KAWASAKI'S DISEASE

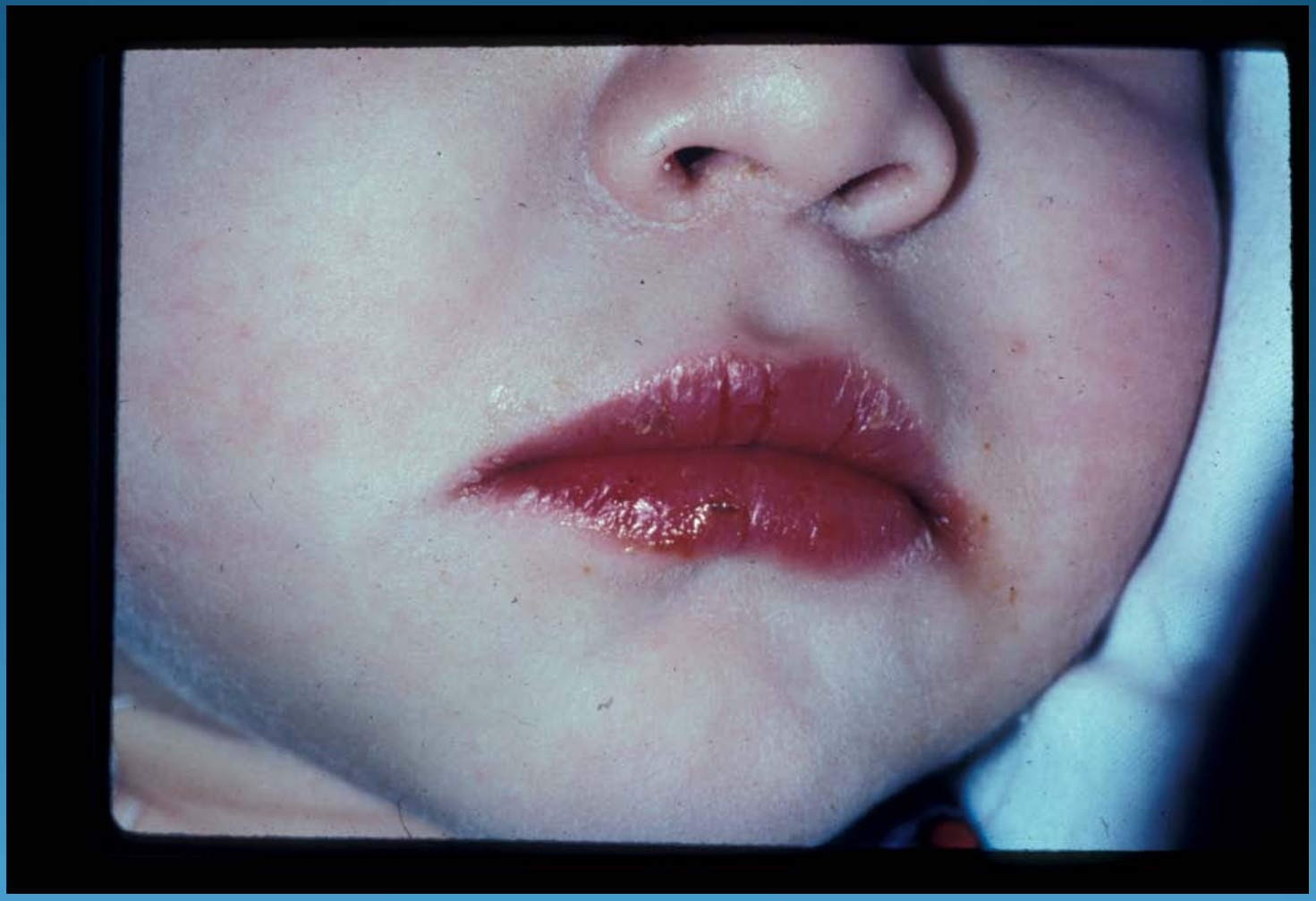
MUCOCUTANEOUS LYMPH NODE SYNDROME

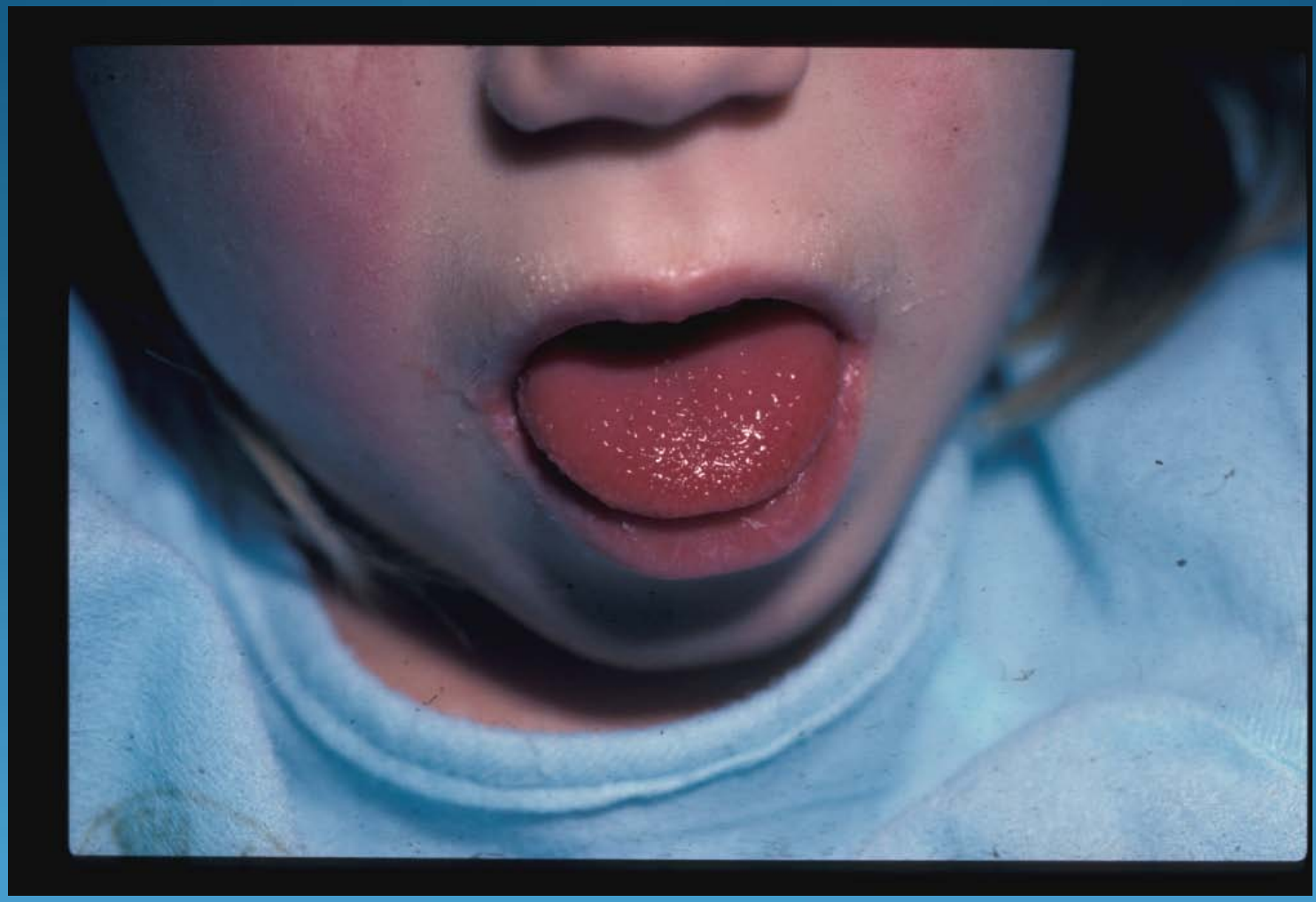
EPIDEMIOLOGY & ETIOLOGY

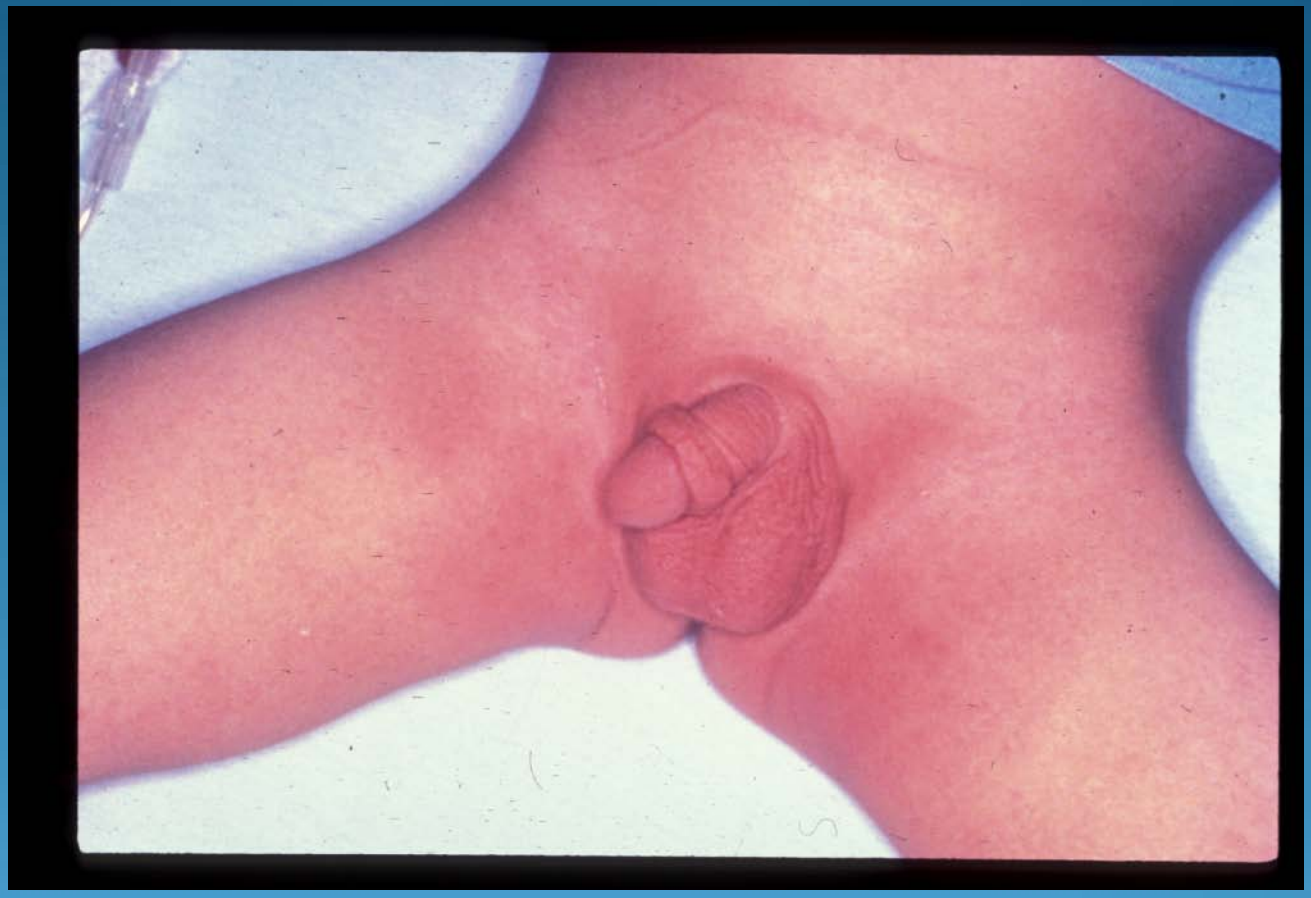
- Highest incidence is in Japanese children
- Ages 7wks-12yr, most < 5yrs old
- HLA types BW22, BW22j2
- Etiology is unknown, possibly viral
- Estimated 3000 cases per year in US

CDC DIAGNOSITIC CRITERIA

- **FEVER**: > 5 days not responsive to ABX or NSAIDS.
- Bilateral Conjunctival Injection
- Acral changes
- Mucous membrane changes
- Rash
- Cervical Lymphadenopathy > 1.5cm

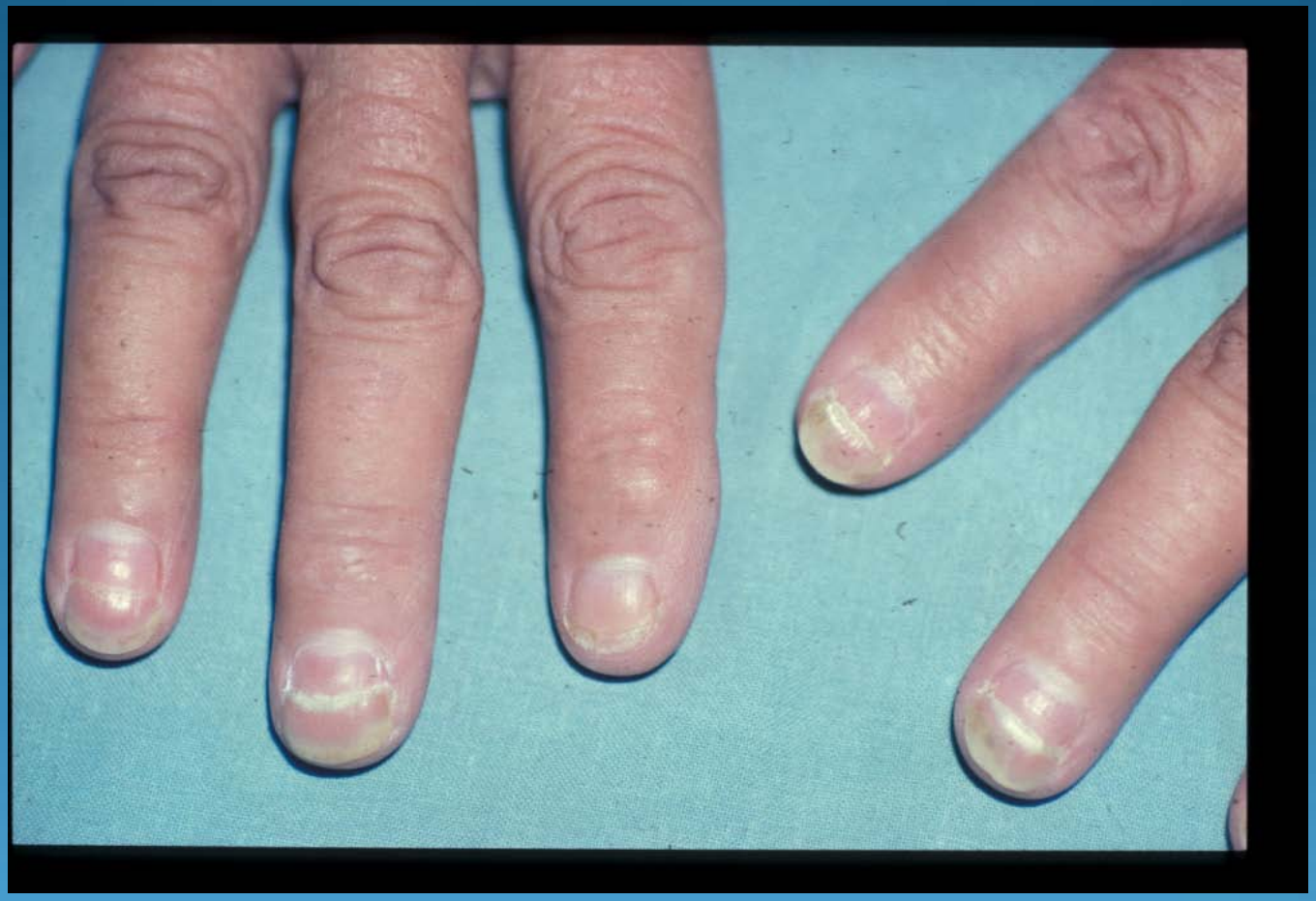






OTHER CLINICAL FINDINGS

- Beau Lines, or nail loss
- Cough, and rhinorrhea
- Diarrhea, vomiting, abdominal pain
- Arthralgias
- Very fussy inconsolable infants and toddlers

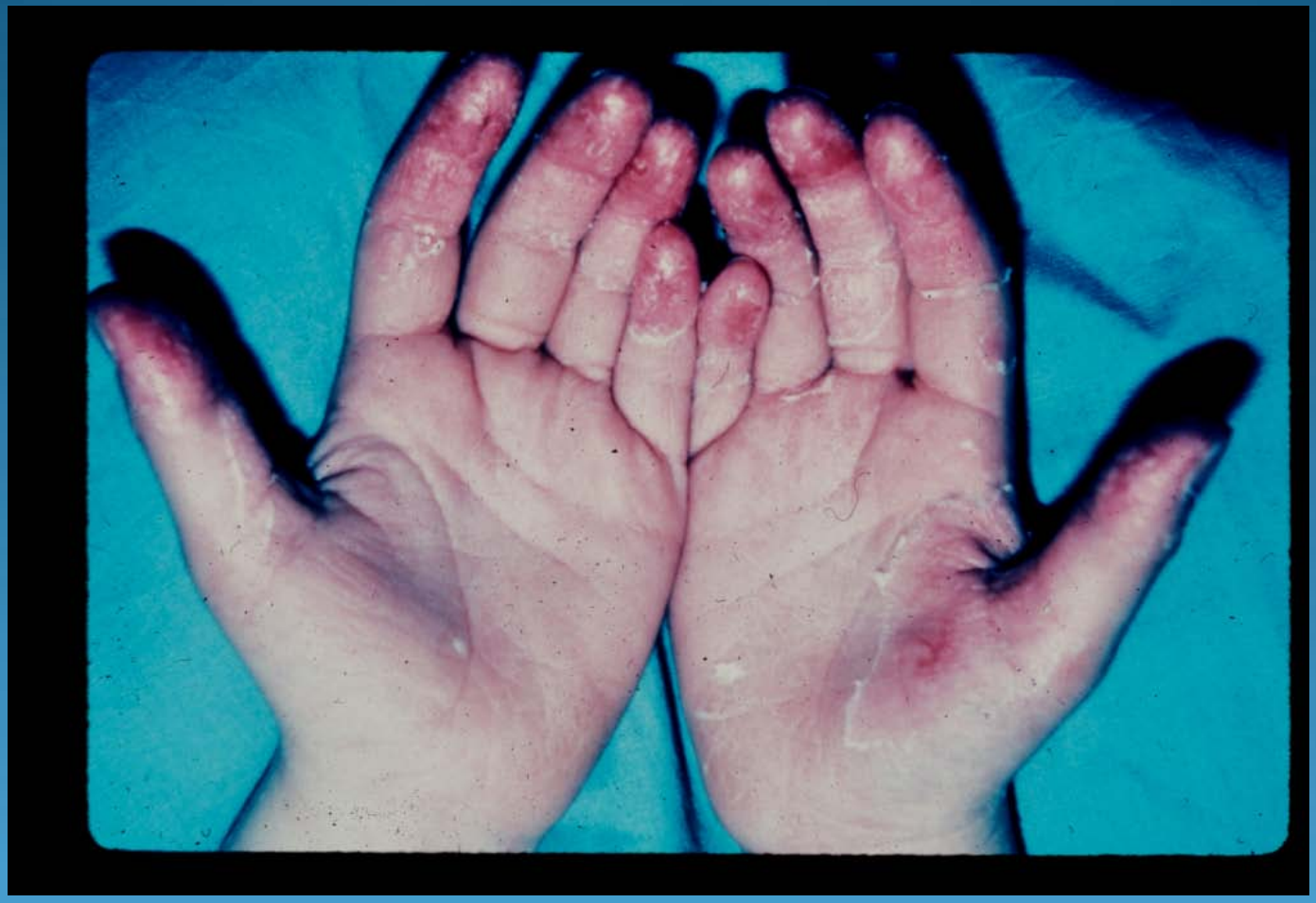


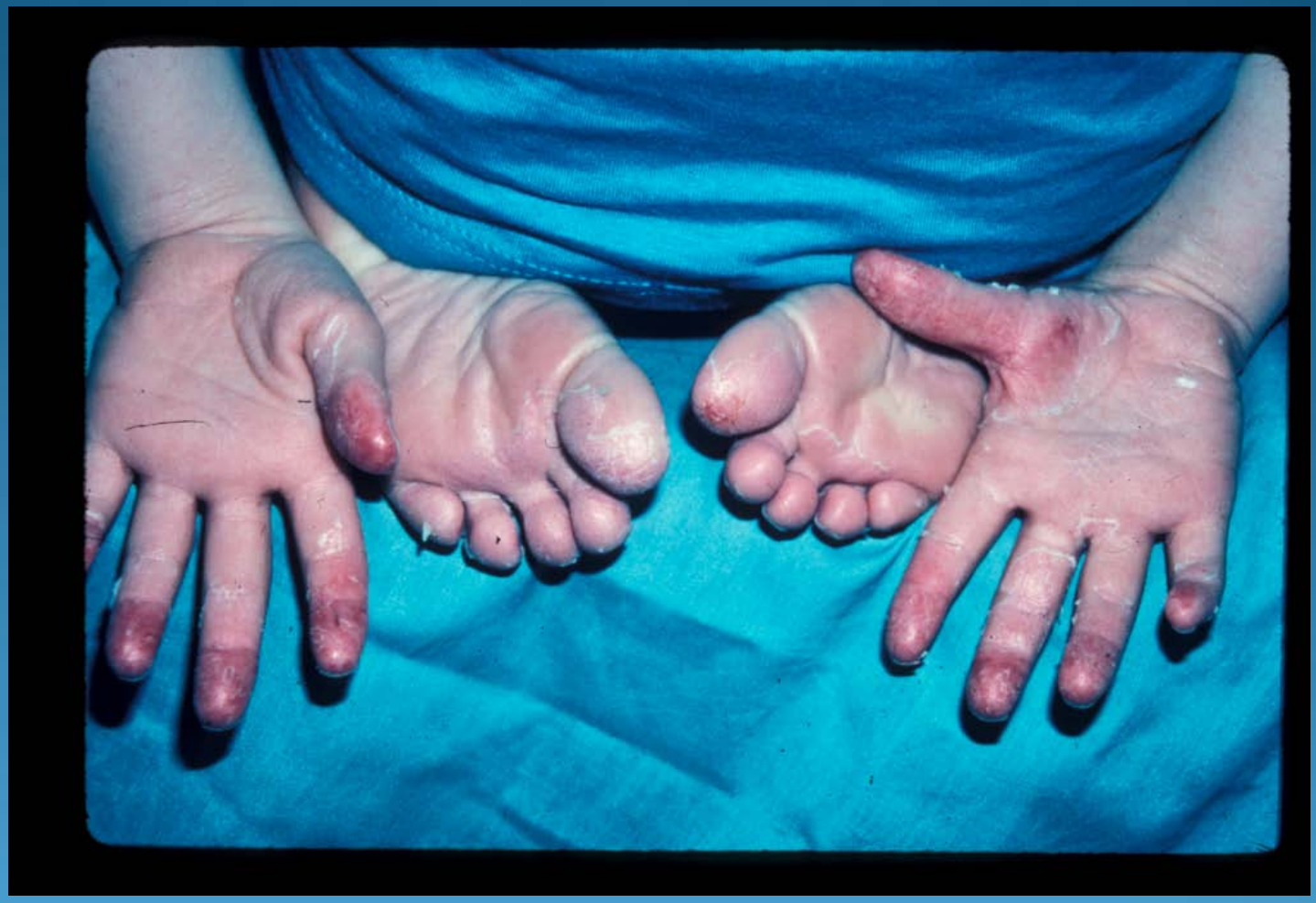
LABORATORY FINDINGS

- **THROMBOCYTOSIS**: > 1 million in 3rd wk
- **STERILE PYURIA**: Urethral inflammation
- **LEUKOCYTOSIS, ESR, CRP**: 2nd stage
- **ECG, ECHO CHANGES**: tachy, decrease EF from myocarditis and aneurysms in 2nd stage.

3 CLINICAL PHASES

- **Acute Phase**: Last 10-14days, includes diagnostic clinical findings.
- **Sub acute Phase**: Begins when fever subsides, and rash improves. Period of carditis, coronary angiitis, thrombocytosis, and elevated CRP and ESR.
- **Convalescent Phase**: Begins in 4^{th} or 5^{th} week when clinical signs resolve, and ends when ESR normalizes.





TREATMENT

- IVIG 2 g/kg over 10-12hrs
- ASA 80-100mg/kg/d divided Q6 x 14days
- ASA 3-6mg/kg/d for 6-8wks
- Currently may be changing to low dose ASA instead of high
- Check IgA level prior to IVIG
- **NO STEROIDS**, Increase Aneurysms

COMPLICATIONS

- Carditis and Coronary Angiitis: Occurs in 20% of pts, but only 1% get serious hrt dz.
- If Aneurysms occur, F/U with ECG, Echo and stress test yearly.
- 50% of aneurysms will resolve in 1-2yrs
- Mortality 1-2%, most during 2-7th week.
- Recurrence rate of 2-3%