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CASE REPORT ON TAKAYASU ARTERITIS

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Abstract: **Takayasu arteritis, also known as pulseless disease is a chronic inflammatory arteritis affecting large vessels, mainly the aorta and its main branches. Current incidence status reveals 106 patients over 16 years in India. The most common clinical findings are bruit, Hypertension, weak or absent pulses in extremities, widely varying blood pressure and dizziness. A middle aged women presented with complaints of giddiness, fever, and generalized body ache at multiple points, generalized weakness and visual disturbances. She meets all the criteria for diagnosis of takayasu arteritis (TA) and treated with specific treatment for TA and preventive medications of complications.**

1. INTRODUCTION

Takayasu arteritis, also known as pulseless disease is a chronic inflammatory arteritis affecting large vessels, mainly the aorta and its main branches.[1]It was first reported in 1908 by Japanese

Ophthalmologist Dr. Mikkito takayasu, autoimmunity appears to be the most plausible mechanism.[2] the clinical presentation of TA ranges from asymptomatic to catastrophic with stroke. The most common clinical findings are bruit, Hypertension, weak or absent pulses in extremities, widely varying blood pressure and dizziness. Diagnosis of Takayasu arteritis (TA) is often delayed because of a non-specific clinical presentation. Ishikawa's criteria (1988) has been widely used for the diagnosis of this disease[3] which is based on the natural history and complications of the disease. The 4 major complications were defined as takayasu retinopathy, secondary hypertension, aortic regurgitation and and aneurism formation, each being graded as mild/moderate or severe at the time of diagnosis.[4]

Takayasu arteritis is classified on the basis of the angiographic presentation, there are 5 types

Type 1 is includes the involvement of branches from aortic arch, in type 2 there is involvement of ascending aorta, aortic arch and its branches and thoracic descending aorta, type 3 is where there is thoracic descending aorta, abdominal Aorta and /or renal arteries, type 4 is includes abdominal aorta and renal arteries and type 5 is having combined features of type 2 and 4. [4]

2. CASE REPORT

A 33 year old female came with complaints of giddiness , fever , generalized body ache at multiple points ,generalized weakness and visual disturbances .She had a 4- year history of hypertension , because of uncontrolled blood pressure she was referred to tertiary care hospital from a clinic.

At physical examination she had elevated body temperature and heart rate of 100 bpm.

Laboratory findings evidenced a higher erythrocyte sedimentation rate of 105mm/1st hr and also an elevated C- reactive protein for which he referred to a rheumatologist and treated sequentially with steroids. Blood culture shown normocytic and hypochromic anemia.

At physical examination there was a evident pressure difference between the left and right arm.

Her CT report showed left common carotid occlusion from the arch onward and left and right sub clavian artery stenosis. There was no family history of TA .Patient had a weight loss from 67 to 50 in a duration of 1 month. She had a previous hospital admission because of abdominal cramps and treated for the same. From the objective and subjective data

physician confirmed the diagnosis and started with inj.taclizumab 600 mg infusion and tab. Prednisolone 5 mg od for TA. Oral tryptomer and pyridoxine was started. Supportive medications were given for cardio protection, anti-hypertensive were continued as she had a history of Hypertension.

3. DISCUSSION

Takayasu arteritis large vessel vasculitis of unknown etiology. Depends upon the vessels involved TA is classified into different classes. This patient belongs to type 2a as the aortic arch is involved. Female to male ratio of incidence of disease in is 1:8.Abdominal discomfort, generalized weakness, visual disturbances and generalized aches can be because of the compromised blood flow. Major complications of specific disease results in patient condition such as hypertension and retinopathy. Patient have left and right mid sub clavian artery stenosis, erythrocyte sedimentation, hypertension and carotid artery tenderness by which she meets the diagnostic criteria for TA. Current incidence status reveals 106 patients over 16 years in India this case report adds an evidence to it.[5]

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