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TAKAYASU ARTERITIS: A CASE REPORT OF RARE ASSOCIATION WITH SUBCLAVIAN STEAL SYNDROME.

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BACKGROUND

Takayasu's Arteritis (TA), also known as pulseless disease, is a granulomatous vasculitis of large vessels affecting the aorta and its main branches. Its annual incidence varies from 1 to 2 cases per million, although it occurs frequently in Japan, India and Southeast Asia. Women are more commonly affected at a ratio of 9:1 in relation to men and the median onset of symptoms is 25 years. The clinical picture is marked mainly by symptoms of systemic inflammation, vascular insufficiency or both. The subclavian steal syndrome (SSS) might occur in rare cases and it is characterized by dizziness, ataxia and fall-attacks as a result of posterior cerebral circulation deficit. The aim of the present study is to describe a case report of SSS associated with TA.

CASE REPORT

A 26-years-old woman presented intermittent pain in her left shoulder and arm for about 14 months. Symptoms worsened with physical exertion, partially improving with analgesics and resting. After multiple medical visits she was diagnosed with cervicobrachialgia and treated with duloxetine without improvement. Symptoms worsened 2 months later developing fatigue, malaise, increased pain, coldness, intermittent pallor, dizziness and ataxia. There was no past medical history. Physical examination revealed: difference in temperature and pallor on the left upper limb in comparison to the contralateral arm; non-palpable left brachial and radial pulses; blood pressure was 118x76 mm Hg in the right upper limb and inaudible in the upper left limb. Laboratory tests showed: normochromic-normocytic anemia and erythrocyte sedimentation rate (ESR) of 65 mm/hour. Doppler study showed occlusion of the left subclavian artery from the ostium to the axillary artery and a patent vertebral artery with retrograde flow. Chest angiotomography evidenced marked parietal thickening of the left subclavian artery, determining important stenosis with downstream filiform flow (see in picture). Six weeks after treatment with prednisone 0.7mg/kg/day, patient obtained significant improvement of her symptomatology and normalization of ESR. Methotrexate was then initiated in order to decrease the steroid therapy.

CONCLUSION

TA is a rare vasculitis affecting young individuals. Due to the intensity of symptoms, especially vascular, is associated with high morbidity rate. Diagnostic delay from months to years exacerbates the severity of the vascular lesions, impacting on severity of these lesions. Although intermittent limb claudication is a hallmark of TA, SSS rarely occurs secondary to this vasculitis. In conclusion, a high degree of suspicion is mandatory in young patients when clinical history points to claudication, demanding a thorough physical examination.