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VASO-RENAL HYPERTENSION IN NON-SPECIFIC AORTOARTERITIS

(Clinical case)

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Abstract. The most common causes of death in nonspecific aortic arteritis are: stroke, myocardial infarction, rupture of an aortic aneurysm. One of the topical issues of the introduction of patients with this disease is the correction of basic treatment after surgery on the affected vessels. This article presents a clinical case of Takayasu arteritis in a patient who was admitted after prosthetics of the abdominal aorta and left renal artery with vasorenal hypertension.

Keywords: nonspecific aortoarteritis, vasorenal hypertension.

Introduction. Nonspecific aortic arteritis (Takayasu's disease) is a granulomatous inflammation with the development of occlusion of the aorta and its main branches and the absence of a pulse on one or both hands. Mostly women aged 40-50 years are ill [1-10]. The disease was first identified in 1908 by Takayasu. The highest prevalence rate (40 cases per 1 million population) was registered in Japan, the lowest (0.9 per 1 million) in the USA. Modern epidemiological studies record an increasing prevalence of AT in Europe (from 0.4 to 1.5 cases per 1 million) [11-22]. Vasorenal hypertension (VRH) is one of the types of symptomatic arterial hypertension that is not associated with a predominant lesion of the renal parenchyma and urinary tract due to impaired blood flow in the renal arteries [23-35]. Among all types of arterial hypertension, vasorenal hypertension accounts for 2-5%. The basis of HRG is a single- or bilateral narrowing or occlusion of the renal arteries or their segmental branches. As a result, blood flow to the kidney through a pathologically narrowed section of the artery is significantly reduced, which in turn causes ischemia of the renal tissue. The degree of ischemia directly depends on the degree of artery stenosis [36-55].

The purpose of the study: to study the clinical situation and evaluate the effectiveness of basic and hypertensive treatment for nonspecific aortic arteritis and to identify shortcomings in the treatment of the patient.

A clinical case.

General information: The girl is 26 years old.

From anamnesis: In 2015, he was diagnosed with "Nonspecific aortoarteritis". In 2020, thoracophrenolumbotomy, prosthetics of the abdominal aorta and left renal artery were performed"

Complaints on admission: Pain throughout the body, tingling in the arms and legs, cold hands and feet, dizziness and headache. increased blood pressure, general weakness.

Objective inspection: It's a common medium-sized disease. Active status, you can move independently. Temperature bodies 36.6 C. The normostenichskaya Constitution. Skin pale, clean. Lymphatic uxplancer. not enlarged. I did not see any

peripheral changes. then operations in left toracoabdominal areas determined rubetz. Musculoskeletal apparata: pain in the calf, numbness of ruck and foot, poise of ruck and foot. Objective:when palpations in the ring and torso determine painful points. Respiratory urgentablab. Objective: tuberous cell cylindrical shape aposematic, percutaneous leg sound, number D aposematic movable 18 in 1 min, vesicular d aposematic in auscultation legkich. Serdec-socudic system Serdecordation: serdecordation and pain in areas serdecordation. Overall: no pathological changes in the osmotre regions of serdza. A lot of hard work. Border. border. serdza expanded. vlevo at +1.5 cm. Tone repeatable heart muffled repeater, rhythmic repeater. Arterial discharge (ad) of the left arm is equal to 180/60 mm PT.St., at right ruck AAD 160/60 mm PT.St. in the equal. Stul inclined to seize. When auscultation in the extravehicular, there is a noise over the Brushy aorta, the left and the right palatal arteries. To date, prinimala preparation has been circulated: prednisolone 5 mg 1 tablet; Amlodipine 10 mg 1 tablet of 1 mg; 1 tablet Telmisartan 80 mg; clopidogrel 75 mg 1 tablet of 1 max.

Laboratory and instrumental studies:

Ultrasound examination of the liver, kidneys: echo signs of minor changes in liver parenchyma. Kidney - hypoplasia of the right kidney. Left-sided pyelonephritis, salt diathesis.

ECG: hypertrophy of the left ventricle, hypoxic changes of the myocardium.

ECHOCG: concentric hypertrophy of the left ventricle (LV), LV ejection fraction 58%.

Biochemical blood analysis: C-reactive protein - 32 mg/l; Rheumatoid factor - 7 IU/ml; Antistreptolysin O – 420 IU/ml; Total cholesterol - 3.9 mmol/l; urea - 12.8 mmol/l; creatinine - 202.0 mmol/l; Glomerular filtration rate - 61 ml/min/ 1.73 m².

General blood test: hemoglobin - 74 g/l; ESR – 24 mm/h

Clinical diagnosis: Main: Nonspecific aortoarteritis. Occlusion of the infrarenal branch of the abdominal aorta. Occlusion of the right renal artery. Critical stenosis and occlusion of the left renal artery. Critical bilateral stenosis of the common carotid artery. Condition after thoracophrenolumbotomy, prosthetics of the abdominal aorta and left renal artery. Angioplasty of the renal artery

Complication: A shrunken kidney. Chronic kidney disease stage 2. Severe vasorenal hypertension.

Recommended treatment: The patient underwent pulse therapy (Cyclophosphane) in stationary conditions; As a hypotensive treatment: Indap 2.5 + Nebivalol 5 mg 1/2 + Amlodipine 10 mg + Telmisartan 80 mg; Basic treatment: Azothioprine 50 mg 2 times; Against autoimmune inflammation: Prednisolone 5 mg 1 tab 1 time; Antiplatelet: Curantil 25 mg 1 tab 3 times.

After 1 month. Complaints: there is no shortness of breath during physical exertion. In the left arm, blood pressure is 140/60 mmHg, in the right arm, blood pressure is 130/60 mmHg. During auscultation, noise is detected over the abdominal

aorta, left and right renal arteries. C-reactive protein - 16 mg/l; Total cholesterol - 3.9 mmol/l; urea - 10.2 mmol/l; Creatinine - 124.0 mmol/l.

Conclusion. In patients with nonspecific aortic arteritis, the patient's condition remains satisfactory for a long time, which is associated with the development of collateral circulation. The most common causes of death in this syndrome are: stroke, myocardial infarction, rupture of an aortic aneurysm. This clinical case is about a successful operation. But it should be noted that basic therapy and correction of blood pressure is a necessary aspect in patients with aortoarteritis. Joint management of these patients by rheumatologists, cardiologists and angiosurgeons will improve the prognosis and quality of life of patients.

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