Giant cell arteritis treatment

No known cure for giant cell arteritis. Steroids can produce symptomatic relief and usually prevent blindness (progression of ocular problems 24–48 hrs after the institution of adequate steroids is rare). Totally blind patients or those with longstanding partial visual loss are unlikely to respond to any treatment.

1. for most cases:

a) start with prednisone, 40–60 mg/d PO divided BID-QID (qod dosing is usually not effective in initial management)

b) if no response after 72 hrs, and diagnosis certain, ↑ to 10–25mg QID

c) once response occurs (usually within 3–7 days), give the entire dose as q AM dose for 3–6 weeks until symptoms resolved and ESR normalizes (occurs in 87% of patients within ≈ 4 weeks) or stabilizes at < 40–50 mm/hr

d) once quiescent, a gradual taper is performed to prevent exacerbations: reduce by 10 mg/d q 2–4 weeks to 40 mg/d, then by 5 mg/d q 2–4 wks to 20 mg/d, then by 2.5 mg/d q 2–4 wks to 5–7.5 mg/d which is maintained for several months, followed by 1 mg/d decrements q 1–3 mos (usual length of treatment is 6–24 mos; do not D/C steroids when ESR normalizes)

e) if symptoms recur during treatment, prednisone dose is temporarily increased until symptoms resolve (isolated rise in ESR is not sufficient reason to increase steroids)

f) patients should be followed closely for ≈ 2 years

2. in severely ill patients: methylprednisolone, 15–20mg IV QID

3. anticoagulant therapy: controversial

4. acute blindness (onset within 24–36 hrs) in a patient with giant cell arteritis:

a) consider up to 500mg methylprednisolone IV over 30–60 mins (no controlled studies show reversal of blindness)

b) some have used intermittent inhalation of 5% carbon dioxide and oxygen