another lipid metabolism gene to the list of genes causing spinocerebellar ataxia.

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OBSERVATION

Successful Antiviral Treatment of Giant Cell Arteritis and Takayasu Arteritis

A patient who satisfies American College of Rheumatology criteria for both giant-cell arteritis (GCA) and Takayasu arteritis had a dramatic favorable response to antiviral treatment. The virological and pathological findings followed by successful antiviral treatment support earlier notions that GCA and Takayasu arteritis may represent a spectrum of the same disease produced by varicella-zoster virus (VZV).

Report of a Case | A woman in her 70s developed severe right-sided temporal pain and jaw claudication. Two months later, she developed bilateral arm pain, which was worse on the left; chest pain on exertion; and shortness of breath. No arm pulses were detected and blood pressure was unobtainable by auscultation or Doppler. Angiography findings revealed bilateral subclavian artery stenosis and left axillary artery occlusion without intracranial vasculopathy. Her erythrocyte sedimentation rate was normal and C-reactive protein level was 1.6 mg/0.1 L (normal <1.0 mg/0.1 L; to convert to nanomoles per liter, multiply by 9.524). Results from a temporal artery (TA) biopsy were initially negative for GCA. Despite treatment with oral prednisone, 30 mg twice daily, she experienced progressive arm pain, intractable fatigue, anorexia, and weight loss.
She underwent additional angiograms, one complicated by deep-seated right hemispheric infarction. Seven months later, she developed gangrene in her left hand and underwent bilateral carotid to brachial artery bypass surgery. She continued prednisone, 20 mg daily, and stopped 2 months later.

Sixteen months after initial presentation, she was cachectic and weighed 30.8 kg. Her fingers were bright red and hypoperesthetic with flexion contractures. Except for weak right popliteal artery pulse, there were no temporal or radial artery pulses, no pulses over the supraclavicular or left popliteal fossa, and both dorsalis pedis pulses were absent. Deep tendon reflexes were increased in the legs with a left extensor plantar response. The erythrocyte sedimentation rate was 30 mm/h (normal <20 mm/h) and C-reactive protein level was 0.3 mg/0.1 L. Computed tomographic angiography revealed extensive large-artery disease involving the right brachiocephalic, left subclavian, and vertebral, bilateral axillary and common carotid arteries; the celiac trunk; and the right renal artery (Figure 1).

Based on detection of VZV in GCA-positive TAs, documented involvement of other large arteries in most patients with GCA, and pathological changes of extensive arteritis with giant cells in both GCA and Takayasu arteritis, we treated our patient with intravenous acyclovir, 15 mg/kg 3 times daily for 2 weeks, followed by oral valacyclovir, 1 g 3 times daily. Immunohistochemical analysis of the TA biopsy obtained 14 months earlier detected VZV antigen, and histopathological examination of 17 sections revealed GCA (Figure 2). The response to antiviral therapy was dramatic. Within a week, she felt energetic and began to eat voraciously. Two weeks later, both TA pulses, left supraclavicular fossa pulse, and left radial and popliteal artery pulses were present. Erythrocyte sedimentation rates and C-reactive protein level during the next...
4 months were normal or mildly elevated. Our patient continues to improve. Four months later, she weighed 39.5 kg, and pulses noted here remain patent. Permanent finger contractions limit mobility and other activities of daily living.

Discussion | Herein, we describe a remarkable case that satisfies American College of Rheumatology criteria for both GCA and Takayasu arteritis. Noteworthy features include development of GCA followed months later by Takayasu arteritis, consistent with findings that large-artery disease frequently complicates GCA. Furthermore, although the original TA biopsy was GCA negative, histopathological examination confirmed the diagnosis of GCA, underscoring the close relationship between VZV antigen and GCA pathology. Most important, however, was the patient’s rapid clinical response to antiviral treatment as manifested by improved energy, appetite, and weight gain, as well as detection of multiple pulses that were absent 2 weeks earlier.

Overall, the virological and pathological findings in this case followed by the favorable response to antiviral therapy sup-
port earlier assumptions that GCA and Takayasu arteritis may represent a spectrum of the same disease produced by VZV.

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Fragile X Tremor Ataxia Syndrome With Rapidly Progressive Myopathy

In this report, we describe a patient with clinically definite fragile X-associated tremor/ataxia syndrome (FXTAS) who experienced rapidly progressive, painless, noninflammatory proximal and distal myopathy after surgery with general anesthesia.

Report of a Case | A right-handed man in his 60s presented with a 10-month history of rapidly progressive motor impairment. His medical history was significant for type 1 diabetes mellitus, peripheral neuropathy, diabetic amyotrophy of the left lower extremity, and complex partial sei-