] J. Hernández-Rodríguez,[2] Alfons Lopez-Soto,[2] Debora Bork,[1] Diane B. Hoffman,[1]

Conclusion. The results of this randomized, multicenter trial do not support the adjunctive use of MTX to control disease activity or to decrease the cumulative dose and toxicity of CS in patients with GCA.

Supported in part by grants from the Food and Drug Administration and the Office of Orphan Products Development (FD-R 001040). Dr. Hoffman's work was supported by the George B. Storer Foundation and the Ayhan Sahenk Foundation. Dr. Cid's work was supported by a grant (FIS 98/0443) from Fondo de Investigación Sanitaria.

[1]Gary S. Hoffman, MD, Leonard H. Calabrese, DO, Geri A. Locker, BS, Kirk A. Easley, MS, Carol Tuggle, RN, Debora Bork, MA, Diane B. Hoffman, MSN, William S. Wilke, MD, Raymond J. Scheetz, MD, Brian F. Mandell, MD, PhD, Barri J. Fessler, MD, Gregory Kosmorsky, DO, Richard Prayson, MD, Allen M. Segal, DO: Cleveland Clinic Foundation, Cleveland, Ohio; [2]Maria C. Cid, MD, J. Hernández-Rodríguez, MD, Alfons Lopez-Soto, MD: Hospital Clinic i Provincial, Barcelona, Spain; [3]David B. Hellmann, MD, John H. Stone, MD, MPH, John A. Flynn, MD: Johns Hopkins University School of Medicine, Baltimore, Maryland; [4]Loic Guillevin, MD, Pascal Cohen, MD, Martin Soubrier, MD, Xavier Puechal, MD: Universite

ments and diminishes disease- and treatment-related morbidity.

***Methods*. This was a multicenter, randomized, double-blind study. Over 4 years, 16 centers from the International Network for the Study of Systemic Vasculitides enrolled patients with unequivocal GCA. The initial treatment was 1 mg/kg/day (≤60 mg every day) prednisone, plus either 0.15 mg/kg/week MTX (increased to 0.25 mg/kg/week, for a maximum weekly dosage of 15 mg) or placebo. Two physicians, both blinded to treatment allocation, evaluated each patient at every trial visit. One physician was responsible for providing global medical care. The other assessed GCA status according to a standard protocol. Treatment**

EULAR recommendations for the management of large vessel vasculitis

C Mukhtyar1,L Guillevin2, M C Cid3, B asgupta4,K de Groot5, W Gross6, T Hauser7, B Hellmich8, D Jayne9, C G M Kallenberg10, P A Merkel11, H Raspe6, C Salvarani12, D G I Scott13, C Stegeman10, R Watts14, K Westman15, J Witter16, H Yazici17, R Luqmani1, for the European Vasculitis Study Group

4. We recommend that an immunosuppressive agent should be considered for use in large vessel vasculitis as adjunctive therapy (level of evidence 1A for giant cell arteritis, strength of recommendation B; level of evidence 3 for Takayasu arteritis, strength of recommendation C)

Giant cell arteritis requires long-term glucocorticoid therapy; 86% of patients suffer glucocorticoid-related adverse events at 10-year follow-up.[52] In an effort to reduce the duration of glucocorticoid therapy, there have been three randomised controlled trials of **methotrexate** as adjunctive therapy to glucocorticoid.[54] [62] [64] A meta-analysis of these three trials demonstrates a modest role for methotrexate (10–15 mg/week) in reducing relapse rate and lowering the cumulative dose of glucocorticoid therapy.[65] The combination of infliximab and glucocorticoid therapy does not reduce the risk of relapse as compared to glucocorticoid monotherapy, and is not recommended in giant cell arteritis.[61]

Annals of Internal Medicine | ARTICLE

Infliximab for Maintenance of Glucocorticosteroid-Induced Remission of Giant Cell Arteritis

A Randomized Trial

Gary S. Hoffman, MD; Maria C. Cid, MD; Karen E. Rendt-Zagar, MD; Peter A. Merkel, MD, MPH; Cornelia M. Weyand, MD; John H. Stone, MD, MPH; Carlo Salvarani, MD; Weichun Xu, PhD; Sudha Visvanathan, PhD; and Mahboob U. Rahman, MD, PhD, for the Infliximab-GCA Study Group*

Background: Tumor necrosis factor-α is present in arteries in giant cell arteritis.

Objective: To evaluate the efficacy of infliximab, an anti–tumor necrosis factor-α agent, in giant cell arteritis.

Design: Randomized, controlled trial.

Setting: 22 sites in the United States, the United Kingdom, Belgium, Italy, and Spain.

Patients: 44 patients with newly diagnosed giant cell arteritis that was in glucocorticosteroid-induced remission.

Intervention: Participants were randomly assigned in a 2:1 ratio to receive infli
patients we
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remained relapse-free while the glucocorticosteroid dosage was tapered to 10 mg/d.

Results: Infliximab therapy did not increase the proportion of patients without relapse at week 22 compared with placebo (43% vs. 50%, respectively; difference, −7 percentage points [95% CI, −38 to 23 percentage points; $P = 0.65$), nor did it increase the proportion of patients whose glucocorticosteroid dosages were tapered to 10 mg/d without relapse (61% vs. 75%, respectively; difference, −14 percentage points [CI, −42 to 14 percentage points]; $P = 0.31$). The incidence of infection was 71% with infliximab and 56% with placebo (difference, 15 percentage points [CI, −14 to 45 percentage points]).

Limitations: The sample was too small to rule out modest effects of infliximab and included only patients with a new diagnosis. Only
as termi-

Conclusions: This trial is too small to draw definitive conclusions, but it provides evidence that using infliximab as maintenance therapy in patients in glucocorticoid-induced remission of newly diagnosed giant cell arteritis is of no benefit and may be harmful. If infliximab has benefit, it is unlikely to be great.

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www.annals.org

For a list of the members of the Infliximab-GCA Study Group, see the Appendix (available at www.annals.org).

ClinicalTrials.gov registration number: NCT00076726.

A double-blind placebo controlled trial of etanercept in patients with giant cell arteritis and corticosteroid side effects

V M Martínez-Taboada,[1] V Rodríguez-Valverde,[1] L Carreño,[2] J López-Longo,[2] M Figueroa,[3] J Belzunegui,[3] E M Mola,[4] G Bonilla[4]

Results: Baseline characteristics were similar in the two groups, although patients in the etanercept group showed higher levels of basal glycaemia (p=0.02) and a higher erythrocyte sedimentation rate (ESR) (p=0.01). After 12 months, 50% of the patients in the etanercept group and 22.2% in the placebo group were able to control the disease without corticosteroid therapy (p value not significant). Patients in the etanercept group had a significant lower dose of accumulated prednisone during the first year of treatment (p=0.03). There were no differences in the number and type of adverse events.

Conclusion: The limited number of patients included in this study does not allow us to draw definitive conclusions. Etanercept therapy was well tolerated in this aged population. The therapeutic role of etanercept in patients with GCA should be evaluated in studies with a larger number of patients.

groups, although patients in the etanercept group showed higher levels of basal glycaemia ($p = 0.02$) and a higher erythrocyte sedimentation rate (ESR) ($p = 0.01$). After 12 months, 50% of the patients in the etanercept group and 22.2% in the placebo group were able to control the

mononuclear cells close to the internal elastic laminae of the inflamed vessels in patients with GCA has been reported.[15] The localisation of TNFα and its receptors in close proximity to the internal elastic laminae suggest that TNF could be involved

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Besides corticosteroids and before TCZ onset,

19 of 22 patients had also received several conventional immunosuppressive and/or biologic drugs.

Of 22 patients,

- 19 achieved rapid and maintained clinical improvement following TCZ therapy
- after a median follow-up of 9,
  - the **C-reactive protein** level had fallen from 1.9 (1.2–5.4) to 0.2 (0.1–0.9) mg/dL (p o 0.0001) and
  - the **erythrocyte sedimentation rate** decreased from 44 (20–81) to 12 (2–20) mm/1st hour (p ¼ 0.001).
  - The median dose of **prednisone** was also tapered from18.75 (10–45) to 5 (2.5–10) mg/day (p o 0.0001).

Tocilizumab for induction and maintenance of remission in giant cell arteritis: a phase 2, randomised, double-blind

	Tocilizumab plus prednisolone (N=20)	Placebo plus prednisolone (N=10)	Risk difference (95% CI)	p value
Endpoints				
Complete remissions				
After 12 weeks	17 (85%)	4 (40%)	45% (11 to79)	0·0301
After 52 weeks	17 (85%)	2 (20%)	65% (36 to 94)	0·0010
Patients whose prednisolone dose tapered to 0 mg per day	16 (80%)	2 (20%)	60% (30 to 90)	0·0041
Cumulative prednisolone dose (mg/kg)				
After 12 weeks	34 (32 to 35)	36 (34 to 39)	..	0·0477
After 26 weeks	41 (39 to 46)	66 (52 to 75)	..	0·0015
After 52 weeks	43 (39 to 52)	110 (88 to 150)	..	0·0005
Patients with any adverse event	15 (75%)	7 (70%)	5% (–29 to 39)	1·00
Patients with a serious adverse event	7 (35%)	5 (50%)	–15% (–52 to 22)	0·46
First relapse*				
Timepoint of first relapse (weeks)	11·0	12·0 (10·1 to 17·1)	..	0·77
Prednisolone dose at first relapse (mg/kg per day)	0·11	0·10 (0·09 to 0·17)	..	0·77
Erythrocyte sedimentation rate at first relapse (mm/h)	2·00	20·0 (10·0 to 30·0)	..	0·14
C-reactive protein concentration at first relapse (mg/L)	3·00	16·0 (11·0 to 25·0)	..	0·23

Data are n (%) or median (IQR) unless stated otherwise. *One patient in the tocilizumab group and five in the placebo group had first relapse.

Table 2: **Treatment effect on primary and secondary endpoints**

Tocilizumab in GCA (GiACTA)

ABSTRACT NUMBER: 911

Efficacy and Safety of Tocilizumab in Patients with Giant Cell Arteritis: Primary and Secondary Outcomes from a Phase 3, Randomized, Double-Blind, Placebo-Controlled Trial

251 patients with GCA (confirmed by temporal artery biopsy or cross-sectional imaging),

- 50 pts short-course prednisone (26 week taper) + sc placebo
- 51 pts long-course prednisone (52-week taper) + sc placebo
- 100 pts weekly subcutaneous tocilizumab, 162 mg + 26-week prednisone taper
- 49 pts every other week tocilizumab, 162 mg, plus 26-week prednisone taper.

Date of first publication: September 28, 2016

Table. Efficacy and Safety During GiACTA Part 1

	A) Short-course prednisone n = 50	B) Long-course prednisone n = 51	C) Weekly SC TCZ n = 100	D) Every other week SC TCZ n = 49
Patients in sustained remission at 52 weeks, n (%)	7 (14.0)	9 (17.6)	56 (56.0)	26 (53.1)
Cumulative CS dose, median (min-max)	3296.00 932.0-9777.5	3817.50 822.5-10697.5	1862.00 630.0-6602.5	1862.00 295.0-9912.5
AEs Patients with event, n (%)	48 (96.0)	47 (92.2)	98 (98.8)	47 (95.9)
Withdrawals Patients withdrawn from study, n (%)	6 (12.0)	5 (9.8)	15 (15.0)	9 (18.4)
Withdrawals due to an AE, n (%)	2 (4.0)	0	7 (7.0)	3 (6.1)
SAEs Patients with event, n (%)	11 (22.0)	13 (25.5)	15 (15.0)	7 (14.3)
Infection SAEs Patients with event, n (%)	2 (4.0)	6 (11.8)	7 (7.0)	2 (4.1)

At month 12, sustained remission

56% pts tocilizumab /w + prednisone
53.1% pts tocilizumab /2w + prednisone.
14% pts placebo + short-course prednisone ($P<0.0001$)
17.6% pts placebo + long-course prednisone ($P\leq0.0002$)

ACR Meeting Abstracts - http://acrabstracts.org/abstract/efficacy-and-safety-of-tocilizumab-inpatients-with-giant-cell-arteritis-primary-and-secondary-outcomes-from-a-phase-3-randomizeddouble-blind-placebo-controlled-trial/

Περιστατικό :

Έλαβε ώση 500 mg μεθυλ-πρεδνιζολόνης/3d

Εξήλθε με 32 mg Medrol (ΒΣ: 45 kgr)
Αντιοστεοπορωτική αγωγή (risendronate)
Βιταμίνη D3

Επανεξέταση 28/2/2017

- Η ασθενής σε πολύ καλή γενική κατάσταση

- Μείωση της κορτιζόνης σε 28 mg Medrol
- Προσθήκη MTX 15mg/w

Επανεξέταση 24/5/2017

- 12 mg Medrol
- MTX 15mg/w

Επανεξέταση 28/2/2017

	8/2/2017	28/2/2017	24/5/2017
WBC	7.540 (74- 18- 5)	11.210 (73,6- 21,7- 4,3)	10.920 (73-21-3,8)
Ht	31,4	38,8	40,4
Hb	9,5	12,1	13
PLT	539.000	282.000	319.000
TKE	76	7	6
CPR	7,9	0,0	0,0
Urea	16	32	27
Cr	0,7	0,71	0,76
SGOT	12	13	17
SGPT	13	18	26

Ευχαριστώ πολύ για την προσοχή σας !!