

Mortality rate of patients with giant cell arteritis as isolated inflammation or fever of unknown origin, typo or sensational?

Sirs,

Recently, de Boysson *et al.* have published a paper in which they present four clinical patterns of giant-cell arteritis (GCA) and raise the questions about different potential pathophysiology, phenotypes and treatment of these clinical groups (1).

Table I also presents death in the four groups, with significantly different follow-up periods. However, when calculating the annual mortality rate (dividing the total mortality by the numbers of years of follow-up), the “GCA as isolated inflammation or fever of unknown origin (IFUO)” group has the highest mortality rate (% mortality of that group is 32.8%, and not 31% as written in the original table) (1). In order to understand the statistical significance of this finding, a multivariate analysis is required. Only then should the potential clinical meaning be searched.

However, in a previous publication by the same group, the authors had used the same patient cohort, and the follow-up time was 50 months (2), instead of 28 months indicated in their present publication (1). Recalculating the annual death rate for “GCA

Table I.

Group	Follow-up			Death		
	No.	Months	years	No.	crude (%)	annual (%)
Isolated cranial GCA	554	50	4.17	163	29.4%	7.1%
Symptomatic LVV GCA	63	76	6.33	18	28.6%	4.5%
GCA as isolated IFUO	61	28	2.33	20	32.8%	14.1%
GCA as clinically isolated PMR	15	27	2.25	1	6.7%	3.0%

GCA: giant cell arteritis; LVV: large-vessel vasculitis; IFUO: isolated fever of unknown origin; PMR: polymyalgia rheumatica.

as isolated IFUO” would yield an annual death rate of 7.9% (total death of 32.8% divided by 4.17 follow-up years).

In my opinion, there are two possible options:

1. Typo error: the follow-up presented in the current paper was not 28, but 50 months.
2. The finding is real, and that makes it even more important, as all deaths have occurred during the first 28 months.

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