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【 PICTURES IN CLINICAL MEDICINE 】

Large-vessel Vasculitis of Extremities without Aortic Involvement

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Key words: RS3PE syndrome, giant cell arteritis, large-vessel vasculitis, limb arteritis

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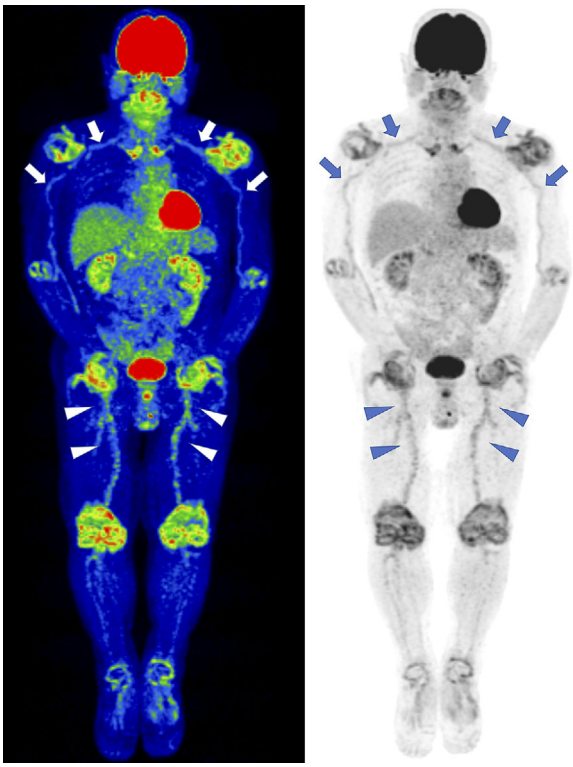

Picture.

An 82-year-old man presented with a 3-month history of polyarthritis. Musculoskeletal ultrasound revealed bursitis, and synovitis in shoulders, wrists, and knee joints. A blood test revealed high C-reactive protein (CRP) (14.3 mg/dL) and erythrocyte sedimentation rate (ESR) (95 mm/h) with negative rheumatoid factor and anti-cyclic citrullinated peptide antibody. Whole-trunk contrast-enhanced computed tomography (CT) did not show aortitis. There were no halo signs in the temporal arteries. He was diagnosed with polymyalgia rheumatica (PMR). Prednisolone 15 mg/day did not completely relieve the symptoms. Two months later, he developed intermittent claudication of the lower legs, occurring several minutes after walking. Positron emission tomography-CT revealed a mildly increased uptake in the subclavian and brachial arteries (arrows) and an apparently increased accumulation in the femoral arteries (arrowheads) in addition to the shoulders, elbows, wrists, knees and ankle joints (Picture). Tocilizumab, initiated at the diagnosis of large-vessel vasculitis, led to the resolution of claudication. Giant cell arteritis uncommonly presents with upper or lower extremities vasculitis alone (1, 2). However, concomitant limb vasculitis should be suspected in patients with PMR who do not respond to standard treatment.

The authors state that they have no Conflict of Interest (COI).

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