Response to: 'The role of temporal artery biopsy in patients with giant cell arteritis is debated' by Moiseev *et al*

Christian Dejaco,[1,2] Sofia Ramiro,[3] Christina Duftner,[4] Wolfgang A Schmidt[5]

[1]Department of Rheumatology and Immunology, Medical University Graz, Graz, Austria
[2]Department of Rheumatology, Hospital of Bruneck, Bruneck, Italy
[3]Department of Rheumatology, Leiden University Medical Center, Leiden, The Netherlands
[4]Department of Internal Medicine VI, Medical University Innsbruck, Innsbruck, Austria
[5]Medical Centre for Rheumatology Berlin-Buch, Immanuel Krankenhaus Berlin, Berlin, Germany

Correspondence to Dr Christian Dejaco, Department of Rheumatology and Immunology, Medical University Graz, Graz 8036, Austria; christian.dejaco@gmx.net

Handling editor Josef S Smolen

Contributors All authors contributed significantly to this manuscript and read and approved the submitted version.

Competing interests None declared.

Patient consent Not required.

Provenance and peer review Commissioned; internally peer reviewed.

To cite Dejaco C, Ramiro S, Duftner C, *et al*. *Ann Rheum Dis* 2019;**78**:e32.

Received 25 February 2018
Revised 27 February 2018
Accepted 28 February 2018
Published Online First 13 March 2018

Linked

► http://dx.doi.org/10.1136/annrheumdis-2018-213282

Ann Rheum Dis 2019;**78**:e32. doi:10.1136/annrheumdis-2018-213284

Moiseev *et al*[1] underlined the main message of the new European League Against Rheumatism (EULAR) recommendations for the use of imaging in large vessel vasculitis (LVV), namely the importance of imaging as a first-line test for the diagnosis of LVV.[2] The EULAR task force also emphasised that the recommendations should not be understood as a recommendation against performing temporal artery biopsy (TAB) in giant cell arteritis (GCA), rather a biopsy still has its place when there is diagnostic doubt after having performed imaging or when imaging is not available or not performed with sufficient expertise. When a diagnosis can be made on clinical grounds in conjunction with imaging, TAB is dispensable thus reducing burden to patients and saving costs to the society.[3]

One caveat is the unknown competency of rheumatologists, radiologists and other health professionals across different regions to acquire and interpret imaging results in LVV, thus potentially hampering the implementation of the new recommendations in clinical practice. In France for example, Doppler ultrasound is little used, as pointed out by the authors, leading to a limited endorsement of this technique by the French study group for LVV.[4] In addition to adequate training, modern, high-quality equipment is needed to obtain valuable results. In the retrospective French experience, cited by the authors, colour Doppler ultrasound was conducted with a low-frequency probe (7.5 MHz) and consequently, only a 10%–17% sensitivity for the diagnosis of GCA has been obtained.[5] This is much lower than the sensitivity of almost 80% that can be achieved with modern 15–22 MHz devices.[6]

Moiseev *et al* state that they prefer a [18F]-fluorodeoxyglucose positron emission tomography (PET) scan over other modalities in patients with suspected GCA and negative ultrasound,[1] given that many patients with GCA have extracranial manifestations.[7 8] This approach is in line with the new EULAR recommendations suggesting that patients with a high clinical probability of GCA and a negative ultrasound scan should undergo further diagnostic testing which might include other imaging or TAB.[2] Availability, costs and radiation are disadvantages of PET, but a high local expertise with this technique may be an important factor driving towards the choice of this modality.

We also agree with Moiseev *et al* that ultrasound is a possible alternative to MRI in the diagnosis of Takayasu arteritis (TAK) even though it provides only a limited access to the thoracic aorta.[1] Consequently, ultrasound is presumed to have a lower sensitivity in the diagnosis of TAK compared with MRI.[9] Many imaging studies in TAK are of small sample size, retrospective or cross-sectional design and low methodological quality; hence, there is an urgent need for further research in the field.[6]

In summary, we appreciate the supportive letter from Moiseev *et al* and hope that imaging will be increasingly used for the diagnosis of LVV across Europe and the world.

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