A 15-year-old Caucasian patient was diagnosed as having Takayasu arteritis in 2002. She presented with left arm claudication and fatigue. Physical examination revealed decreased brachial artery pulses and bruit over subclavian arteries. Laboratory studies disclosed: erythrocyte sedimentation rate: 80 mm/h, C-reactive protein: 104 mg/l. Angiography showed inflammatory arteritis involving: bilateral subclavian and axillary arteries, common carotid arteries and thoracic aorta. The patient was given steroid therapy (at an initial dose of 1 mg/kg/day), resulting in improvement of clinical manifestations and disappearance of biochemical abnormalities. In October 2007, the patient still received prednisone therapy (15 mg daily) and methotrexate. She was admitted for a 2-month history of fatigue and hypertension. Blood tests revealed elevated erythrocyte sedimentation rate (76 mm/h) and C-reactive protein (58 mg/l). Computed tomography angiography showed extensive wall thickening in both thoracic and abdominal aorta; furthermore, there was severe stenosis, with post-stenotic dilatation, of the right renal artery and the right kidney was small.

Because of Takayasu arteritis-related renal vascular hypertension, the patient underwent percutaneous transluminal angioplasty with stent of right renal artery.

Takayasu arteritis is a rare inflammatory arteritis, affecting large vessels, including aorta and its major branches, especially renal arteries (30–35% of cases); Takayasu arteritis-associated renal artery impairment more often leads to stenosis (23–31%), other lesions (occlusion, dilatation and aneurysm) being more uncommon. In patients with Takayasu arteritis, renal artery stenosis is more often not eligible for medical therapy, requiring prompt surgical procedures; the risk of underlying surgical procedures has been, in fact, reported to increase progressively during the first phase of Takayasu arteritis, tending to reach a plateau from 6-year duration of Takayasu arteritis.

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