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On the Cover

What's the diagnosis? A 14-years-old girl was admitted to our department due to hypertension of unknown aetiology and claudication after moderate physical exercise. Brachial and femoral pulses differed in timing and amplitude, with a decrease of 10 mmHg in systolic blood pressure between lower and upper extremities. A colour-Doppler ultrasound was performed in order to exclude renovascular hypertension. Since abdominal aorta was not clearly recognizable, contrast-enhanced tomography was carried out, showing the presence of abdominal aortic coarctation a few centimetres below superior mesenteric artery origin. Extensive collateral circles between the first tract of abdominal aorta and iliac, splenic and renal arteries were observed. Little aneurysms were present in the intermediate tract of both renal arteries.

Although most patients have a discrete narrowing of the descending aorta at the insertion of the ductus arteriosus, coarctation may be located in the abdominal tract as well. In previously undiagnosed adults, the classic presenting sign is hypertension. Despite the variability in blood pressure in the upper and lower extremities, regional blood flow is generally maintained within normal limits by autoregulatory vasoconstriction in the hypertensive areas and by vasodilation in the hypotensive areas. Most patients are asymptomatic unless severe hypertension is present. In addition, claudication of the lower extremities can occur due to reduced flow, especially with physical exertion.

In the case we described, two bypasses between renal arteries and homolateral common iliac arteries were performed using saphenous veins. Claudication improved promptly. Telmisartan was also administered and optimal blood pressure control was obtained, with a normal renal function at six months. (*Image and text provided by Dr. Anna Clementi and Dr. Antonio Granata, Nephrology and Dialysis Unit - San Giovanni di Dio Hospital, Agrigento, Italy*)