

Comment on “Polymyalgia rheumatica as the manifestation of unclassified aortitis”

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Dear editor:

We followed with great interest the case report by Kataoka et al. [1], and would like to share our experiences based on our patient diagnosed with aortitis during the course of polymyalgia rheumatica (PMR).

Our patient was a 66-year-old woman. She presented typical clinical and laboratory signs of PMR and the diagnosis was made in accordance with the Bird criteria [2]. She did not meet the 1990 ACR criteria for giant cell arteritis (GCA) [3]. Ultrasonography of the temporal arteries revealed no pathological signs. We did not perform temporal artery biopsy. Contrast-enhanced computerized tomography (CT) of the whole aorta was performed, revealing up to 5.5 mm aortic wall thickening that had spread over the whole aorta and pericardial effusion (Fig. 1). The aortic wall thickness was the mean of measurements taken at four positions: 3, 6, 9 and 12 o'clock, perpendicular to the center of the vessel lumen, at the level of maximal wall thickness, in the absence of atherosclerotic plaques. We made a diagnosis of PMR with suspected GCA, and applied high-dose methylprednisolone therapy (500 mg/

day, for three days). We consequently obtained prompt remission of all clinical and radiological signs (Fig. 2).

Aortitis can be a symptom of many different connective tissue diseases. It is most characteristic of Takayasu arteritis followed by GCA [4]. There are also some documented cases of PMR with aortic wall involvement [5], although for a practicing doctor aortitis seems inconsistent with a mild course of the disease. Therefore, we agree with Kataoka et al. that it is difficult to classify aortitis in patients with symptoms of PMR but without evidence of GCA. However, we find contrast-enhanced CT of the aorta to be a useful aid when deciding on the treatment intensity and monitoring treatment efficacy. We find that early diagnosis and intensive treatment are crucial to avoiding GCA complications, like ischemic optic neuropathy [5]. In patients with symptoms of PMR and signs of aortitis in CT we tend to apply more aggressive treatment. Methylprednisolone pulse therapy, which we applied in our patient, is not a standard treatment of PMR or GCA, as it does not permit better disease control [6]. However, there are no studies that compare different treatment strategies in patients with aortitis during the course of PMR or GCA. We hypothesize that immediate therapeutical response and the possible reduction of arteritis complications could be great advantages in methylprednisolone pulse therapy. This also allows a lower oral prednisolone dose to be then administered. Based on experience with lupus aortitis, long-term prednisolone therapy in patients with aortitis might enhance atherosclerosis and aneurysm formation [7].

We regret that Kataoka et al. did not supply any information on the aortic wall thickness before and after the treatment, as to our knowledge this problem has not been extensively studied, and no normal values are defined. The

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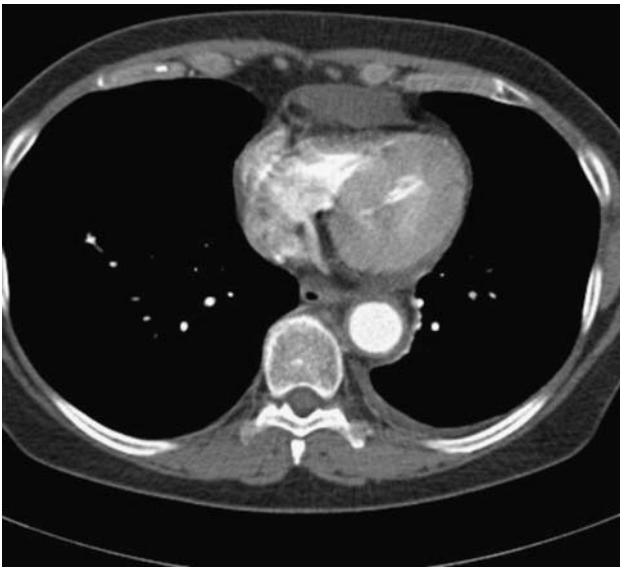


Fig. 1 Contrasted CT, revealing thickening of the aortic wall, pericardial and pleural effusion

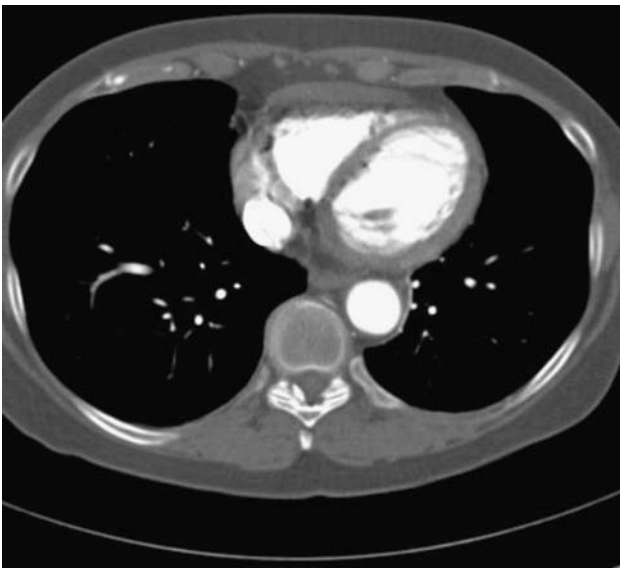


Fig. 2 No aortic wall thickening and no pleural effusion in CT performed 3 weeks after the start of treatment. Reduction of pericardial effusion also occurred

diagnosis of aortitis is often based on a comparison with a control image after the treatment.

We agree with Kataoka et al. that an imaging evaluation of the aorta should be recommended for patients with PMR symptoms. Based on our experiences, this may be especially helpful in severe, recurrent or drug-resistant PMR cases where GCA is suspected. The utility of CT of the aorta when choosing the treatment strategy should be further examined in prospective studies of patients with PMR symptoms.

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