Response to: 'Correspondence on 'Novel ultrasonographic Halo Score for giant cell arteritis: assessment of diagnostic accuracy and association with ocular ischaemia' by Evangelatos *et al*

We thank Evangelatos *et al*¹ for their interest in our study on the ultrasonographic Halo Score for giant cell arteritis (GCA).² The evaluation of patients with suspected GCA can be challenging.³ Ultrasonography is an important diagnostic tool for GCA and allows to evaluate key arteries affected by the disease.⁴ Currently, it is recommended to perform ultrasonography of the temporal and axillary arteries in patients with suspected GCA.^{5,6} For this reason, the ultrasonographic Halo Score is based on measurements of these two arteries. Whether or not additional arteries should be evaluated remains a topic of debate.^{7,8}

We welcome the effort of Evangelatos *et al* to evaluate the 'diagnostic yield' of ultrasonography of the facial arteries,^{1,9} in addition to standard examination of the temporal and axillary arteries. The authors observed a halo of the facial artery in 4 out of the 11 patients with a halo of the temporal artery. In the absence of a temporal artery halo, no facial artery halo was observed. Examination of the facial artery thus provided little diagnostic yield, as previously reported by Ješe *et al*.¹⁰ The study by Evangelatos *et al* underscores that ultrasonography of temporal and axillary arteries might be sufficient for the initial evaluation of patients with suspected GCA. Bearing in mind the need for additional time and technical skills, other arteries (eg, facial artery, subclavian artery) could be evaluated in selected cases.

In essence, the ultrasonographic Halo Score is a tool to estimate the burden of inflammation in patients with GCA. We have previously reported on the diagnostic accuracy of the Halo Score and its relationship with systemic inflammation and clinical features of GCA.² Molina Collada *et al* confirmed the diagnostic value of the Halo Score in standard clinical practise.^{11,12} More recently, we observed that the ultrasonographic Halo Score associates with intimal hyperplasia, a key biopsy feature linked to GCA-related ocular ischaemia (Van der Geest *et al*, in press). The value of the Halo Score for monitoring of disease activity is currently under investigation in a prospective, multicentre study.¹³ Although inclusion of additional arteries in the Halo Score could potentially make the estimation of the inflammatory burden more precise, it is questionable whether this would significantly improve the diagnostic accuracy of the Halo Score and its relationship with systemic inflammation, as outlined by Evangelatos *et al*. It may make the Halo Score more burdensome and imprecise to assess—reflecting the increased time commitment and variability of skills not only in demonstrating a facial artery halo but also in measuring its halo thickness.

Kornelis SM van der Geest ¹, Bhaskar Dasgupta ²

¹University Medical Center Groningen, Rheumatology and Clinical Immunology, University of Groningen, Groningen, The Netherlands

²Rheumatology, Southend University Hospital NHS Foundation Trust, Westcliff-on-Sea, UK

Correspondence to Dr Bhaskar Dasgupta, Rheumatology, Southend University Hospital NHS Foundation Trust, Westcliff-on-Sea SSO ORY, Essex, UK; bhaskar.dasgupta@southend.nhs.uk

Handling editor Josef S Smolen

Twitter Bhaskar Dasgupta @profbdasgupta

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ORCID iDs

Kornelis SM van der Geest <http://orcid.org/0000-0003-2798-6765>

Bhaskar Dasgupta <http://orcid.org/0000-0002-5523-6534>

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