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Takayasu's arteritis: report of a case with unusual jaw pain

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Abstract

Introduction: Takayasu's arteritis (TA), often referred to as a pulseless disease, is a chronic inflammatory disorder affecting the aorta and its main branches. First reported in 1908 from Japan, it occurs worldwide, but is more prevalent in young oriental females from China and Southeast Asia. The main complications of the disease are due to occlusion of major branches of the aorta. We report a case of an Iranian female who developed left-sided leg intermitent claudication, left arm weakness and left-sided neck and jaw pain.

Keywords: Cardiovascular disorders, Vasculitis, Takayasu's arteritis.

Case Presentation

A 21-year-old woman was referred to the Cardiology Department by otorhinolarynogologistsuspiciousof vasculitis in November 2002. She has experienced gradual and progressive left-lower limb intermittent claudication after 10 meters walking for the last 45 days. She has felt weakness in her left arm activity while combing etc. Left-sided neck pain has also been present for 30 days, and jaw pain on the same side had existed since 8 days before, without tenderness, swelling, inflammation and activity limitation. Adding to her problems. She was also recommended by a denlist for tooth repair, but after two days she felt something like thrilling on the left-side of her neck. After being visited by an otorhinolaryngologist who requested color doppler ultrasonography of the neck vessels she was referred to a cardiologist.At admission, her height was 1.59 cm and she weighed 40 kg.

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Her right radial pulse was normal but it was not palpable in the left side. The blood pressune of her right arm left arm, right and left-leg wene 155/85, undetectable, 160/85 and 120/70 ^{mmHg} respectively. Palpebra was pale but not icteric. Thrilling on the left side of the neck, and to a lesser degree on right side was palpable. Pulmonary examination was unremarkable. No cardiac murmur was audible. The abdomen was soft and flat without tenderness on pressure. Liver, kidney and spleen were not palpable. There was bilateral abdominal bruit around the umblical area. No edema was noticed on legs. Neurological and ophtahalmological examination were normal and fundoscopy showed normal retinal arteries.

Leukocytosis (10000), and a low hemoglobin (10mg/dl) concentration were recorded. Platelet aggregation test revealed no abnormality. A greatly accelerated erythrocyte sedimentation rate of 65 mm/h and an increased C-reactive protein concentration of 3+(no quantitative data) were noted.