

IMAGE CHALLENGE

An unusual finding in a 57-year-old woman with new onset hypertension and a diastolic murmur

CLINICAL INTRODUCTION

A 57-year-old woman presented to our clinic with breathlessness brought on while walking uphill. She had been recently diagnosed with systemic hypertension. There was no known family history of cardiac disease, or prior smoking habit. On examination, pulse was 73 bpm and blood pressure 155/73 mm Hg, which was asymmetrical in her arms. Auscultation revealed a readily audible early diastolic murmur in the aortic area and

bilateral subclavian bruits. ECG showed sinus rhythm with no abnormality. Transthoracic echocardiography demonstrated mild-to-moderate aortic regurgitation, and normal left ventricular size and function. The ascending aorta was mildly dilated (41 mm), with para-aortic thickening noted. Owing to the abnormal appearance of the aortic wall, cardiac MRI, and subsequently ^{18}F -fluorodeoxyglucose (FDG) positron emission tomography (PET) scan was performed (figure 1).

QUESTION

Which complication of the underlying disease is evident in figure 1, panel C?

- A. Aortic aneurysm
- B. Aortic dissection
- C. Aortic thrombus
- D. Coronary artery aneurysm
- E. Coronary sinus fistula

For the answer see page 1771

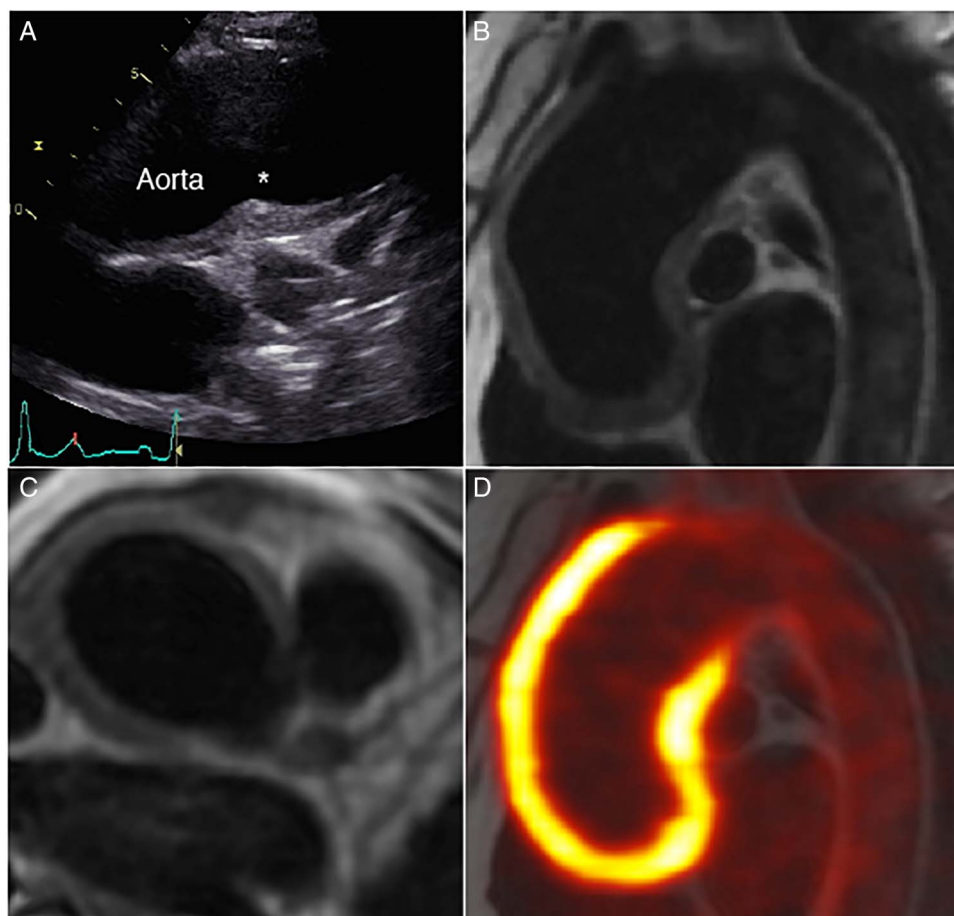


Figure 1 Transthoracic echocardiogram in high left parasternal long-axis view (A); cardiac MRI with black-blood sequence in sagittal (B) and axial planes (C); fused ^{18}F -fluorodeoxyglucose positron emission tomography-MRI (D). The asterisk in 1A refers to para-aortic thickening.

An unusual finding in a 57-year-old woman with new onset hypertension and a diastolic murmur

For the question see page 1762

ANSWER: D

Cardiac MRI shows marked circumferential proximal para-aortic soft tissue thickening, measuring 8.5 mm. Strikingly, a large (8 mm) coronary artery aneurysm involving the left main stem and proximal left anterior descending artery is also evident on MRI. The coronary artery aneurysm (arrows) was further characterised using CT angiography, shown in axial view and three-dimensional volume-rendered CT (figure 2). There was also a non-calcified atherosclerotic plaque at the transition of the aneurysmal and tubular left anterior descending artery, and bilateral subclavian stenoses. ^{18}F -FDG PET images demonstrated severe inflammation of the proximal aorta (maximum standardised uptake value 6.7) and the coronary aneurysm. The underlying unifying diagnosis was vasculitis, most likely Takayasu's arteritis in type. While other vasculitides can cause aortitis, coronary involvement and presence of subclavian stenoses support the diagnosis of Takayasu's arteritis. This large-vessel granulomatous vasculitis typically affects the aorta and its main branches, causing stenosis at the vessel origin.¹ Up to 40% of patients with Takayasu's arteritis also exhibit cardiac complications, which include aortic regurgitation, accelerated atherosclerosis, and, rarely, coronary artery aneurysm.² Multi-modal cardiac imaging plays an important role in diagnosis and therapeutic monitoring.^{3,4}

Jason M Tarkin,¹ James H F Rudd,¹ David R Jayne,² Rosemary A Rusk,³ Deepa Gopalan⁴

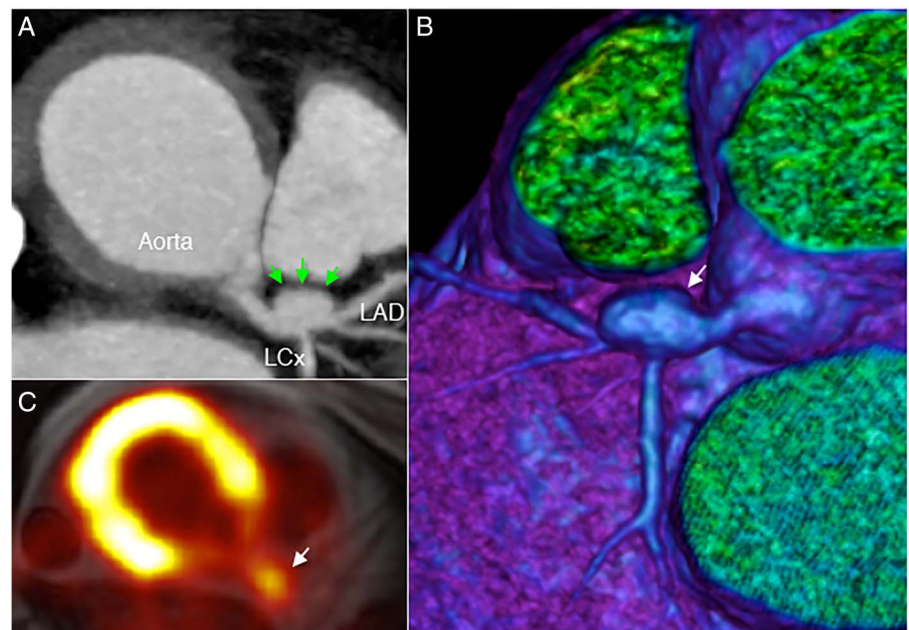
¹Division of Cardiovascular Medicine, University of Cambridge, Cambridge, UK

²Vasculitis and Lupus Service, Cambridge University Hospitals NHS Trust, Cambridge, UK

³Division of Cardiovascular Medicine, Cambridge University Hospitals and Papworth Hospital NHS Trust, Cambridge, UK

⁴Department of Radiology, Cambridge University Hospitals and Imperial College Healthcare NHS Trust, Cambridge, UK

Figure 2 Coronary artery aneurysm (arrows) shown using CT angiography (A), three-dimensional CT reconstruction (B) and ^{18}F -fluorodeoxyglucose positron emission tomography-MRI (C). LAD, left anterior descending artery; LCx, left circumflex artery.



Correspondence to Dr Jason M Tarkin, Division of Cardiovascular Medicine, University of Cambridge, Box 110, Addenbrooke's Centre for Clinical Investigation, Addenbrooke's Hospital, Hills Road, Cambridge CB2 2QQ, UK; jt545@cam.ac.uk

Twitter Follow James Rudd at @jhfrudd

Acknowledgements J.M.T. is supported by a Wellcome Trust research training fellowship (104492/Z/14/Z). J.H.F.R. is part-supported by the HEFCE, the NIHR Cambridge Biomedical Research Centre, the British Heart Foundation, and the Wellcome Trust.

Contributors JMT drafted the article. DG performed imaging. JMT, JHFR, RAR, DRJ and DG revised the article and contributed to its intellectual content.

Funding Wellcome Trust (104492/Z/14/Z).

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.



OPEN ACCESS

Open Access This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: <http://creativecommons.org/licenses/by/4.0/>



CrossMark

To cite Tarkin JM, Rudd JHF, Jayne DR, et al. *Heart* 2016;**102**:1771.

Received 2 April 2016

Revised 4 June 2016

Accepted 10 June 2016

Published Online First 13 July 2016

Heart 2016;**102**:1771. doi:10.1136/heartjnl-2016-309661

REFERENCES

- Weyand CM, Goronzy JJ. Medium- and large-vessel vasculitis. *N Engl J Med* 2003;349:160–9.
- Kerr GS, Hallahan CW, Giordano J, et al. Takayasu arteritis. *Ann Intern Med* 1994;120:919–29.
- Mason JC. Takayasu arteritis—advances in diagnosis and management. *Nat Rev Rheumatol* 2010;6:406–15.
- Hartlage GR, Palios J, Barron BJ, et al. Multimodality imaging of aortitis. *JACC Cardiovasc Imaging* 2014;7:605–19.