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 adjuvantive 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 73.8 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 (90%). For those with risk factors, 53 (54%) were on antplatelet or anticoagulant therapy and 46 (47%) were not.

Of the patients on antplatelet 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 (3%) of 20 on warfarin. In contrast, bleeding occurred in 5 (7%) of 57 patients on prednisone (Arthritis Rheum. 2006;54:306-9).

Anticoagulant or antplatelet 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 anticoagulant therapy in GCA.”

Interferon Shows Benefit as a 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.

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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) 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.

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