Coagulopathy in Takayasu's disease CASE PRESENTATION

UNDER THE GUIDANCE **OF PROFESSOR DR NAGAMANI**

Presenter: *DR DIVYA AKULA*

Postgraduate

Department of General Medicine

OSMANIA MEDICAL COLLEGE

COMPLAINTS

A 23 year old female, house wife , resident of mahaboobnagar came to the hospital with complaints of

1.difficulty in using left lower limb since 20 days
2.difficulty in using right upper limb since 14 days

3.Inability to move right lower limb since 1 day

HISTORY OF PRESENT ILLNESS

- 20 days ago patient sensed heaviness in her left lower limb up to knee for which she took herbal medication. Later the heaviness gradually ascended up to the thigh during which time she gradually was unable to move the limb when she managed walking with support and had drag her leg

- 6 days later similar complaints of heaviness followed by weakness over a period of 5 days in the right upper limb. At this point she noticed the flabby left lower is now stiff with involuntary contractions when supine. She continued using herbal medications for the same

- 10 days later she felt the tightness in the right upper limb similar to left lower limb. Now heaviness was noted since 4 days in the right lower limb which she was unable to move at the time of presentation to hospital

- Patient had history of headache bilateral diffuse not associated with nausea ,vomiting, blurred vision, seizures since 20 days
- No history s/o cranial involvement
- No history of fever, trauma
- No history of bladder ,bowel impairment

PAST HISTORY

- Patient had history of loss of consciousness after which she became normal in 8 hours, with normal CT brain done outside 35 days ago
- No history of hypertension, diabetes, previous cardiac diseases, tuberculosis
- Known hypothyroid using 25 micrograms every day

MENSTRUAL HISTORY

- Cycles lasting for 7 days occurring at intervals of 6 to 7 months
- Married 4 years ago , no children, not on any contraceptives

EXAMINATION

- Conscious, coherent
- Moderately built moderately nourished
- VITAL DATA:
- Temperature normal
- Pulse rate: 86/min --- bilateral radial, brachial and axillary absent pulses, all other pulses felt
- BP: 130/80mm hg(lower limb)
- Respiratory rate: 15/min

NERVOUS SYSTEM EXAMINATION

- INTELLECTUAL FUNCTIONS: normal
- CRANIAL NERVES: normal
- FUNDUS: normal
- MOTOR SYSTEM:

BULK: normal

TONE: spasticity in both lower limbs and right upper limb with normal tone in left upper limb

POWER: all movements at all joints in left upper limb were 4/5, rest everything was 0/5 at admission

- REFLEXES:
- All superficial reflexes normal except abdominal which were absent
- Plantars were up going bilaterally
- DEEP TENDON REFLEXES:

	BICEPS	TRICEPS	SUPINATOR	KNEE	ANKLE
RIGHT	3+	3+	3+	3+	4+
LEFT	2+	2+	2+	3+	4+

- Flexor spasms were noted occasionally
- SENSORY SYSTEM: normal
- SKULL AND SPINE: normal
- NO MENINGEAL IRRITATION SIGNS PRESENT

COURSE IN THE HOSPITAL

- 7 days later in the hospital patient developed spasticity in right lower limb
- As per the opinion of neurophysician she was started on methylprednisolone 1g iv daily
- There was improvement in the power of all 3 limbs which had 0/5 power came to 3/5
- Patient is able to sit without support but unable to sit from supine position

INVESTIGATIONS

COMPLETE BLOOD PICTURE:

Hemoglobin: 9gm%(normocytic normochromic)

ESR: 60mm at 1st hour

CRP levels: 75mg/dl

CUE, RFT, LFT were all within normal limits

TSH: 3.23(0.34-5.6uIU/ml)

Lipid profile: normal

2D ECHO: normal

PT, Aptt: normal

MRI CERVICAL SPINE

- Straightening of cervical spine
- Disc desiccative changes noted at C2-C3 and C5-C6 levels

MRI BRAIN

- Patchy altered signal lesions on T1W1 with few hyperintense areas on T2W1, FLAIR and restricted on DW1 noted in the left fronto parietal, right high parietal, bilateral centrum ovale- **suggestive subacute infarcts**
- Altered signal intensity hyper intense on T2W1, FLAIR and restriction on DW1 noted along bilateral corticospinal tracts- **suggestive subacute infarcts**

MRA BRAIN

- NONVISUALIZATION OF THE RIGHT INTERNAL CAROTID ARTERY WITH SEVERE THINNING OF PETROUS PORTION SUGGESTIVE OF THROMBOSIS

FACOR V LEIDEN MUTATION

- NEGATIVE

HOMOCYSTEINE LEVELS

- 12.49 (3.7 to 13.9 umol/L)

PROTEIN C & S LEVELS

- Protein c :Abnormal 33%(70% - 140%)
- Protein s: Abnormal 20.4%(60%-150%)

ANA LEVELS

- 0.6 (<0.9 negative)
- ANTITHROMBIN III ASSAY:
- 30.7(19-31)

CT WHOLE BODY ANGIOGRAM

- UPPER LIMB ANGIOGRAM:
- Except proximal brachiocephalic artery rest of the great vessels of arch of aorta show no enhancement
- Nonenhancement of bilateral common carotid and subclavian arteries
- Extensive collateral formation noted
- Venous system normal

- Abdomen and lower limb:
- Except short segment narrowing of right superficial femoral artery, all other arteries are normal
- SUGGESTIVE OF TAKAYASU’S ARTERITIS

DIAGNOSIS

- CVA- MULTIPLE INFARCTIONS- RIGHT INTERNAL CAROTID ARTERY THROMBUS- PROTEIN C AND S DEFICIENCY- ASSOCIATED WITH TAKAYASU'S ARTERITIS

TREATMENT

- ANTICOAGULANTS: ACETROM 2mg daily started under cover of HEPARIN 5000U IV QID
- ANTIPLATELETS: ASPRIN 150 mg daily once
- STEROIDS: PREDNISOLONE 40 mg daily on tapering
- PHYSIOTHERAPY

Thank You