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When Vascular Events Reveal Takayasu Arteritis in a Man an Unusual Case

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ABSTRACT

Takayasu arteritis is a rare chronic large-vessel vasculitis that predominantly affects young women and is less frequently reported in men. We report the case of a 50-year-old man presenting with progressive lower-limb claudication and multiple vascular events, including hypertension, acute coronary syndrome, and transient ischemic attacks. Examination revealed diminished peripheral pulses and vascular bruits, with a marked inflammatory syndrome. Vascular imaging showed circumferential thickening of the aortic and supra-aortic vessels, confirming the diagnosis.

Keywords

Takayasu arteritis, Large-vessel vasculitis, Male patient, Lower-limb claudication, Aortic wall thickening, Multivascular involvement.

Introduction

Takayasu arteritis is a chronic granulomatous vasculitis of unknown etiology that predominantly affects the aorta and its major branches. The disease mainly occurs in young women, although men may also be affected. Because of its progressive and often asymptomatic course, diagnosis is frequently delayed until significant vascular damage has occurred. Early recognition remains essential to prevent irreversible ischemic complications [1-0].

Case Presentation

A 50-year-old male patient with a significant vascular history was admitted to the Department of Internal Medicine for evaluation of progressively worsening intermittent claudication of the lower limbs.

The patient's medical history revealed the diagnosis of lower limb obliterative arterial disease at the age of 41 years despite the absence of conventional cardiovascular risk factors. Two years later, he developed arterial hypertension. In 2019, he experienced a non-ST elevation acute coronary syndrome requiring coronary stenting. In 2022, he presented three episodes of transient ischemic attack within one month.

On admission, the patient was in good general condition. Blood pressure was 110/70 mmHg. Physical examination showed intermittent claudication with a walking distance of less than 200 meters. The right anterior tibial pulse was absent, whereas the right posterior tibial, left anterior tibial, and left posterior tibial pulses were weakly palpable. Vascular bruits were detected over the abdominal aorta and both iliac arteries. The remainder of the examination was unremarkable.

Laboratory investigations demonstrated normochromic microcytic anemia with a hemoglobin level of 11.6 g/dL. Inflammatory markers were markedly elevated, with an erythrocyte sedimentation rate of 85 mm/hour and a C-reactive protein level of 74 mg/L. Serum protein electrophoresis revealed polyclonal hypergammaglobulinemia.

Doppler ultrasonography of the supra-aortic trunks showed circumferential thickening of the common carotid artery wall associated with non-stenotic bulbar plaques. Computed tomography angiography of the aorta and lower limb arteries revealed circumferential inflammatory thickening of the infrarenal abdominal aorta associated with diffuse calcified atherosclerotic lesions.

Based on the patient's age at disease onset, the presence of vascular

events, intermittent claudication, vascular bruits, inflammatory syndrome, and characteristic imaging findings, the diagnosis of Takayasu arteritis was retained.

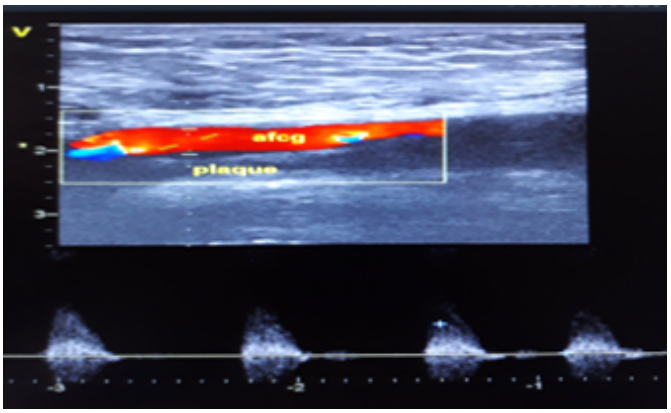


Figure 1: Circumferential carotid wall thickening

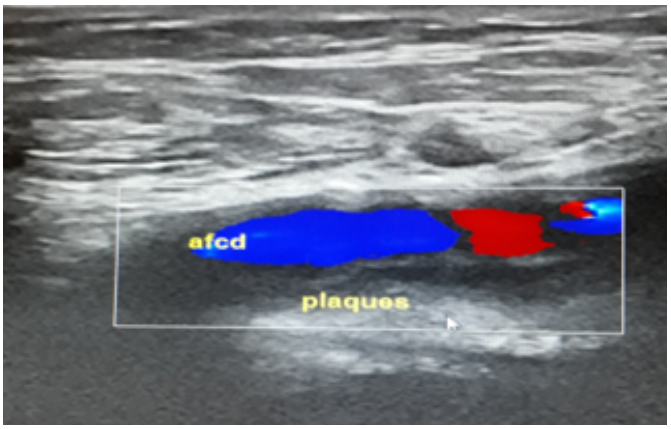


Figure 2: Inflammatory thickening of the infrarenal abdominal aort.

Treatment and Outcome: The patient was treated with oral corticosteroid therapy at a dose of 1 mg/kg/day combined with methotrexate. Clinical and biological follow-up demonstrated significant improvement, with regression of inflammatory markers and stabilization of vascular symptoms.

Discussion

Takayasu arteritis is a rare chronic inflammatory vasculitis involving large vessels, particularly the aorta and its primary branches. The disease evolves through a prolonged inflammatory process leading to arterial wall thickening, stenosis, occlusion, and occasionally aneurysm formation [2,5,6,10].

Although the disease predominantly affects young women, male patients are not exempt and may present with severe vascular manifestations. In our patient, the diagnosis was established only after the occurrence of multiple ischemic events involving several vascular territories, reflecting the insidious nature of the disease [5,10].

The diagnosis remains challenging because no specific biological marker is available. Elevated inflammatory markers may support the diagnosis, while vascular imaging plays a central role in identifying arterial wall inflammation and structural abnormalities [4,9,10].

Differential diagnoses include atherosclerosis, giant cell arteritis, infectious aortitis, and other systemic vasculitides. Chronic inflammation itself contributes to accelerated atherosclerosis, which may further complicate disease assessment [9,10].

Corticosteroids remain the cornerstone of treatment. However, immunosuppressive agents such as methotrexate are frequently required to achieve sustained remission and reduce corticosteroid exposure. In refractory cases, biologic therapies may be considered [6-8].

Conclusion

Takayasu arteritis remains an underrecognized disease and is often diagnosed at an advanced stage after severe vascular complications have occurred. Early recognition based on clinical suspicion, inflammatory markers, and vascular imaging is crucial to improve patient outcomes [4,9,10]. This case illustrates the importance of considering Takayasu arteritis in patients with unexplained vascular events occurring at a relatively young age, particularly in the absence of traditional cardiovascular risk factors.

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