Short communication

Giant cell arteritis—an incidental finding

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Abstract

Giant cell arteritis is a systemic, inflammatory, and vascular syndrome that requires early diagnosis and immediate management because of the risk of loss of vision. Local symptoms include headache, scalp tenderness, jaw claudication, visual disturbances, and scalp necrosis. Systemic symptoms include weight loss, fever, malaise, fatigue, and polymyalgia rheumatica. We describe a case that was identified histologically as an incidental finding after excision of a basal cell carcinoma from the parietal area of the scalp. A search of PubMed and Medline using the keywords “giant cell arteritis”, and “incidental histopathological diagnosis” returned no similar previously published cases in the head and neck. We present this as an unusual and interesting case.

Keywords: Giant cell arteritis; Incidental diagnosis; Asymptomatic patient

Case report

An 86-year-old woman presented to the department of maxillofacial surgery for wide local excision of a basal cell carcinoma from the parietal area of the scalp after referral by her general medical practitioner. Her medical history of note was previous excision of multiple cutaneous basal cell carcinomas, a lacunar infarct in 2000, and controlled hypertension. Biopsy examination confirmed diagnosis of the lesion (Fig. 1) and it was excised under local anaesthetic. Histopathological examination showed giant cell arteritis in the tissue deep to the excised tumour. The report described “striking inflammatory changes with luminal obliteration and frequent mural giant cells” (Figs. 2 and 3), which is indicative of giant cell arteritis. Her C-reactive protein (CRP) was 90 mg/L (normal is up to 5), and plasma viscosity was 2.15 mPa s (normal 1.5–1.72). Although asymptomatic, she was started on a reducing course of oral prednisolone supervised by her general medical practitioner.

Discussion

Giant cell arteritis occurs almost exclusively in patients over 50 years of age and varies greatly in reported incidence.1–3 However, there is strong suggestion that the incidence is increasing even after compensation for the increasing age of the population.4 We have described a very unusual, incidental diagnosis of giant cell arteritis in an asymptomatic patient. We know of no published reports of this in the head and neck, but similar findings have been published in gynaecological publications. Onuma et al. described an incidental finding that involved the bilateral adnexa in a 75-year-old woman.5 Incidental findings have also been suggested on positron emission tomography computed tomography (CT) following investigation for other conditions. The abnormal finding compatible with arteritis is increased uptake of fluorodeoxyglucose in the aorta, carotid, iliac, femoral, and subclavian arteries. Two cases were described were confirmed by positive biopsy findings from the temporal artery.6,7

We diagnosed the condition pathologically and by the raised CRP. The vessel on which the diagnosis was made is most likely a parietal branch of the superficial temporal
artery. CRP is a more sensitive diagnostic test for giant cell arteritis than erythrocyte sedimentation rate.8

A diagnosis of giant cell arteritis is classed as an ophthalmological emergency as visual loss has been reported in up to 60% of patients. As biopsy examination of the temporal artery is the gold standard technique for diagnosing the condition, and because of the risk of severe complications, our patient was managed medically. Scalp necrosis is a complication,9

so it was interesting that the surgical site on the scalp had healed uneventfully before prednisolone had been started.

References


