Commentary

Giant cell arteritis (GCA) is the most common form of systemic vasculitis affecting adults aged ≥50 years. The most common clinical features of GCA are constitutional symptoms, headache, visual symptoms, and jaw claudication. Headache is reported in nearly three-quarters of patients,[1] which is most commonly localized in the temporal area. However, the nature and location of the headache are highly variable. GCA may result in devastating complication, which is irreversible loss of vision. In the current study, atypical type of headache; tension-type headache; was the initial presentation of GCA, which resulted in diagnostic dilemma.[2]

Around 40% of GCA patients presented with atypical clinical manifestations such as fever of unknown origin, respiratory symptoms, and neurological symptoms.[3] Thereafter, it is not uncommon the diagnosis of GCA is delayed when the patient is presented with atypical clinical features. Indeed, some of the typical manifestations may also be caused by other diseases such as chronic infections or malignancies.

Because GCA is a treatable disease and the character of headache is highly variable, it should be considered in elderly patients who present with any type of headache with anemia and/or elevated inflammatory markers. The physician faced with such a patient, who present with atypical clinical features of GCA, has a difficult challenge. The goal is to rule out other diseases that may mimic GCA and to quickly and correctly identify and treat patients who have GCA. In this interesting study, the authors have emphasized the importance of considering GCA as a potential diagnosis for elderly patients with new onset headache located in a non-temporal region.[2]

Glucocorticoids are the cornerstone treatment for GCA; however, using glucocorticoids for a long time is associated with numerous side effects that results in a significant morbidity burden. The evidence about different disease modifying anti-rheumatic drugs

(DMARDs) as adjunctive and steroid-sparing agents in patients with GCA is not that strong. In the era of biological therapy, tumor necrosis factor α (TNF-α) inhibitors have been tried but unfortunately, the therapeutic efficacy of these agents has not been observed for GCA. Interestingly, Tocilizumab, IL-6 blocker, has been used successfully to treat patients with GCA.[4]

In conclusion, this study is helpful for demonstrating the difficulty in diagnosing GCA when presented with atypical clinical features as well as the importance of starting the effectiveness treatments as soon as possible.

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