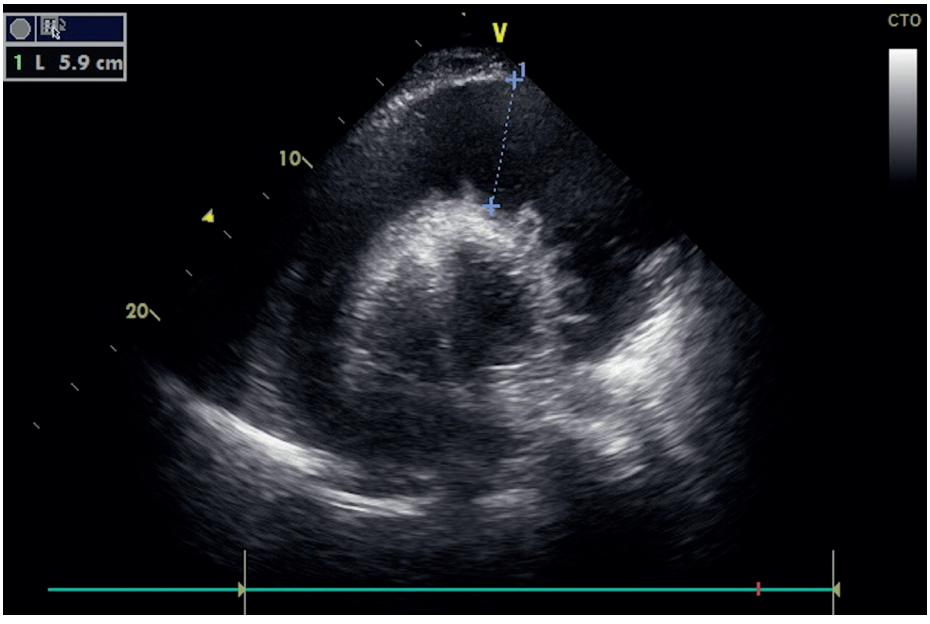
Figure 1. Transthoracic echocardiography, apical four-chamber view showing a large pericardial effusion of 5.9 cm.




## Conclusions

This article describes a very rare case of pericardial actinomycosis secondary to lung actinomycosis in a patient with oesophageal dysmotility and a high level of PM/Scl 75 autoantibodies. To the authors' knowledge this is the first case in which pericardial actinomycosis has been reported in a patient with positive PM/Scl 75 autoantibodies. BJHM

### LEARNING POINTS

- Beyond the obvious causes of pericardial effusion, physicians should consider rarer causes and combine symptoms, clinical signs and laboratory investigations in order to reach a diagnosis in such challenging cases.
- Early involvement of different specialists, such as infectious diseases and rheumatologists, is vital in order to reach a diagnosis in challenging cases.
- Understanding the sequence of events and the aetiology of abnormal findings is very important in order to undertake further investigations and reach a definitive diagnosis.

Fife TD, Finegold SM, Grennan T (1991) Pericardial actinomycosis: case report and review. *Rev Infect Dis* **13**(1): 120–126.

Janoskuti L, Lengyel M, Fenyvesi T (2004) Cardiac actinomycosis in a patient presenting with acute cardiac tamponade and a mass mimicking pericardial tumour. *Heart* **90**(5): e27. https://doi.org/10.1136/hrt.2003.031633

Vandergheynst F, Ocmant A, Sordet C et al (2006) Anti-pm/scl antibodies in connective tissue disease: Clinical and biological assessment of 14 patients. *Clin Exp Rheumatol* **24**(2): 129–133.



# Occult giant cell arteritis with an abnormal temporal artery finding and normal blood markers

A 77-year-old woman presented with a 3-month history of intermittent blurred vision and diplopia, with two episodes of visual loss in her right eye lasting less than 10 minutes. Systemically she reported feeling unsteady but presented no other characteristic symptoms of giant cell arteritis. She had a normal ocular examination, but had a grossly thickened, cord-like, pulseless, right superficial temporal artery (*Figure 1*). Her blood results were normal, with a C-reactive protein level of 1 mg/litre and erythrocyte sedimentation rate of 10 mm/hour. She was treated with oral prednisolone and had a temporal artery biopsy the next day which revealed a thrombosed and swollen artery (*Figure 2*). Histology was supportive of giant cell arteritis. On follow up 1 month later she was asymptomatic with no further episodes of visual disturbance. This case posed a diagnostic challenge because of the scarcity of symptoms characteristic of giant cell arteritis combined with normal blood markers. BJHM

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Figure 1. Right superficial temporal artery.

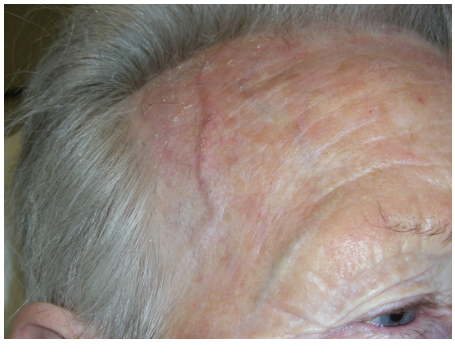

Figure 2. Right superficial temporal artery dissected in theatre.