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TAKAYASU ARTERITIS PRESENTING AS MULTIFOCAL ACUTE INFARCTS IN A YOUNG FEMALE: A CASE REPORT

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ABSTRACT

Takayasu arteritis (TA) is a rare, chronic granulomatous large-vessel vasculitis that involves the aorta and its major branches and predominantly affects young women. We report a 30-year-old woman with a six-month history of right upper-limb claudication who presented with sudden-onset altered sensorium following a one-day febrile illness. Clinical examination revealed bilateral carotid bruits with absent right upper-limb pulses and preserved lower-limb blood pressure. MRI brain demonstrated acute infarcts in the left fronto-temporal region and right caudate nucleus, and CT aortogram showed circumferential wall thickening with significant luminal narrowing of both common carotid arteries, confirming the diagnosis of Takayasu arteritis. The patient was managed with high-dose oral corticosteroids and antiplatelet therapy, with endovascular stenting of the right common carotid artery planned. This case highlights the importance of considering TA in young women presenting with stroke and limb claudication, and the need for early immunosuppressive therapy to prevent irreversible vascular damage.

KEYWORDS: Takayasu arteritis; large-vessel vasculitis; stroke in young; carotid stenosis; aortitis.

ABBREVIATIONS

- TA – Takayasu Arteritis
- CCA – Common Carotid Artery
- MRI – Magnetic Resonance Imaging
- MRA – Magnetic Resonance Angiography
- MRV – Magnetic Resonance Venography
- CTA – Computed Tomography Angiogram/Aortogram
- ANA – Antinuclear Antibody
- ANCA – Anti-Neutrophil Cytoplasmic Antibody

INTRODUCTION

Takayasu arteritis is a chronic granulomatous large-vessel vasculitis that predominantly affects women under 40 years of age, involving the aorta and its major branches and leading to stenosis, occlusion, or aneurysm formation.[1,2] The disease classically evolves through an early "systemic" phase marked by nonspecific constitutional symptoms such as fever, malaise, and arthralgia, followed by a later "occlusive" phase dominated by features of vascular insufficiency, including limb claudication, diminished or absent pulses, and inter-limb blood pressure discrepancies.[3]

Neurological involvement, including transient ischemic attacks and stroke secondary to carotid or vertebral artery stenosis, is an important and under-recognized cause of morbidity in patients with untreated disease, and may occasionally be the presenting feature before the diagnosis is suspected.[4,5] We report a young woman with longstanding limb claudication who presented acutely with multifocal cerebral infarcts, illustrating the diagnostic pathway from clinical suspicion to angiographic confirmation of Takayasu arteritis.

CASE REPORT

History

A 30-year-old woman presented with sudden-onset altered sensorium preceded by a one-day febrile illness. She gave a six-month history of progressive right upper-

limb claudication with associated easy fatigability of the limb. There was no history of joint pains, skin rash, recurrent oral ulcers, or prior thromboembolic events, and no significant family history of vascular or autoimmune disease.

Clinical Examination

- Irritable and emaciated general appearance.
- Bilateral carotid bruits on auscultation.
- Absent/unrecordable right upper-limb pulses and blood pressure.
- Preserved lower-limb blood pressure (130/90 mmHg).
- Altered sensorium with focal neurological deficits localizing to the left fronto-temporal region.

INVESTIGATIONS

Investigation	Finding
MRI Brain	Acute infarcts in the left fronto-temporal region and right caudate nucleus (Fig. 2, Fig. 3)
MRA	Attenuated flow in the right internal carotid artery (Fig. 3)
MRV	Hypoplastic right transverse and sigmoid venous sinuses
CT Angiogram (Neck vessels)	Circumferential wall thickening of bilateral common carotid arteries with ~60% luminal stenosis, consistent with Takayasu arteritis (Fig. 1)
Non-contrast CT Brain	Correlative axial sections obtained during initial evaluation, correlating with the MRI findings (Fig. 4)
CBC, RFT, LFT, ECG, CXR, ECHO	Within normal limits
ANA, p-ANCA, c-ANCA	Negative

MANAGEMENT AND OUTCOME

- Initiated high-dose oral corticosteroids (prednisolone 1 mg/kg/day) for disease control.
- Started on antiplatelet therapy (aspirin) for secondary stroke prevention.
- Referred for endovascular stenting of the right common carotid artery in view of critical stenosis.
- Serial vascular imaging planned to monitor disease activity and treatment response.

FIGURES

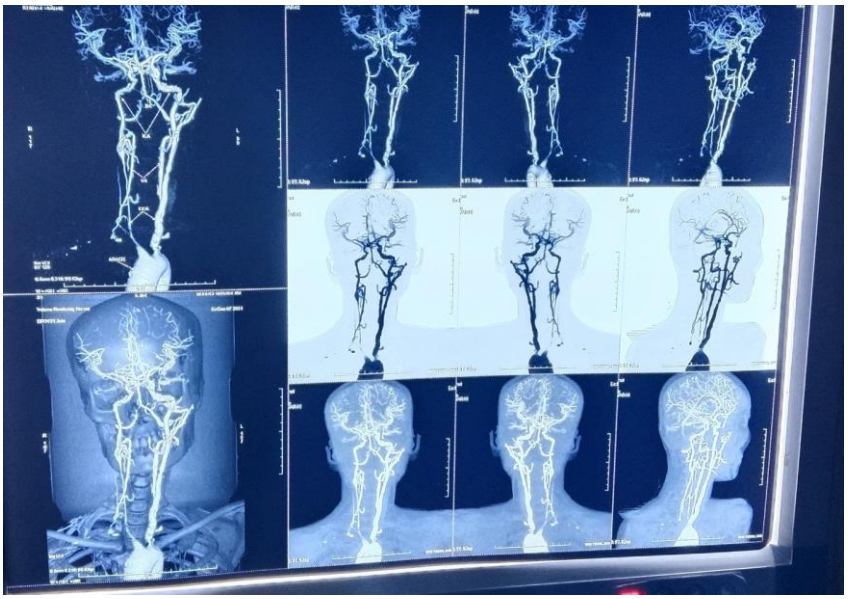

Fig. 1: ***Volume-rendered CT angiogram of the neck vessels showing circumferential wall thickening and luminal narrowing of both common carotid arteries.***

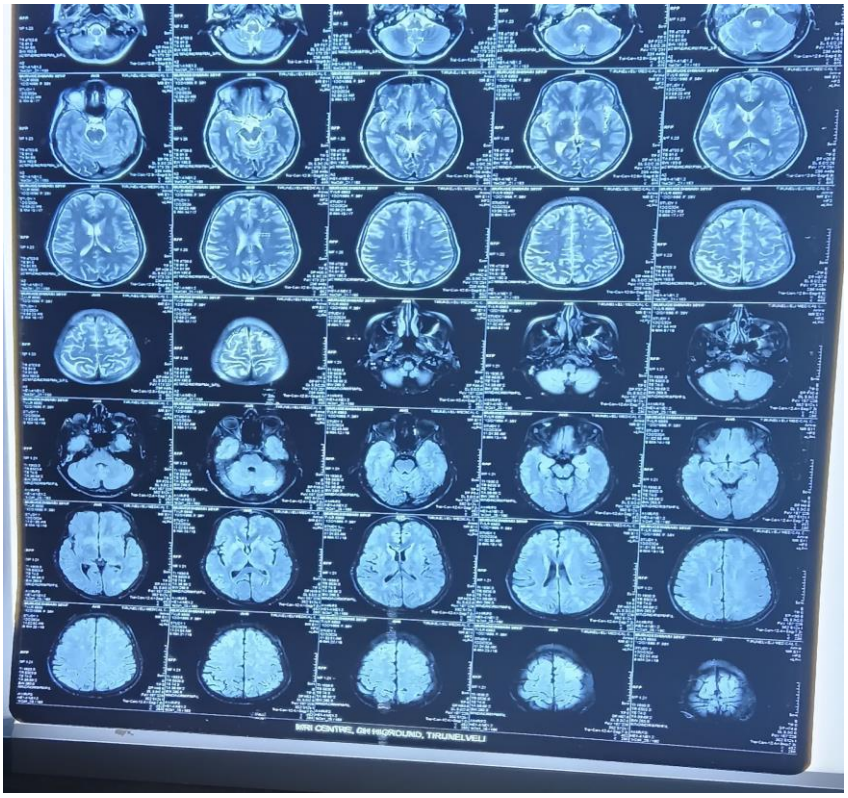

Fig. 2: ***Axial MRI brain sections demonstrating acute infarcts involving the left fronto-temporal region and right caudate nucleus.***

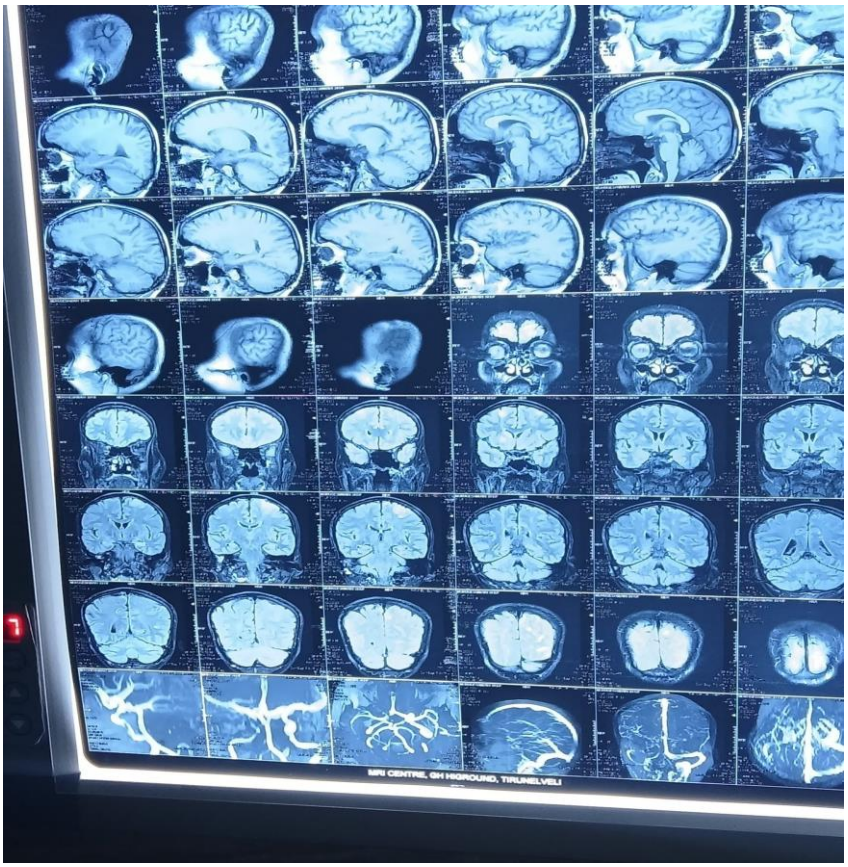

Fig. 3: ***MRI brain (sagittal and coronal sections) with accompanying MR angiogram showing attenuated flow in the right internal carotid artery.***

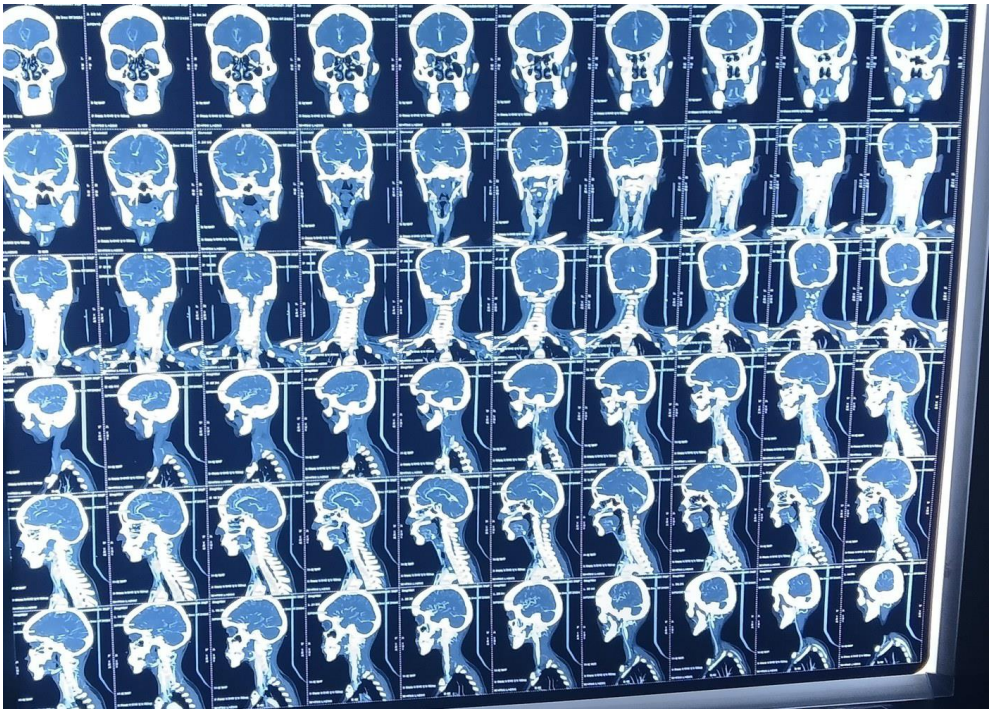

Fig. 4: ***Non-contrast CT brain (axial sections) obtained during initial evaluation, correlating with the MRI findings.***

DISCUSSION

Takayasu arteritis is a rare but important cause of stroke in young individuals, particularly women, and should be considered whenever cerebrovascular symptoms coexist with diminished peripheral pulses or inter-limb blood pressure discrepancy.[1,3] Carotid and vertebral involvement can produce cerebral hypoperfusion or embolic phenomena, resulting in the multifocal infarcts seen in this patient.[4]

The systemic inflammatory phase of TA is frequently silent or mistaken for a nonspecific febrile illness, as in this case, delaying recognition until an occlusive vascular event brings the patient to attention.[2,5] Early diagnosis with cross-sectional or catheter angiography, together with prompt initiation of corticosteroids and, where indicated, steroid-sparing immunosuppressants, is essential to arrest disease activity and prevent progression of vascular stenosis.[3]

Endovascular or surgical revascularisation is reserved for critical stenosis, recurrent ischemic events, or haemodynamically significant lesions unresponsive to medical therapy, and is generally best performed once inflammatory activity has been controlled.[1,5] This case underscores the value of a careful pulse and blood pressure examination in young patients presenting with stroke-like syndromes, as it may be the only clue pointing toward an underlying large-vessel vasculitis.

CONCLUSION

This case highlights the importance of considering Takayasu arteritis in young women presenting with stroke or transient neurological deficits, especially when accompanied by limb claudication or asymmetric pulses. Early recognition, angiographic confirmation, and timely immunosuppressive therapy are crucial to prevent irreversible vascular occlusion and further ischemic complications.

DECLARATIONS

Conflict of Interest: The author declares no conflict of interest.
Patient Consent: Obtained.
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