Gynecologic Vasculitis: Positron Emission Tomography–Computed Tomography Contribution in a Rare Localization of Giant Cell Arteritis

To the Editor:

We read with great interest the letter entitled “Unusual presentation of giant cell arteritis in 2 patients: uterine involvement,” published in *The Journal of Rheumatology*¹. We have observed a case of ovarian involvement of giant cell arteritis (GCA) whose characteristics allow us to reinforce some key messages regarding the investigation of inflammatory disorders.

A 67-year-old female (who has given her written informed consent to publish this material) presented with a history of fever over 6 months, associated with abdominal pain, predominant in the right iliac fossa. Biological analysis showed only inflammation (C-reactive protein: 70 mg/l). Abdominal and pelvic computed tomography (CT) scan was normal. An exploratory coelioscopy showed a left ovarian cyst with nodules on the tube and a slightly inflammatory contralateral ovary. Histological analysis on the adnexectomy piece showed giant cell granulomatous arteritis affecting small- and medium-sized arteries. Given the persistence of the symptomatology, a second coelioscopy was performed 1 month later, with contralateral adnexectomy. The same anatomopathological findings were found. Because there was no improvement, an 18F-fluorodeoxyglucose positron emission tomography/CT (FDG-PET/CT) was performed, revealing extended hypermetabolism of the aorta, and of the subclavian, humeral, iliac, and femoral arteries (Figure 1) in favor of GCA. A biopsy of the temporal artery confirmed this diagnosis. Corticosteroids were started initially at 0.7 mg/kg for an 18-month regimen, with effectiveness on the fever and normalization of the C-reactive protein. At the 4-year followup, there was no sign of relapse with no current treatment.

Gynecologic vasculitis is divided into 2 forms: isolated gynecologic

vasculitis (70%) and systemic gynecologic vasculitis (30%). The ovaries are the sites most often affected in the systemic condition, emphasizing the value of a PET scan to investigate biological inflammatory disorders, even in cases without clinical signs, as was the case in our patient^{2,3}.

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Figure 1. 18F-fluorodeoxyglucose positron emission tomography/computed tomography showing hypermetabolism of thoracic and abdominal aorta, subclavian arteries, and iliofemoral arteries.