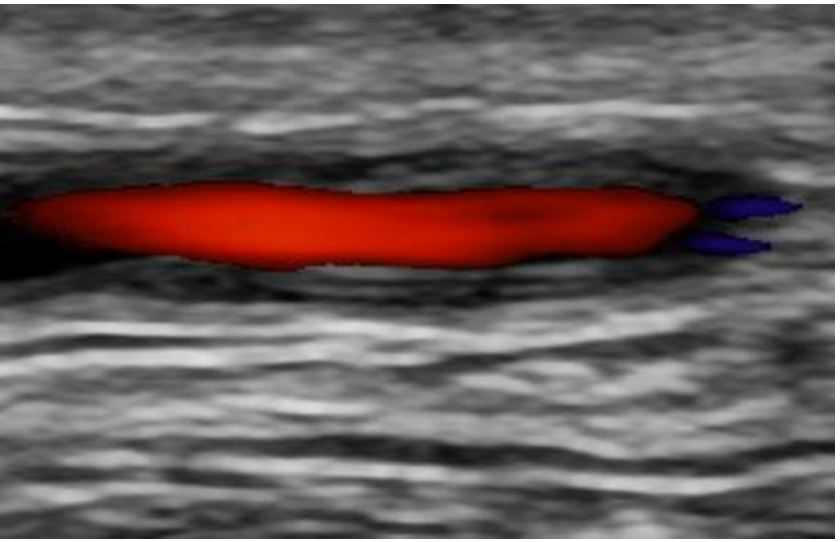
Balancen mellem gavn og skade i diagnostik og behandling af kæmpecellearterit og polymyalgia reumatika



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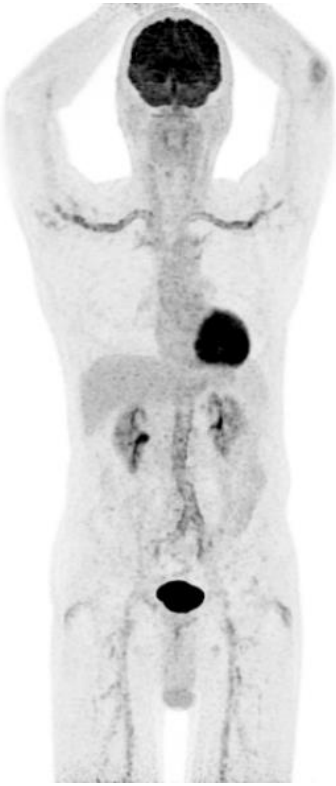
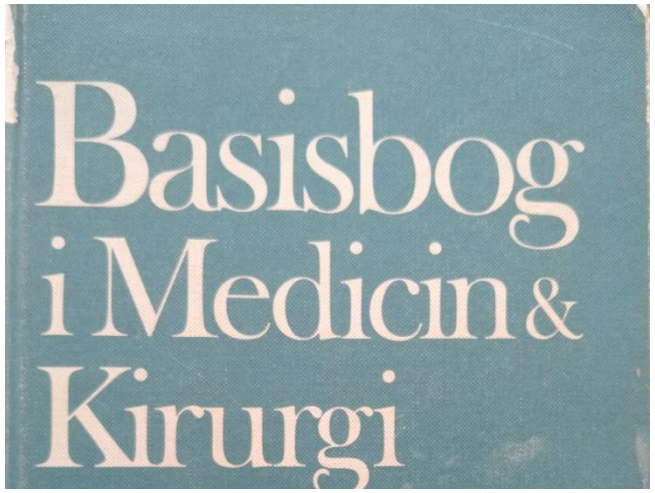


Kæmpecellearterit dengang far var ung



Basisbog i Medicin og Kirurgi
2. udgave 1. oplag

DIAGNOSE

Sygdommen diagnosticeres på grundlag af arteriebiopsi, som, hvis den kliniske mistanke er stærk og den primære biopsi er negativ, må gentages, eventuelt udført bilateralt.

TERAPI

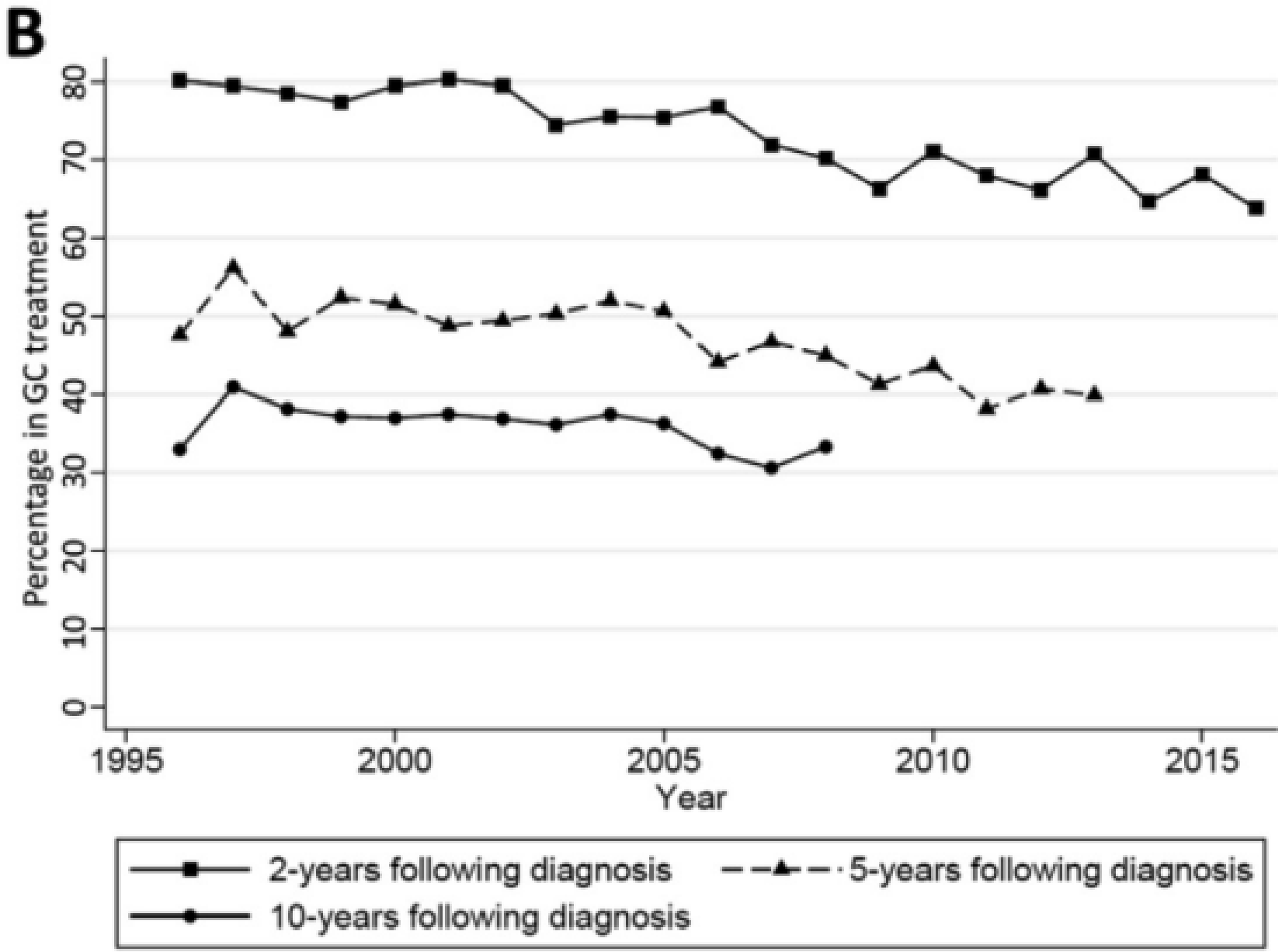
Hovedmidlet er glukokortikoider, som fremkalder en prompte klinisk og laboratoriemæssig remission. De virker ganske vist kun symptomatisk og afkorter næppe sygdomsvarigheden, men de reducerer hyppigheden af de alvorlige komplikationer: synsnedsættelse og cerebrale vaskulære insulter stærkt. Derfor må behandlingen startes omgående, eventuelt allerede før biopsisvar foreligger. Initialt gives f. eks. prednison 10–15 mg 3 gange dagligt per os. Den fortsatte dosering afhænger af den kliniske virkning og SR. Behandlingen må fortsætte, indtil der ikke ses fornyede aktivitetstegn ved reduktion af dosis.

Medicinsk Kompendium, 16. udgave, 2004.

Parakliniske fund. *Biopsi* fra arteria temporalis superficialis er den vigtigste diagnostiske undersøgelse. Biopsien bør tages, så snart mistanke om

Behandling. Kæmpecellearteriitis behandles med glukokortikoider. Hos patienter med lokale symp-

Forløb og prognose. Sygdomsforløbet er som regel langvarigt, og strækker sig over 1-3 år, undertiden længere, men sygdommen helbredes i langt de fleste tilfælde. Ved recidiv under behandlingen



Therkildsen 2021, Seminars in Arthritis and Rheumatism

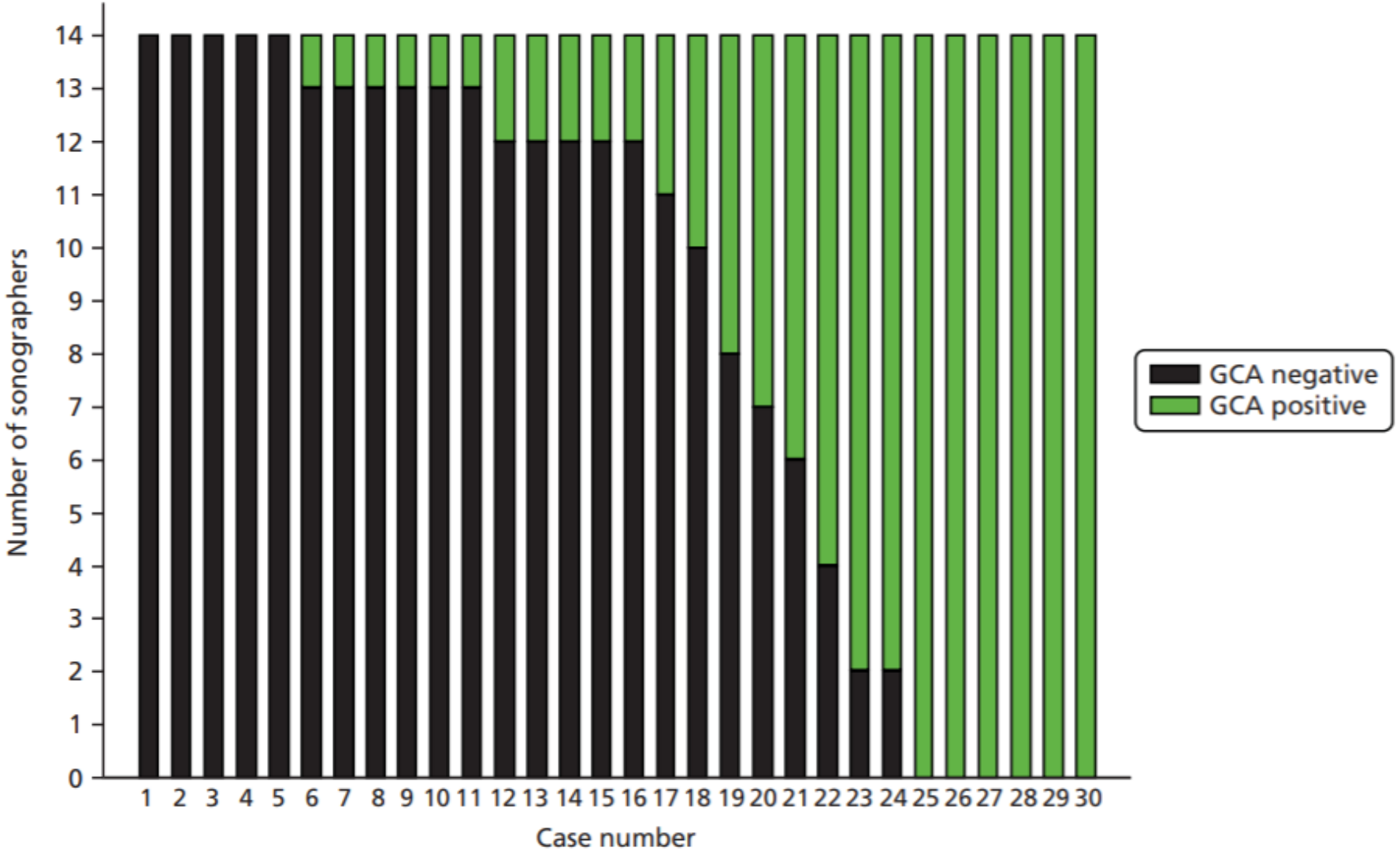


FIGURE 14 Frequency of evaluations consistent with or not consistent with GCA by 14 pathologists rating 30 cases.

Luqmani 2016, Health Technol Assess

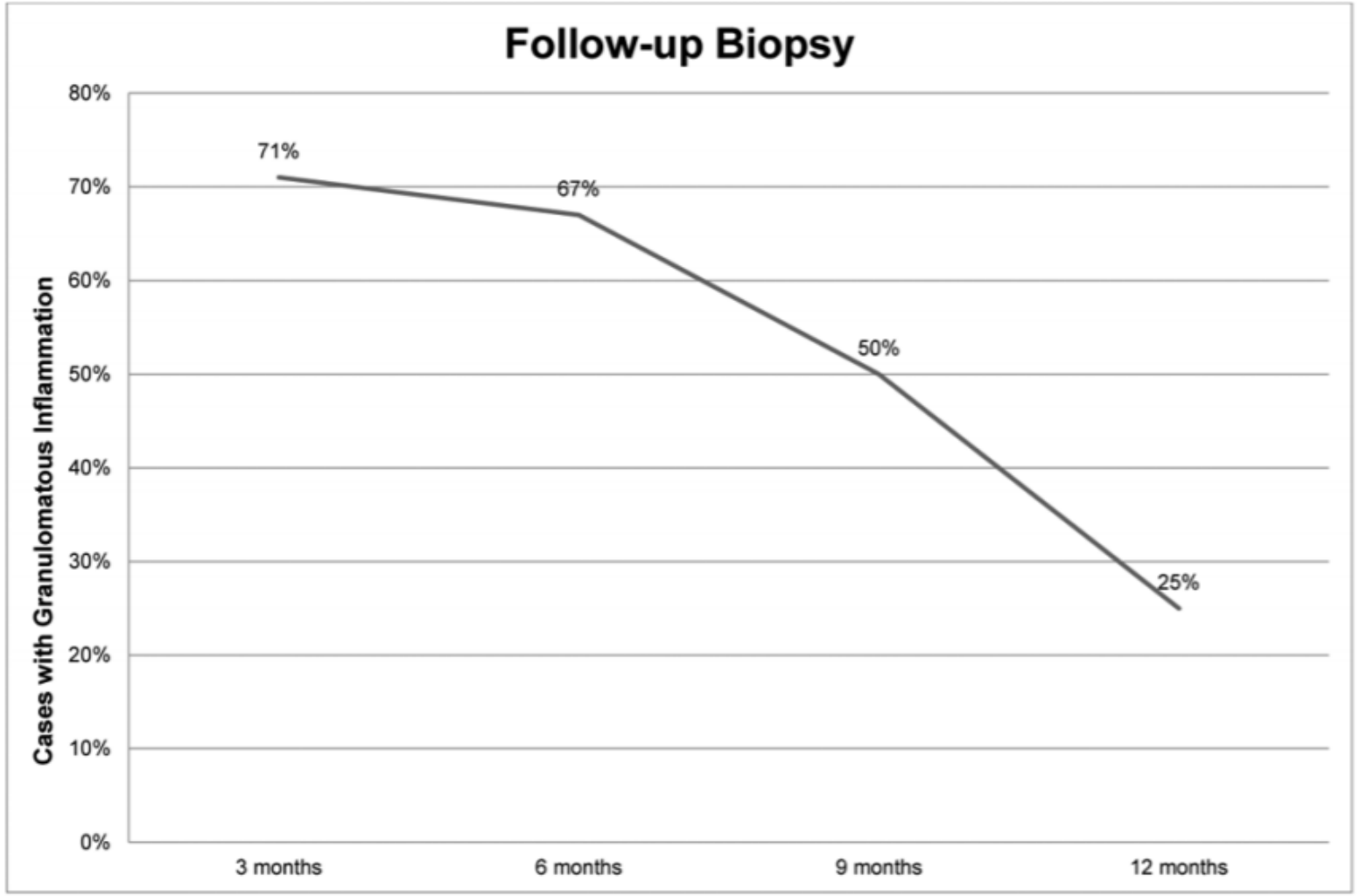


Figure 2.
The incidence of granulomatous inflammation in second temporal artery biopsies by cohort. Overall, the incidence of granulomatous inflammation detected in a biopsy is indirectly related to the length of glucocorticoid therapy.

Maleszewski 2017, Mod Pathol.

GCA- Ultralyd

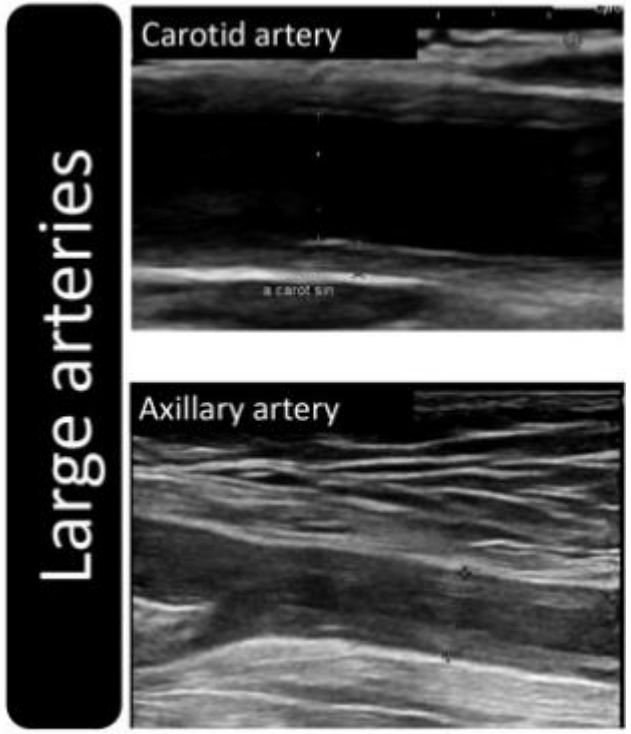
RHEUMATOLOGY

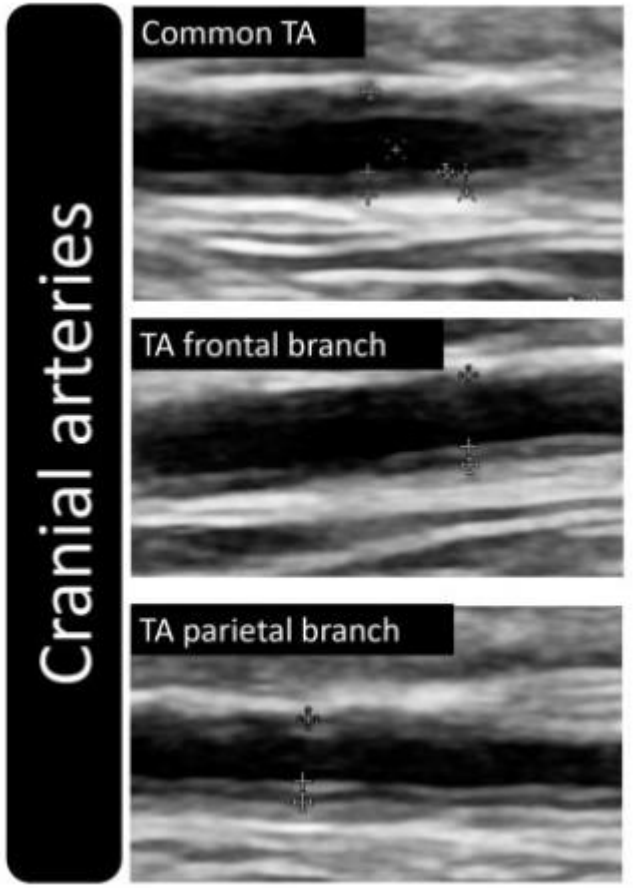
Rheumatology 2019;0:1–12
doi:10.1093/rheumatology/kez568

Original Article

Diagnostic accuracy of ultrasound for detecting large-vessel giant cell arteritis using FDG PET/CT as the reference

Berit Dalsgaard Nielsen [1,2,3], Ib Tønder Hansen[1,2], Kresten Krarup Keller[1,3], Philip Therkildsen[1,2], Lars Christian Gormsen[2,4] and Ellen-Margrethe Hauge[1,2]





Ultrasound

(A) US of temporal and large arteries in overall GCA diagnosis

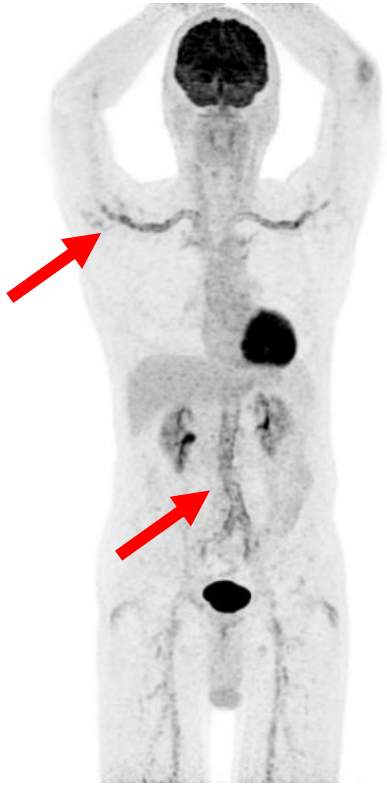
	All GCA (LV-GCA + c-GCA)	Controls
LV or TA US pos	51	1

Sensitivity	91% (80–97)
Specificity	97% (85–100)

Nielsen 2019, Rheumatology

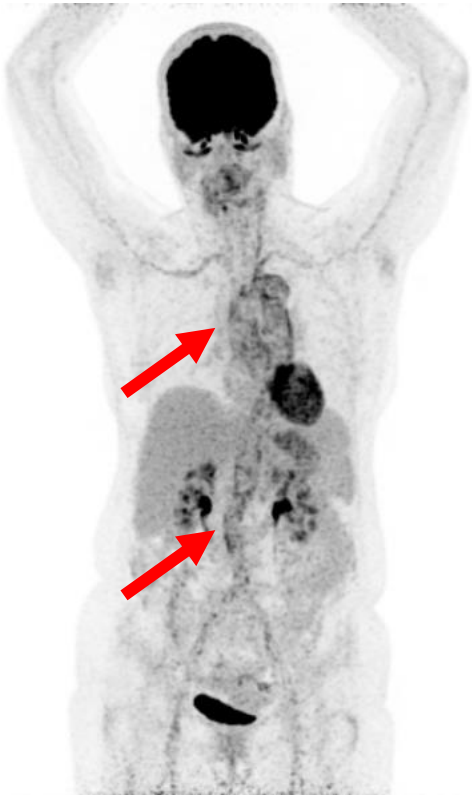
PET kan diagnosticere LV-GCA

LVV – Aorta + subclavia



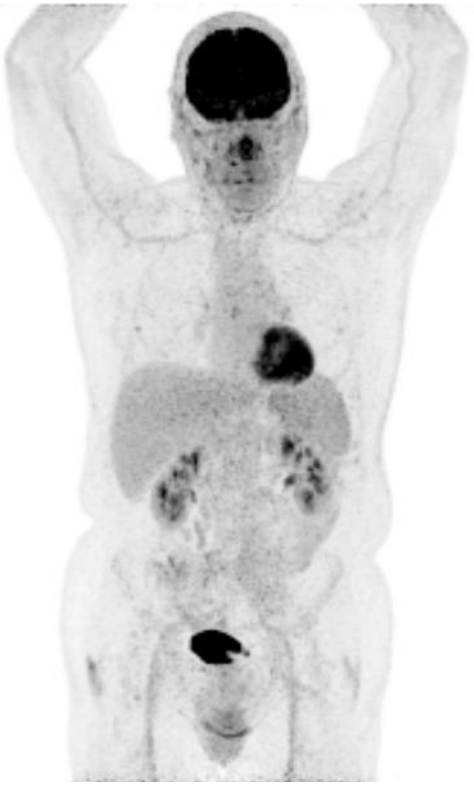
”T-shirt”

LVV – Aorta



”Stok”

Vaskulit?



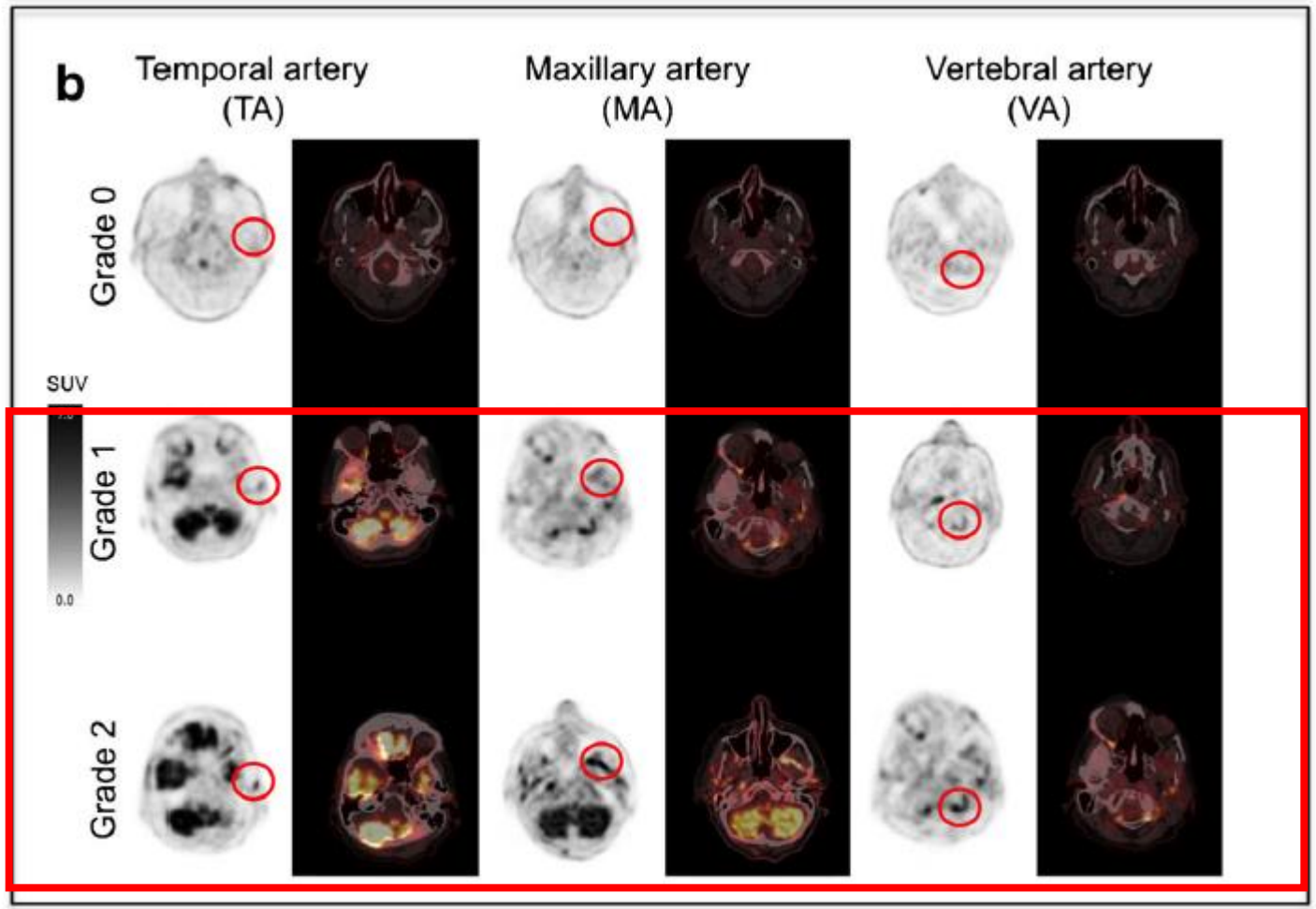
Dejaco 2018, Ann Rheum Dis

European Journal of Nuclear Medicine and Molecular Imaging
https://doi.org/10.1007/s00259-018-4106-0

ORIGINAL ARTICLE

Simple dichotomous assessment of cranial artery inflammation by conventional 18F-FDG PET/CT shows high accuracy for the diagnosis of giant cell arteritis: a case-control study

Berit Dalsgaard Nielsen[1,2] · Ib Tønder Hansen[1,2] · Stine Kramer[3] · Ate Haraldsen[3] · Karin Hjorthaug[3] · Trond Velde Bogsrud[3] · June Anita Ejlersen[4] · Lars Bjørn Stolle[5] · Kresten Krarup Keller[1] · Philip Therkildsen[1,2] · Ellen-Margrethe Hauge[1,2] · Lars Christian Gormsen[3]

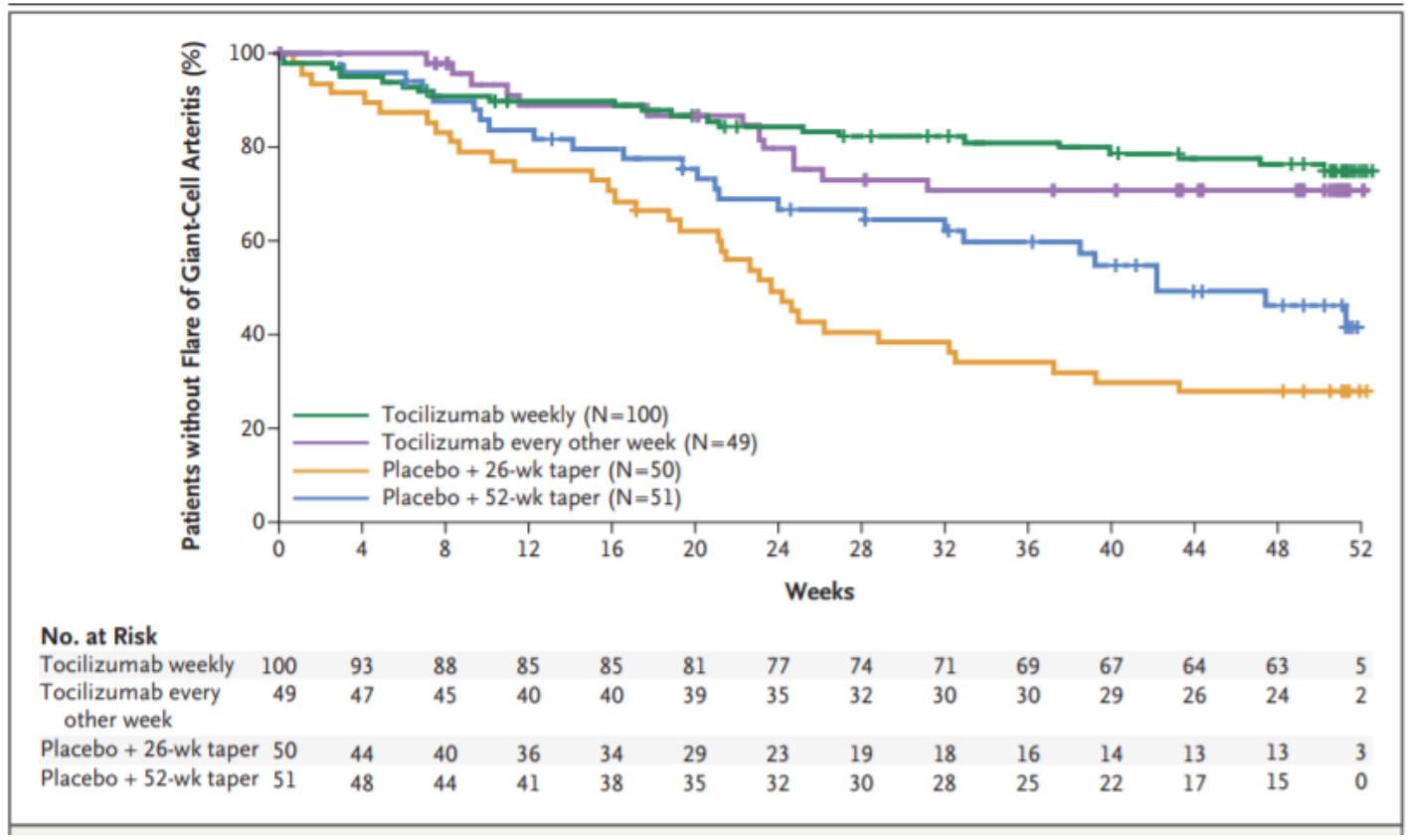


The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JULY 27, 2017 VOL. 377 NO. 4

Trial of Tocilizumab in Giant-Cell Arteritis

J.H. Stone, K. Tuckwell, S. Dimonaco, M. Klearman, M. Aringer, D. Blockmans, E. Brouwer, M.C. Cid, B. Dasgupta, J. Rech, C. Salvarani, G. Schett, H. Schulze-Koops, R. Spiera, S.H. Unizony, and N. Collinson



No. at Risk

Tocilizumab weekly	100	93	88	85	85	81	77	74	71	69	67	64	63	5
Tocilizumab every other week	49	47	45	40	40	39	35	32	30	30	29	26	24	2
Placebo + 26-wk taper	50	44	40	36	34	29	23	19	18	16	14	13	13	3
Placebo + 52-wk taper	51	48	44	41	38	35	32	30	28	25	22	17	15	0

Udfordring med komplikationer er ikke løst

TABLE 3 Risk of thoracic aortic aneurysms in the GCA cohort compared with the reference cohort strati

	Number	10 years following index				
		Crude			Adjusted[a]	
		CIP (95% CI)	RD (95% CI)	RR (95% CI)	RD (95% CI)	RR (95% CI)
Overall	9908	1.1 (0.9, 1.4)	1.0 (0.7, 1.2)	6.52 (4.90, 8.67)	1.0 (0.7, 1.2)	7.39 (5.23, 10.5)
Female, positive TAB	2330	1.8 (1.2, 2.4)	1.7 (1.0, 2.3)	12.6 (7.58, 21.0)	1.7 (1.0, 2.3)	12.9 (7.64, 21.8)
<70 years, positive TAB	1018	3.0 (1.7, 4.2)	2.9 (1.6, 4.1)	30.1 (13.5, 67.3)	2.9 (1.6, 4.1)	29.6 (12.9, 67.9)
Female, <70 years, positive TAB	667	3.2 (1.7, 4.8)	3.1 (1.6, 4.7)	34.9 (12.9, 94.6)	3.1 (1.6, 4.7)	41.0 (12.2, 138)

<70 years, Female, Positive biopsy:

Relative risk: 41 (12.2, 138)

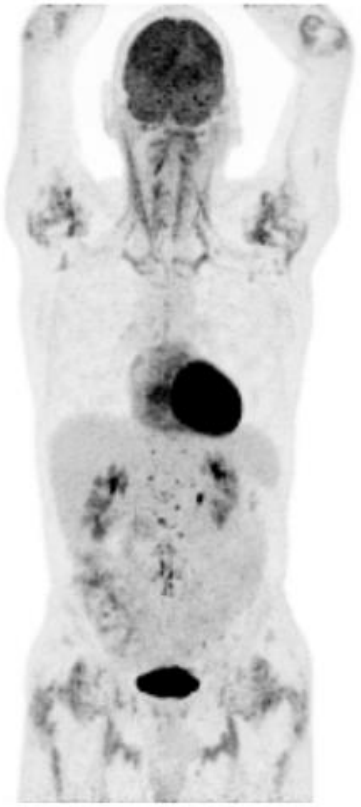
Risk difference: 3.1

Therkildsen 2022, Rheumatology

Polymyalgi

- Diagnostik:
  - Stor risiko for fejldiagnosticering.
  - PET/CT mulig ny diagnostisk metode.
    - PET/MR og nye tracere kan blive afgørende i fremtiden.

- Behandling:
  - Studier med IL6 hæmmer har vist effekt (behandlingsrefraktære).
  - Mange igangværende studier.
    - Studier med behandlingsstrategi vigtige.



Hvor skal patienterne diagnosticeres og følges

Table 2. Management of referrals and treatment strategy for rheumatologists

		Geographical region						Income	
	All participants	Europe and Central Asia	North America	Latin America	East Asia and Pacific	South Asia	Middle East and Africa	High-income countries	Low- and middle-income countries
Management of referrals									
GPs can discuss patients prior to referral, *n* (%)	579 (64)	260 (81)	61 (79)	67 (46)	45 (78)	32 (57)	114 (47)	359 (78)	220 (50)
Referred patients seen by rheumatologist (%), median (IQR)	100 (80–100)	100 (90–100)	100 (100–100)	100 (90–100)	100 (100–100)	100 (80–100)	90 (10–100)	100 (95–100)	100 (20–100)
Evaluation of suspected new PMR patients >2 weeks after referral, *n* (%)	348 (39)	127 (40)	57 (75)	86 (59)	30 (53)	3 (6)	43 (18)	234 (51)	117 (27)
Evaluation of suspected new PMR patients >4 weeks after referral, *n* (%)	166 (19)	63 (20)	18 (24)	48 (33)	14 (24)	1 (2)	24 (10)	106 (23)	61 (14)
Referred patients with established PMR diagnosis (%), median (IQR)	20 (3–50)	30 (10–50)	37 (10–55)	10 (1–50)	50 (15–70)	10 (0–25)	5 (0–25)	30 (10–50)	5 (0-33)
Diagnosis changed upon evaluation of patients with established PMR diagnosis (%), median (IQR)	15 (5–30)	15 (10–30)	20 (10–45)	10 (0–50)	20 (15–40)	20 (0–50)	10 (0–30)	20 (10–30)	10 (0–30)
Prednisolone									
Started prior to evaluation (%), median (IQR)	50 (15–75)	50 (30–80)	60 (50–80)	50 (10–60)	55 (30–90)	50 (10–60)	25 (5–50)	50 (30–80)	30 (5–50)
Initial dose (mg), median (IQR)	20 (15–20)	16 (15–20)	20 (15–20)	20 (15–30)	15 (15–15)	20 (15–30)	20 (15–30)	15 (15–20)	20 (15–30)
Initial dose > 25 mg, *n* (%)	216 (23)	34 (10)	5 (6)	47 (31)	0 (0)	20 (35)	110 (41)	4 (8)	178 (38)
Duration of treatment (months), median (IQR)	12 (6–18)	12 (12–18)	12 (10–18)	10 (6–12)	15 (12–18)	11 (6–12)	6 (3–18)	12 (12–18)	6 (3–12)
Duration of treatment <6 month, *n* (%)	133 (14)	13 (4)	2 (3)	35 (23)	4 (7)	6 (11)	72 (27)	14 (3)	118 (25)

IQR: interquartile range; GP: general practitioner.

Donskov 2023, Rheumatology

Fremtidsvision: Hvordan ser det ud om 10 år

- Diagnostik for både GCA og PMR med høj sensitivitet og specificitet.
- Nye og bedre metoder til at monitorere sygdommene.
- Væsentlig flere behandlinger og behandlingsstrategier – På vej mod personlig medicin

Kresten Krarup Keller
krekel@rm.dk