A 35-year-old man was diagnosed with Takayasu’s arteritis aged 11 years when he presented with hypertension. He had raised inflammatory markers, and computed tomography angiography (CTA) revealed narrowing of the thoracic aorta (TA). Drug therapy was recommended, which the family declined for personal reasons.

The patient lead an active life and was asymptomatic until a year ago, when he presented with lower extremity claudication and fatigue on moderate exertion. Physical examination revealed reduced pulses in the lower extremities and hypertension in the upper extremities.

Transthoracic echocardiography demonstrated a preserved left ventricular systolic function and no significant valve abnormalities; negative inflammatory markers indicated disease inactivity.

CTA of the aorta revealed calcification and multiple aneurysms of the TA and abdominal aorta (AA). The largest aneurysm (71 mm in diameter) was located in the TA (Panel D, red arrow). There was significant AA dilatation, associated with dissection of the anterior portion and a probable saccular thrombus in the anterior wall (Panel D, yellow arrow).

Distal AA occlusion following the renal arteries origin (Panels A–D, green arrow) was associated with significant internal thoracic arteries (ITA) dilatation and collateral vessels (CV) directed to the iliac arteries (IAs) (Panels B and C, white arrows). The mesenteric artery (MA), right renal arteries (RRA), and left renal arteries (LRA) were spared (Panel A, blue arrows).

The patient declined surgical resection of the thoracic aneurysm and bypass grafts to the legs. He was discharged on beta-blockers and ACE inhibitors, with outpatient follow-up for close monitoring.

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