An Interesting Case of Gastroenteritis with ‘Shock’

Sir,

A 25 year old male farmer by occupation, presented with colicky abdominal pain, loose stools (3-4 per day) and occasional vomiting since two months. There was no history of fever, dysuria or joint pain. He had no past history of any significant illness or history of illicit sexual contact. He was referred from a peripheral hospital for ‘hypotension’ not responding to treatment.

The patient had a feeble left radial pulse with a pulse rate of 68/min and a BP of 86/60 mm Hg in the left arm, and had no other signs of hypovolemic shock. BP in the right arm was 140/90 mm Hg. Detailed examination revealed a very feeble left carotid pulse and a systolic bruit over the right carotid artery. The cardiac and abdomen examinations were unremarkable. Optic fundi were normal.

Laboratory investigations revealed Hemoglobin 10.5 gm%, leukocyte count 15,200/cmm. ESR, routine biochemistry, lipid profile, stool, urine, chest X-ray, electrocardiogram and abdominal sonography were normal. The two-dimensional echocardiography was normal except mild concentric hypertrophy of the left ventricle. Doppler study of the carotid system showed significant narrowing in both sides. Contrast CT angiography revealed diffuse circumferential wall thickening of ascending aorta, arch of aorta and upper descending thoracic aorta with marked luminal stenosis (80-90%) of bilateral subclavian, proximal common carotid and internal carotid arteries (Fig. 1). Abdominal aorta showed irregular circumferential wall thickening causing 30% luminal narrowing with normal renal, celiac and mesenteric arteries. Our patient satisfied five of the six American College of Rheumatology criteria of Takayasu’s arteritis: age < 40 years, decreased pulsation of one brachial artery, difference of > 10 mm Hg in systolic blood pressure between the arms, right subclavian artery bruit and arteriographic narrowing of the aorta and its primary branches.

Rheumatoid factor and Anti-nuclear antibody were positive. VDRL and Mantoux test were negative. The patient was started on prednisolone and was advised a regular follow up so that vascular intervention, if required may be planned.

Takayasu’s arteritis involves large elastic arteries affecting primarily women in their second and third decades of life. Narrowing of peripheral vessels often leads to a pulseless state.

Presentation as abdominal pain which occurred in our patient is rare; the pain may be either due to mesenteric ischemia or related to colitis.

Involvement of descending and abdominal aorta (reversed coarctation) is more common in India and Type II b variety that was encountered in our patient is comparatively rare.

This case emphasizes the importance of a thorough evaluation in those otherwise normal young persons with ‘unexplained hypotension’. The treating physicians should have a high index of suspicion for this not so uncommon disease in such clinical presentations.

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