Case Report

Early Diagnosis of Large Vessel Vasculitis: Usefulness of Positron Emission Tomography With Computed Tomography

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A R T I C L E   I N F O

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A B S T R A C T

Fever of unknown origin is a diagnostic challenge. Among its causes are Large Caliber Vessels Vasculitis (LCVV), including Takayasu arteritis (TA) and giant cell arteritis (GCA). Early diagnosis is vital to prevent fibrosis of the vessel wall, and consequently, stenoses, aneurysms or occlusions. Imaging techniques can be of great help in recent years, highlighting the temporal artery through ultrasound, MRI and PET-CT.

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Diagnóstico precoz de las vasculitis de grandes vasos. Utilidad de la tomografía por emisión de positrones con la tomografía axial computarizada

R E S U M E N

La fiebre de origen desconocido supone un reto diagnóstico. Entre sus causas se encuentran las Vasculitis de Grandes Vasos (VGV), que incluyen la Arteritis de Takayasu (AT) y de Células Gigantes (AGC). Resulta de vital importancia su diagnóstico precoz para evitar la fibrosis de la pared vascular, y como consecuencia, estenosis, aneurismas o oclusiones. Las técnicas de imagen nos pueden resultar de gran ayuda, destacando en los últimos años la ecografía de la arteria temporal, la RM y el PET-TC.

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Introduction

The diagnosis of large vessel vasculitis (LVV) is challenging because many of the clinical manifestations are nonspecific and are shared with other types of vasculitis and with various systemic diseases. Both Takayasu’s arteritis (TA) and giant cell arteritis (GCA) are considered LVV. It is vital to reach an early diagnosis in order to prevent fibrosis of the vessel wall, and as a result, stenosis, aneurysms or occlusions. Imaging techniques can be helpful, and in recent years the role of temporal artery ultrasound, magnetic resonance imaging (MRI) and the combination of positron emission tomography with computed tomography (PET-TAC) has been highlighted.

This paper describes 2 cases in which the use of PET-CT was definitive for the diagnosis, and then analyzes other imaging techniques.

Case 1

We present the case of a 43-year-old woman with a history of chronic sinusitis, corneal ulcers and relapsing blepharitis, treated with 30 mg of prednisone day after being studied in the infectious diseases unit due to persistent low-grade fever of 37.5 °C, where a microbiological origin was ruled out. A few weeks after presenting clinical improvement, her fever returned for 15 days, improving with antipyretics; her blood pressure (BP) levels were...
100/60 mmHg and she presented paresthesias of her left foot. An electrophysiology study was conducted and showed an electroneu- rogaphic pattern of conduction block at the left distal posterior tibial nerve, compatible with peripheral nervous system vasculitis. Laboratory tests showed mild leukocytosis with a small leftward shift, erythrocyte sedimentation rate (ESR) of 97 mm (normal values up to 25 mm) and C reactive protein (CRP) of 1.22 mg/dl (normal to 0.5 mg/dl) with negative antineutrophil cytoplasm antibodies (ANCAS). A cerebrospinal fluid study showed pleocytes and lymphocytes. The first clinical suspicion was polyarteritis nodosa (PAN), so we decided to perform a muscle and sural nerve biopsies that were nonspecific. Because of the history of sinusitis, the diagnosis of microscopic polyangiitis or Wegener’s granulomatosis (WG) had to be ruled out, which we did after a biopsy of the affected mucosa. At all times peripheral pulses remained present and symmetrical, with no significant differences in BP between the 2 arms; there were no murmurs on auscultation of the aorta or subclavian arteries and the patient did not complain of fatigue or discomfort and presented no claudication. Within 10 days of admission she presented occipital and frontal headache with photophobia and little improvement with analgesic treatment as well as hypertension (160/95 mmHg) which responded with the administration of ACE inhibitors. Keeping with our clinical suspicion of vasculitis we conducted a magnetic resonance angiography (MRA) of the aorta (Ao), which showed no abnormalities, a brain MRI which confirmed the existence of pachymeningitis and a thoracoabdominal CT that showed a small infrarenal aneurysm cm² diameter. Finally, we performed a PET-CT which showed hypermetabolic lesions of the pulmonary bifurcation and the abdominal Ao wall (Fig. 1), which along with gender, age, involvement of large vessels (Ao and pulmonary), the presence of aneurysms, the negativity of ANCAS, the result of the biopsy and exclusion of PAN and GW, very likely led the diagnosis of Takayasu’s arteritis (TA) with the added difficulty of performing a biopsy of the affected area.

Case 2

This case was a 74-year-old woman with pain and weakness of the shoulders and hips, with morning stiffness of more than 1 h and elevated acute phase reactants. Suspecting polymyalgia rheumat-ica (PR) we administered 30 mg/day of prednisone with initial improvement, but rapid recurrence of symptoms and deterioration in the laboratory tests, with a hemoglobin of 8 mg/dl, CRP 19 mg/dl and an ESR of 120 mm in the first hour. The patient reported no headache, jaw claudication or tenderness on the temporal artery and peripheral pulses were normal. Suspecting a neoplasia we requested tumor markers, a thoracoabdominal CT, gastroscopy and colonoscopy, all with normal results; the study was completed, finally, with the performance of a PET-CT (Fig. 2) which evidenced a vasculitic process in the Ao, innominate, carotid and subclavian arteries. Given the strong suspicion of GCA we performed a temporal artery biops, which confirmed the diagnosis.

Discussion

GCA is a granulomatous polyarteritis which affects arteries of medium and large caliber, with a predilection for the cranial branches of the arteries originating from the aortic arch, although in about 15% it may affect the entire Ao and its main branches. Its etiology remains unknown. Diagnosis is histological and done by finding a granulomatous inflammation in which giant cells are located between the intima and media. The lesions and the evolution of focal inflammation lead to a wall thickening and fibrosis with stenosis and subsequent occurrence of ischemic events. Among the most common symptoms found: headache, malaise, fever and myalgia.2 TA is a LVV which mainly affects the Ao and its main branches such as coronary or pulmonary arteries. It predominates in young women. It presents an early stage where the symptoms are non-specific, such as fever, and late-stage symptoms associated with ischemic events such as arm claudication, low pulses or high blood pressure. Histology is shared with GCA, with some authors arguing that this may be the same disease.3

In 1990 the American College of Rheumatology established a series of clinical, radiological and histological classification criteria for LVV, with a sensitivity of 93.5% and a specificity of 90.5% for GCA,4 and 91.2% and 97.8% respectively for TA, in patients with a positive biopsy.4 These criteria are still applied today, although approximately 40% and 70% of these vasculitis do not meet any of
Table 1
Meller Visual Scale.

<table>
<thead>
<tr>
<th>Liver uptake</th>
<th>Tissue uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No uptake</td>
</tr>
<tr>
<td>1</td>
<td>Decreased uptake by the liver</td>
</tr>
<tr>
<td>2</td>
<td>Equal uptake</td>
</tr>
<tr>
<td>3</td>
<td>Increased uptake</td>
</tr>
</tbody>
</table>

Grade 1: probable atheromatosis; Stage 2–3: active inflammation of large vessels in the thoracic aorta.

Any visible uptake in other segments.

Currently, several studies show that PET–CT is effective in the detection of large vessel vasculitis and evaluation of the extent of disease, with a sensitivity which ranges from 77% to 100% and with 85% to 100% specificity, making it an important aid in the diagnosis of patients with fever of unknown origin.12

Conclusions

TA and GCA are LVV that require histopathological confirmation. In the case of TA, due to the location of the involved arteries, arterial biopsy is often not an option, and in the case of GCA, biopsy sometimes does not provide a high diagnostic yield due to the involvement of irregular affection of vessels or the use of glucocorticoids prior to its execution. In both cases imaging techniques may prove highly profitable for diagnostic confirmation. In recent years, PET–CT gained increasing importance as a diagnostic technique, being non-invasive and having a superior sensitivity to magnetic resonance angiography. It detects more affected regions than MRI and at an earlier stage.

However, the main indication for PET–CT, at this time, in the initial diagnosis of arteritis of large vessels would be confirmation of vascular inflammatory disease when the clinical presentation and the findings of other imaging techniques provide nonspecific information.

Ethical Responsibilities

Protection of People and Animals. The authors state that no experiments were performed on humans or animals.

Data Confidentiality. The authors declare that they have followed the protocols of their workplace on the publication of data from patients and all patients included in the study have received sufficient information and gave their written informed consent to participate in this study.

Right to Privacy and Informed Consent. The authors have obtained informed consent from patients and/or subjects referred to in the article. This document is in the possession of the corresponding author.

Conflict of interest

The authors have no conflict of interest to declare.

References

10. Positron emission tomography (PET) is based on the distribution of glucose analog, radiolabeled deoxyglucose which emits positrons –18-fluor–, administered intravenously and distributed through the organs following the metabolic pathway of glucose uptake. PET does not provide a good spatial resolution, so to overcome this limitation, it is complemented by CT, and by overlaying the 2 images a combination of precise anatomic localization and functional status of metabolically active lesions is achieved in a single image, a PET-CT. Glucose is stored not only in the vasculitic vessels but is captured by atheroma plaques, where there is inflammation, which reduces the specificity of the test, although in the thoracic Ao the intensity and pattern of uptake enable differentiation, using the Meller visual scale (Table 1), which compares the vascular uptake of 18F-FDG with the accumulation thereof in the liver, demonstrating its later validity to assess the degree of inflammation and the activity of the disease.11
