Aspirin Therapy May Lessen Risks of Giant Cell Arteritis

Ischemic vision loss and cerebrovascular events occurred less in the patients receiving antiplatelet or anticoagulant therapy.

BY LESLIE SABBAGH
Contributing Writer

Low-dose aspirin appears to be a safe and effective adjunctive therapy in patients whose giant cell arteritis puts them at increased risk for ischemic vision loss and cerebrovascular accidents, judging from data from a retrospective study.

Dr. Michael S. Lee of the University of Minnesota, Minneapolis, and his colleagues from the Cleveland Clinic Foundation reviewed the charts of 143 patients (76% women; 95% white; mean age 71.8 years) who met the American College of Rheumatology's criteria for giant cell arteritis (GCA). The patients had presented between January 1989 and November 2004 and 73% had a biopsy-proven diagnosis.

All of the patients were treated with corticosteroids after their diagnosis.

But not all the patients remained on steroids for the duration of follow-up, which was several years in some cases, Dr. Lee said in an interview.

Aspirin, clopidogrel, or warfarin was given to 86 patients at some point since their diagnosis.

Of these 86, 18 started this therapy only after experiencing an ischemic event and 68 took one of these agents without a prior ischemic event. The remaining 57 patients never received antiplatelet or anticoagulant therapy.

The mean follow-up was 53.8 months for the antiplatelet-anticoagulant treated group and 46.7 months for the untreated group.

'Low-dose aspirin is relatively well tolerated and safe' and, when there are no contraindications, adjunctive low-dose aspirin should be considered in the treatment of GCA patients.

Fewer ischemic events occurred among patients who were on antiplatelet or anticoagulant therapy.

An ischemic event occurred in 11 (16%) of the 68 patients taking antiplatelet or anticoagulant therapy and in 36 (48%) of 75 patients—the 57 patients who were untreated and the 18 patients who had experienced an ischemic event prior to starting therapy, said Dr. Lee.

One or more cerebrovascular risk factors were present in 99 patients (69%).

For those with risk factors, 53 (54%) were on antiplatelet or anticoagulant therapy and 46 (47%) were not.

Of the patients on antiplatelet or anticoagulant drugs, 77% had at least one cerebrovascular risk factor, compared with 61% of the patients not taking these medications.

Nonfatal bleeding occurred in 2 (3%) of 66 patients on aspirin and in 1 (5%) of 20 on warfarin. In contrast, bleeding occurred in 5 (9%) of 57 patients on prednisone (Arthritis Rheum. 2006;54:3306-9).

Antiplatelet or anticoagulant therapy "may reduce the risk of vision loss or hemispheric stroke in patients with GCA. An increased risk of bleeding complications was not observed in this group," the investigators wrote.

"Low-dose aspirin is relatively well tolerated and safe" and, when there are no contraindications, adjunctive low-dose aspirin should be considered in the treatment of patients with GCA, they added. "We also believe that our results provide a rationale for a prospective, randomized, placebo-controlled trial to further determine the role of adjunctive antiplatelet therapy in GCA." ■

Initial Pulsed Steroid Speeds Response in GCA

BY LESLIE SABBAGH
Contributing Writer

Induction therapy with an intravenous pulse of methylprednisolone shortens patients' response time to oral glucocorticoids for giant cell arteritis, enabling the use of lower total dose, earlier tapering of the drug, and longer remission, Dr. Mehrdad Mazlumzadeh of the Mayo Clinic, Scottsdale, Ariz., and his associates reported.

The investigators conducted a double-blind, placebo-controlled study in which 27 patients (19 women; mean age of 74 years) all had biopsy-confirmed, newly diagnosed giant cell arteritis.

They were randomized to intravenous pulse of either methylprednisolone or saline once daily for the first 3 days of treatment, and then switched to a regimen of 40 mg/day of oral prednisone.

The dose was tapered over the course of 9 months in patients with controlled disease. Specifically, the dosage regimen was lowered every 2 weeks to 30 mg/day, 25 mg/day, 20 mg/day, 17.5 mg/day, 15 mg/day, 12.5 mg/day, and 10 mg/day. At the 10-mg/day dosing period, the dosage was lowered 1 mg per day every 2 weeks.

Although both groups responded well to daily oral prednisone, patients who received the initial intravenous pulse methylprednisolone had faster tapering.

Compared with controls, patients treated with pulsed methylprednisolone used lower doses of oral prednisone (5 mg or less daily) without disease recurrence—a difference that persisted at 52- and 78-week follow-up visits (Arthritis Rheum. 2006;54:3310-8).

Of the 27 patients, 14 were randomized to 3-day pulsed intravenous methylprednisolone followed by oral prednisone and 13 randomized controls had saline infusions and oral prednisone.

Only 12 patients (6 in each group) had 10 mg/day or more of prednisone for 10 days before enrollment.

At 36 weeks, 10 of 14 patients who had intravenous glucocorticoids were on 5 mg/day or less of prednisone, compared with only 2 of the 13 controls.

"Possibly more importantly, this difference was maintained at the 52-week and 78-week follow-up visits, thereby documenting the long-term benefits of the initial pulse in controlling the vascular inflammation," the researchers wrote.

Those who had intravenous pulse glucocorticoids took lower median doses than did the controls at all follow-up exams, and their total cumulative glucocorticoid dose (5,636 mg) was significantly lower than that of the controls (7,860 mg). Compared with controls, intravenous pulse patients also had fewer relapses. ■

Interferon Shows Benefit as Second-Line Uveitis Therapy

BY MELINDA TANZOLA
Contributing Writer

Interferon alfa-2a appears to provide some benefit as a second-line treatment for uveitis in patients who relapse after treatment with corticosteroids and immunosuppressants, according to a study published online on October 18 in the British Journal of Ophthalmology.

Among 45 patients (median age, 32 years), 19 of 23 patients with Behçet's disease (BD) and 13 of 22 patients with other conditions achieved control of their uveitis with interferon therapy during a median follow-up of 30 months, wrote Dr. Bahram Bodaghi and colleagues in their report (Br. J. Ophthalmol. DOI:10.1136/bjo.2006.101550).

In the retrospective, single-center study, patients received subcutaneous interferon alfa-2a at 3 million U three times/week, with intravenous pulses of methylprednisolone, followed by oral prednisone. Oral acetaminophen was administered to prevent interferon-associated side effects.

Among 45 patients, 19 of 23 patients with Behçet's disease and 13 of 22 patients with other conditions achieved control of their uveitis with interferon therapy.

Patients continued on interferon until they had been in complete remission for at least 9 months, according to Dr. Bodaghi and colleagues at the University of Paris.

Overall, 10 patients with BD and 4 patients without BD discontinued interferon; of these, 4 patients with BD and 1 patient without BD had subsequent relapses.

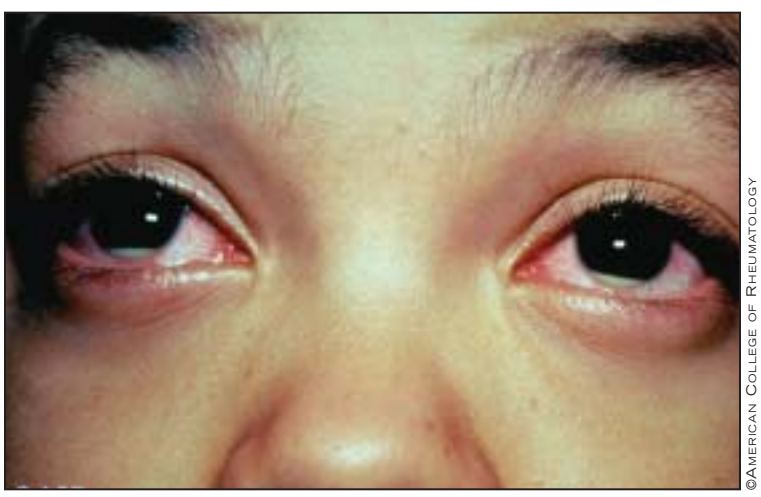
All five of these patients responded to reintroduction of interferon with an initially increased steroid dose.

Multiple relapses occurred in four patients with BD and one patient without BD during treatment, indicating that the treatment was not effective in these patients.

The median oral prednisone threshold, which reflects the dose that leads to relapse during tapering, decreased significantly from 23.6 mg/day at baseline to 10 mg/day at the end of the period of follow-up.

The most common side effect was a flu-like syndrome at treatment initiation.

Two patients had major side effects from interferon treatment, including one case of severe depression requiring treatment discontinuation and one case of major neutropenia requiring temporary interruption.



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Bilateral anterior uveitis (occurring in about two-thirds of BD patients) is shown above in a child. A layer of pus in the anterior chamber is also present, as well as mild bilateral conjunctivitis.

The authors concluded that controlled studies are needed to further investigate the optimal dose and duration of interferon treatment in patients with uveitis. ■