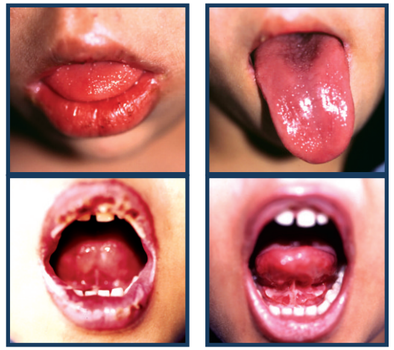
1. Intravenous immunoglobulin (IVIG) 2gms/kg (ideal within first 10 days; do not deny even after day 10 with manifestations of continuing inflammation)
   - Drip to run over 12 hrs (slower or divided doses if cardiac decompensation).
   - May commence treatment before 5 days of fever if sepsis excluded and diagnosis confirmed.

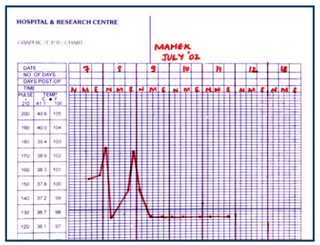
Rate of administration	mg/kg/hr	ml/kg/min
First 30 mins	30	0.01
Next 30 mins	60	0.02
Next 30 mins	120	0.04
Maximum	<200	<0.07

   - Treat ADR with antipyretic, antihistaminic.



Before IVIG 48 hours later

2. Tab Aspirin (80-100mg/kg/day) in 3-4 divided doses till fever resolves for 48 hours then 3-5 mg/kg day for a minimum of 6 weeks or longer guided by the 6 week ECHO.



3.
   - 2 D ECHO at diagnosis and 6 weeks follow up.
   - No live vaccines for at least 3 months after IVIG.
   - Beware false positive serologic/immunologic tests for 3 months after IVIG.

4. Treat in conjunction with specialist if:
   - Diagnosis in doubt.
   - No response to first dose of IVIG (usually, reversal of features in 48 hours).
   - Coronary changes on 2 D ECHO.

"Beaus lines" seen on 6 week follow up

Websites worth visiting
www.kdfoundation.org

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Authors of first version :
Dr Raju Khubchandani / Dr. Chetna Khemani
with inputs from :
Dr. Rachana Hasija, Dr. Vijay Viswanathan, Dr. Anand P.
Pediatric Rheumatology Clinic Jaslok Hospital, Mumbai - 400026.
Revision 2010 :
Dr Raju Khubchandani / Dr Chetna Khemani

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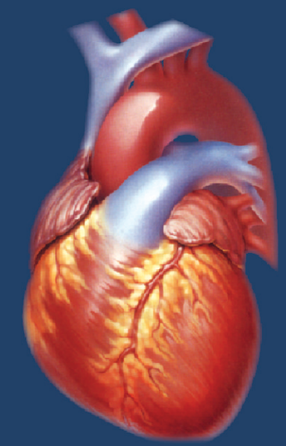
Written for :
K D Registry, MBIAP

Read, Assimilate, Photocopy, Spread, Acknowledge

2nd Edition

Spend a minute SAVE A HEART !



This ready reckoner, is brought to you by
Kawasaki Disease Registry,
Mumbai Branch of IAP
First printed in 2007 & revised 2010

Some golden rules!

1. Most cases of Kawasaki Disease (KD) occur before the fifth birthday.
2. Kawasaki Disease (KD) is a clinical diagnosis.
3. The principal clinical diagnostic criteria may not all be present at one time; watch for temporal evolution while enquiring about previous events.
4. Each of the individual principal criteria is non-specific and commonly seen in other diseases, but put together make a diagnosis.
5. Awareness and recognition of other non-principal signs may improve the diagnostic yield.
6. In a community where most children have been immunised against various vaccine-preventable exanthems, one should suspect KD in children with febrile exanthems.
7. Children below one year tend to have incomplete disease more often and a higher risk of coronary involvement.
8. There is no diagnostic test. Judicious use of laboratory studies could help to lend strength to the diagnosis of KD. Thrombocytosis (an acute phase reactant) is a late second week occurrence but not a diagnostic criterion.
9. Untreated, KD is a self - limiting condition with fever and manifestations of acute inflammation lasting for an average of 12 days without therapy. Upto 25% of untreated patients develop coronary aneurysms.
10. Diagnosing KD is an urgency but not an emergency. In a patient with 5- 6 days of fever and few features, continued close observation and laboratory study is often the best course of action.

The principal signs and...

✓ Typical features X Doubt diagnosis if……

A Fever

✓ >5 days, 38.5°-40°C (101.5 F-104 F) persistent, high grade, poorly responsive to antipyretics

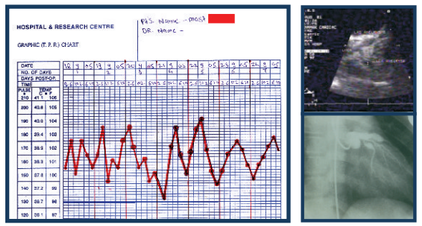
X Low fever!

AND

Four out of five below
not explained by another disease process

or

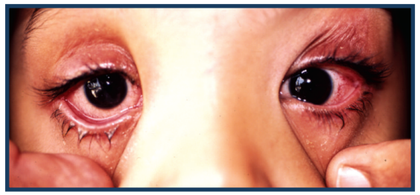
Less than four out of five below
with coronary artery changes abnormalities



B Eye

✓ Bilateral, non exudative, bulbar, perilimbal sparing. Photophobia (anterior uveitis)

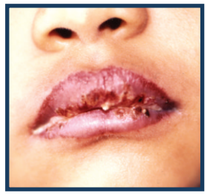
X Purulent discharge



Mouth

✓ Cracked red lips, strawberry tongue, injected pharynx

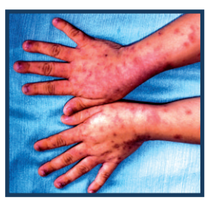
X Discrete oral lesions, vesicles, ulcers, tonsillar exudate

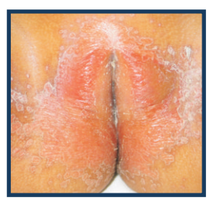


Skin

✓ Truncal and perineal rash (macular, morbilliform, targetoid-Z) Seldom pruritic. Diaper desquamation by end of week 1

X Vesicular, bullous lesions

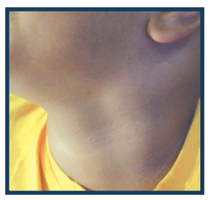


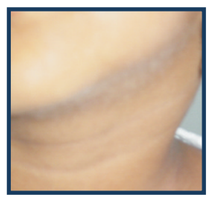


Nodes

✓ Anterior cervical, unilateral > 1.5 cms (cluster of grapes' on ultrasound)

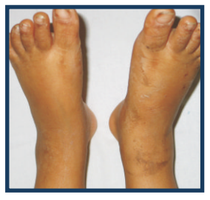
X Diffuse adenopathy, splenomegaly

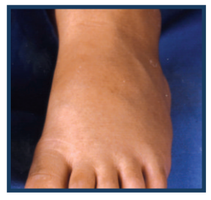




Extremities

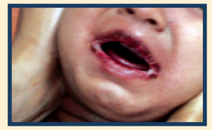
✓ Edema of dorsum of hands and feet. ('iv gone out' appearance); Red purple erythema, palms and soles;
Desquamation starts periungually but is a second week feature (retrospective confirmation)



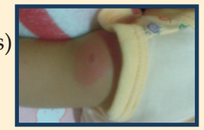


...beyond

- Irritability



- Diarrhoea, vomiting
- Tachycardia,
- S3 gallop, failure
- Arthritis-small joints first week,
  - large weight bearing joints second week
- Hyperemic tympanic membranes
- BCG reactivation (infants)



- Hepatomegaly,
  - raised enzymes, hypoalbuminemia
- Sterile pyuria
- Right upper quadrant pain
  (Gall bladder hydrops on USG)
- Anemia, leucocytosis, thrombocytosis,
  raised ESR / CRP
- Pleural effusion, (Xray chest)
  Pericardial effusion (ECHO)
- Aseptic meningitis
  (Normal CSF protein)
- Periungual
  desquamation