Our child had asymmetric limb hypertrophy, vascular malformations as well as a cutaneous vascular malformation on the lower foot. The lower limb is involved in 95% of the cases [4]. While bleeding from the vascular lesions are infrequent complications (hematuria from a vascular malformation of the urinary tract or rectal bleeding from a gut lesion) [4], intra-articular bleeds from such a lesion are extremely rare [5]. Screening of this child revealed no other associated features such as lymphatic obstruction, spina bifida, hypospadias, polydactyly, syndactyly, oligodactyly, orofacial abnormalities, hyperhidrosis, hypertrichosis, paresthesia, or decalcification of bones [4].

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# Active Tuberculosis with Takayasu Arteritis

A 14-year-old girl presented with the chief complaints of low grade, intermittent fever and persistent cough for 4 months. She had calf pain and exertional dyspnea for 1 month. Her heart rate was 114/minute. Lower limb pulses were not palpable. She had a systolic murmur over the pulmonary area and a bruit over epigastrium. Blood pressure in her upper limb (186/118 mm of Hg) was considerably higher than in lower limb (160/86 mm of Hg). Her blood pressure had never been recorded previously. She had no family history of hypertension. The blood counts were normal but ESR was 114 mm/1st hr. Chest *X*-ray showed haziness of middle and lower zones of bilateral lung fields, with an enlarged cardiac shadow. Echocardiography suggested mild mitral regurgitation with tricuspid regurgitation and mild pulmonary arterial hypertension. Ophthalmoscopy showed bilateral papilledema. Mantoux induration was 32x28 mm. Sputum was positive for acid fast bacilli (2+). Magnetic resonance angiography showed narrowing of abdominal aorta from the point of origin of renal arteries along with absence of collaterals in left femoral region (***Fig.* 1**). There was narrowing of both renal arteries. A diagnosis of tuberculosis in a patient of Takayasu arteritis was made as per 1990 ACR (American College of Rheumatology) criteria for Takayasu arteritis [1].

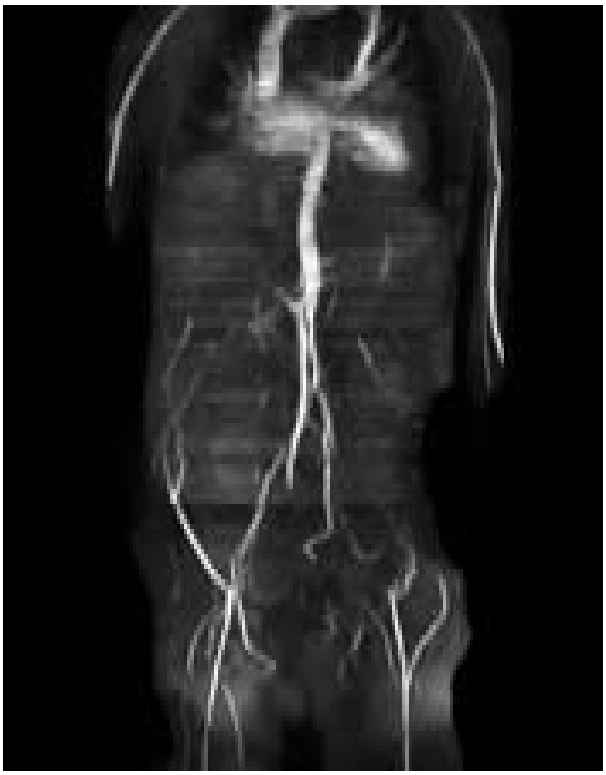

**FIG.**1. *MR angiography showing narrowing of abdominal aorta and absence of collaterals in left femoral region.*

We started treatment for tuberculosis with isoniazid, rifampicin, ethambutol and pyrazinamide. Prednisolone, methotrexate and folic acid were added following consultation with rheumatologist. Amlodipine was also added. Thereafter because of persistence of hypertension we added atenolol, spironolactone and prazosin sequentially. Gradually her fever subsided and blood pressure stabilized at 132/88 mm Hg. She has been discharged and is under regular follow up.

Patients with Takayasu arteritis have increased immune response to *Mycobacterium tuberculosis* antigens, in particular to its 65 kDa HSP, suggesting a role of this organism in the immunopathogenesis of the disease [2]. There have been a few reported cases of active tuberculosis with Takayasu arteritis in the pediatric population. In two of the cases [3,4], patients responded to treatment with antitubercular drugs and prednisolone. In the other case [5], a 12-year-old boy was given cyclophosphamide along with anti- tubercular drugs and prednisolone. He eventually underwent nephrectomy. Anti-hypertensives were used in all cases. Treatment of TA is based on the use of immunosuppressants such as prednisolone and/or methotrexate to decrease inflammatory activity. Our patient received both azathioprine and cyclophosphamide. Mycophenolate mofetil and tacrolimus are also used, especially for corticosteroid-resistant disease. Hypertension should be aggressively managed.

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