ABNORMALITIES. Others include chest wall pain, myalgia and joint pain. Constitutional symptoms such as fever, malaise, weight loss and night sweats precede vascular complications by weeks or months. Bruits over the subclavian artery, carotid and abdomen may be present. Absent or reduced pulse volume in one or more large arteries is detected and blood pressure discrepancy of greater than 30 mmHg between arms. With progression, cardiac symptoms are prominent and massive haemoptysis indicates pulmonary artery involvement. Neurological symptoms are present in 80% of patients with Takayasu's disease that involves the brachiocephalic arteries.

Four late-phases of Takayasu's disease have been described on the basis of the sites of vessel involvement: they are type 1- classic pulseless type that involves the brachiocephalic trunk, carotid arteries, and the subclavian arteries. Type 2 which is a combination of type 1 and 3. Type 3- atypical coarctation, type that involves the thoracic and abdominal aortas distal to the arch and its major branches. Type 4-dilated type that involves extensive dilatation of the length of the aorta and its major branches.

The most common type is the type 3, which is found in as many as 65% of patients. The most commonly involved vessels include the left subclavian artery (50%), the left common carotid artery (20%), the brachiocephalic trunk, the renal arteries, the celiac trunk, the superior mesenteric artery, and the pulmonary artery (50%). Infrequently, the axillary, abnormalities. Others include chest wall pain, myalgia and joint pain. Constitutional symptoms such as fever, malaise, weight loss and night sweats precede vascular complications by weeks or months. Bruits over the subclavian artery, carotid and abdomen may be present. Absent or reduced pulse volume in one or more large arteries is detected and blood pressure discrepancy of greater than 30 mmHg between arms. With progression, cardiac symptoms are prominent and massive haemoptysis indicates pulmonary artery involvement. Neurological symptoms are present in 80% of patients with Takayasu's disease that involves the brachiocephalic arteries.

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brachial, vertebral, coronary and the iliac arteries are involved.
Laboratory findings are non-specific. Anaemia, mild
leucocytosis, elevated ESR (erythrocyte sedimentation rate) and hypoalbuminaemia may be
detected in active inflammation. The diagnosis is
confirmed by arteriography. Other useful
investigations include CT scan, MRI, and gallium
scintigraphy. Management is with steroid (prednisolone), disease
modifying anti-rheumatic drugs (DMARDs) and
vascular bypass surgery.

CASE PRESENTATION
A 17 year old South African boy was referred from
vascular surgery clinic to the rheumatology clinic of
the Inkosi Albert Luthuli Central Hospital, Durban,
South Africa in October 2005 with a working
diagnosis of Takayasu's disease. He was being co-
managed by the cardiology clinic for heart failure
and vascular clinic for valvular heart disease for two
years before referral. His initial echocardiography
revealed significant aortic regurgitation and mild
mitral regurgitation.

He presented with generalized body weakness, left
anterior chest wall pain, fever, and joint pain
involving the knees and the elbows. He was still on
anti-failure drugs at the time of presentation. There
were no symptoms referable to the central nervous
system.

When examined, he was found to be small for age,
with temperature of 37.6°C, he had swollen and tender
left knee. The left radial artery was barely palpable
and a blood pressure difference of 30mmHg between
the two arms. Bruit was picked over the left axillary
region. A diagnosis of Takayasu's disease was made
by clinical and radiological assessment.

Unenhanced coronal magnetic resonant angiogram
revealed focal stenosis of the right external iliac
artery while the post contrast dynamic magnetic
angiogram revealed non-visualisation of the
proximal 3.5cm of the left subclavian artery from the
aortic arch. There was flow noted distally from the
level of the vertebral artery suggesting a retrograde
flow via the posterior circulation of the brain into the
left vertebral artery-subclavian steal. The right
vertebral artery was prominent. The left profunda
brachial artery was not visualized. All other arteries
were patent. The overall angiogram finding was
compatible with Takayasu's disease. Erythrocyte
sedimentation rate was 106mm/hr, PCV was 26%
and he had a leucocytosis of 14,300cells/mm³.

He was placed initially on high dose prednisolone
which was tapered after two months when symptoms
had subsided. He is presently on 5mg prednisolone
daily. He however continued his visit to the
cardiology unit for the management of the heart
failure. He is presently doing well on low dose
prednisolone.

DISCUSSION
Takayasu's disease was named after Japanese
ophthalmologist who first described the ocular
manifestation in 1908. It is also variously known by a
number of synonyms. These include pulseless
disease, aortic arch arteritis, non-specific
aortoarteritis and Takayasu's arteritis.

Takayasu's disease was said to be rare in the black
race. Underdiagnosis of the disease might have
accounted for this rarity. Ogunbiyi and Falase had
reported four cases, all women in the South West of
Nigeria. In 2003, Okeahialam et al also reported a
case in the Northern part of Nigeria. Diagnosis of Takayasu's disease requires a high index
of suspicion. The American College of
Rheumatology has however proposed criteria useful
in the diagnosis of Takayasu's disease. The presence
of three out of six criteria is needed. This is said to be
91% sensitive and 98% specific for Takayasu's
disease.

The criteria met by this patient include age of onset
before 40 years, decreased brachial artery pulse,
onearm arm blood pressure, subclavian bruit and
angiographic evidence of occlusion of subclavian
artery on the left. The last criterion which was not
present in this patient is limb claudication.

This patient presented with minimal joint complaint.
Joint pain may however be severe but actual synovitis
is uncommon and where present is usually mild.

There was no ocular complaint in this patient, and
this is in agreement with the recent presentation of
Takayasu's disease. The ischaemic retinopathy that
was originally reported by Takayasu is very rare
today. The symptoms of this patient were well controlled
with prednisolone without additional drugs. Some
patients will however in addition to Prednisolone
need immunosuppressive agents. The commonly
used immunosuppressives in Takayasu's disease are
methotrexate and mycophenolate mofetil.

This patient was in remission two months after the
commencement of high dose prednisolone. Remission in Takayasu's disease is defined as
resolution of signs, symptoms, and laboratory
markers of inflammation as well as lack of
progression of angiographic abnormalities.

It is too early to determine the prognosis in this
patient. The fact however is that almost all patients
will experience morbidity from Takayasu's disease.
Because of the chronic relapsing and remitting nature
of this disease, a careful monitoring and adjustment
of therapy in this patient is necessary. Mortality is
caused by renal failure, stroke, cardiac failure, or
infection complicating the use of
immunosuppressive agents. This write-up is to heighten the awareness of medical personnel of the presence of this rare disease also in the black race.

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REFERENCES