for providing information to patients about their relative risk of ocular morbidity following a diagnosis of PMR or GCA.

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**Table. Positive US finding in 69 GCA patients**

<table>
<thead>
<tr>
<th>Subclavian</th>
<th>Axillary</th>
<th>Spatial</th>
<th>Palmar</th>
<th>Frontal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right side</td>
<td>13 36</td>
<td>19 20</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Left side</td>
<td>13 27</td>
<td>18 18</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>41 74</td>
<td>47 38</td>
<td>64</td>
<td></td>
</tr>
</tbody>
</table>

**Conclusion:** Our data highlights the importance and value of a complete US of cranial and extracranial arteries diagnosing GCA in daily clinical care. The spread of the data demonstrate the widespread nature of arterial affection in GCA and the fact that it is often more than one site that is affected. The spreading pattern was comparable to older studies in the respect of large vessel and multivessel involvement.

**References:**

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**Conclusion:** A flaring and relapsing course is common to both GCA and PMR especially during steroid dose tapering. Increased clinical surveillance and more gradual steroid tapering, particularly at the time when most flares/relapses are observed may help improve clinical outcomes and reduce glucocorticoid requirements.

**References:**