Atypical kawasaki disease with unusual combination

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On admission

- **3 ½ year old male child, admitted with high grade fever 4 days with loose stools ,vomiting, abdominal pain, erythematous rashes and hepatomegaly with the provisional diagnosis of Dengue illness.**
- **CXR on 3rd day of illness Normal**

Investigations on admission

- Neutrophilic leucocytosis, PCV,platelets, SGOT,SGPT-normal
- CXR-normal
- CRP-positive(90)
- Bacterial inf, UTI was suspected.
- Started on IV.Ceftriaxone.

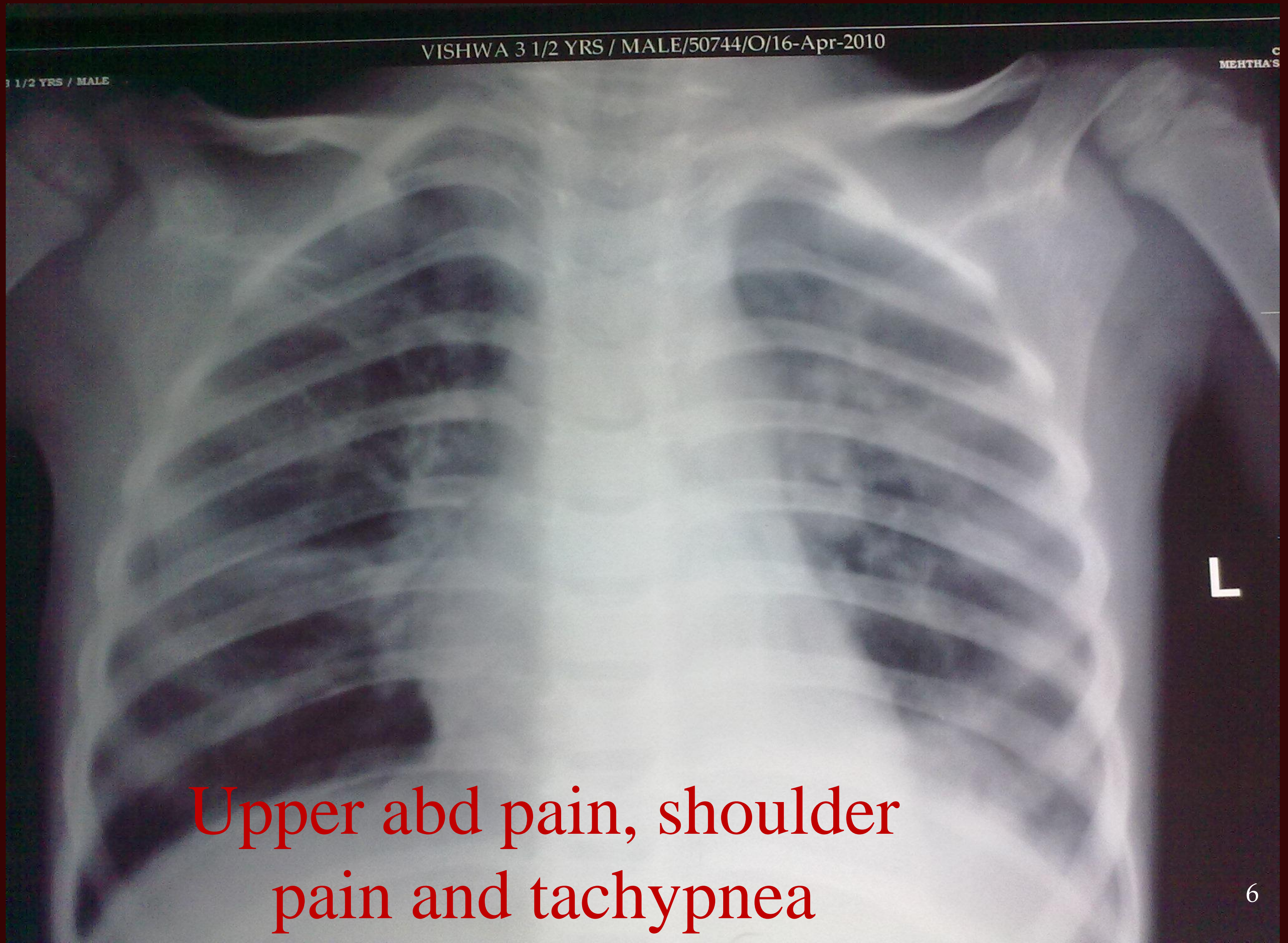
Course of illness…

- Fever spikes- continued (peak 102)
- USG abdomen-minimal pleural fluid left and mild hepatomegaly, kidneys normal.
- CRP:90 → 104
- Leucocytosis
- ESR-42/80

Day 5 of hospitalisation

- Persistent Abdominal pain
- Developed Tachypnoea
- Rpt CXR – Broncho pneumonia predominantly left side
- Antibiotics escalated to IV Linezolid

Repeat Chest X-Ray done



Upper abd pain, shoulder pain and tachypnea

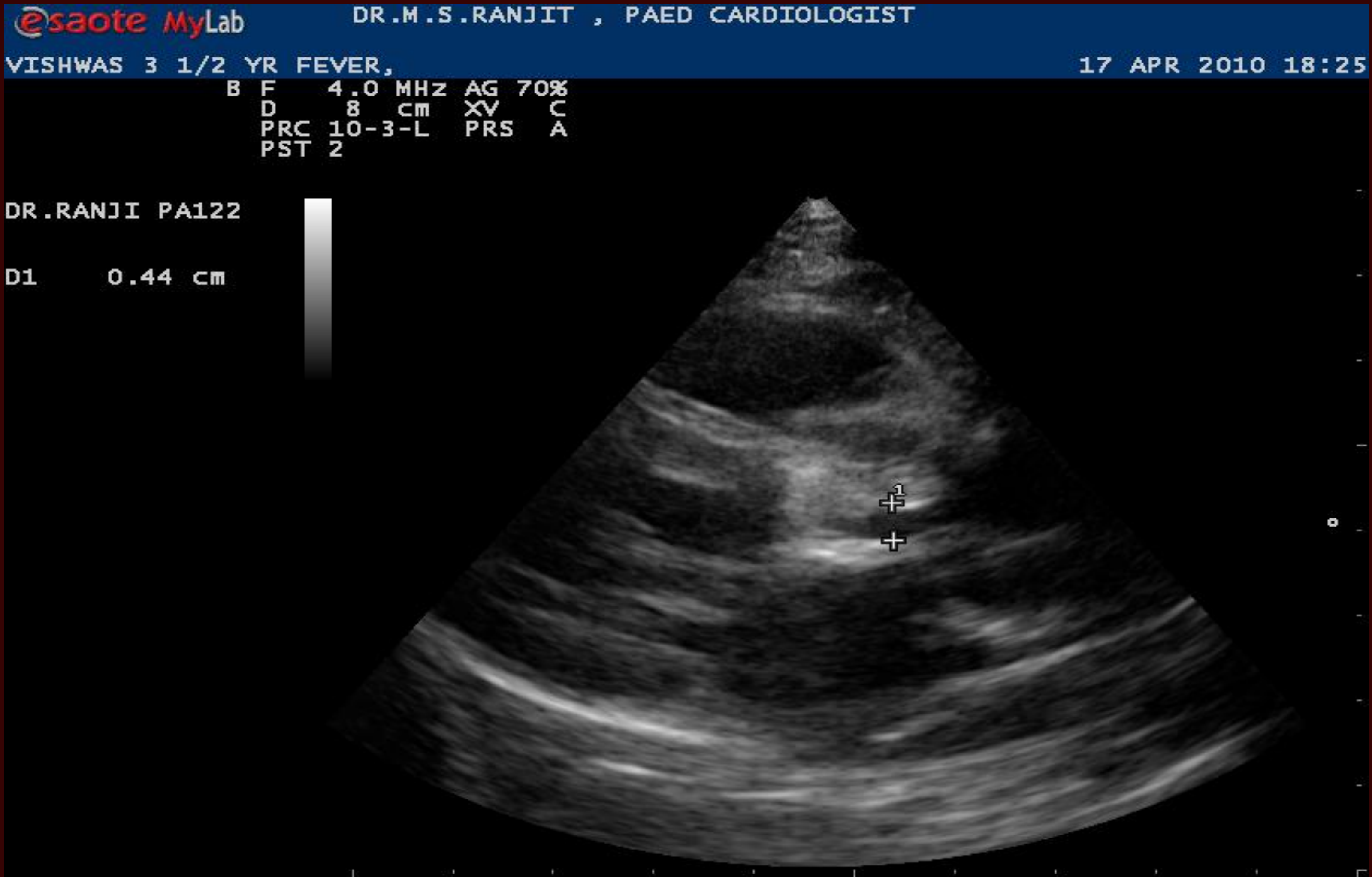
- What possibilities to consider ?

ON 7th Day Of Illness

POSSIBILITY CONSIDERED	ACTION TAKEN
Empyema	CXR repeated – No pleural fluid
Atypical pneumonia	Clarythromycin added. No response
Swine Flu	H1N1 screen negative
Kawasaki disease	Echo screen done- LMCA ectasia.

Bloood, Urine C/S, Widal Negative

Day 9 of illness



Diagnosis ?

INCOMPLETE KAWASAKI

Management

- Started IVIG infusion(1 gm/kg/day for 2 days)
- Aspirin:1oo mg/kg/day
- **Response to treatment within 12 hrs, became afebrile**
- Pneumonia /? II ary to vasculitis
- Shoulder pain, ECG normal

15th day of illness
Showed desquamation after discharge

Diagnostic criteria for kawasaki disease

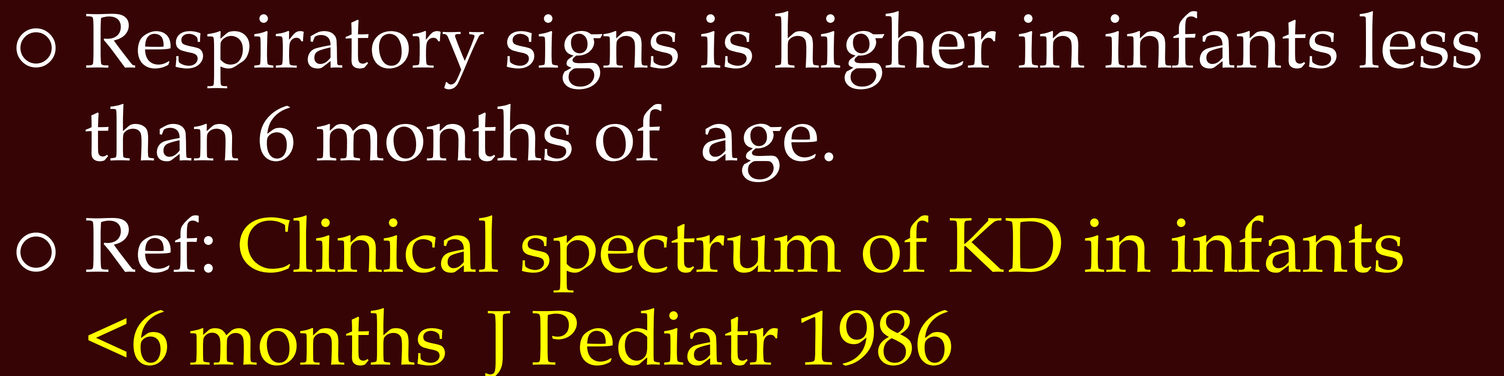
- Fever lasting for at least 5 days

Presence of at least 4 of the following 5 signs

- Bilateral bulbar conjunctival injection
- Strawberry tongue,mucosal changes,fissured lips
- Edema/erythema of hands and feet or periungual desquamation
- Rash ,mainly truncal
- Cervical lymphadenopathy,usually U/L

Atypical KD (Korean J Pediatr 2009)

- Not meeting diagnostic criteria
- Lung involvement is uncommon in KD but on autopsy,interstitial pneumonia was recognised in 30-90% of all cases with KD.
- Ref:Acta PatholJpn.1980(Gen.path of kd on morphological alteration corresponding to clinical manifestations)


Respiratory signs is higher in infants less than 6 months of age.
Ref: Clinical spectrum of KD in infants <6 months J Pediatr 1986

Chest x ray finding in acute phase of KD (Pediatr Radiol 1989)

- 129 pt with KD studied
- Abnormal CxR -14.7%
- Reticulogranular pattern(89.5%), Peribronchial cuffing(21.1%),Pleural effusion(15.8%),Atelectasis(10.5%) and air trapping(5.3%)
- Pathological basis not clear - lack of HPE.
- Probably inflammation &/vasculitis/pulm edema-CCF.

Report from Archives of Diseases of childhood – October 2003

- Two cases of atypical Kawasaki disease (KD) manifested as persistent lobar lung consolidation, prolonged fever, and active inflammatory laboratory markers unresponsive to antibiotic treatment are reported. One of the children developed a giant coronary aneurysm.

Why this case is presented ?

- Increasing diagnosis of Atypical Kawasaki disease …
- Association of Pneumonia
- KD also should be considered as a DD when ever Pneumonia is not responding to higher antibiotics after ruling out other complications like Empyema?

THANK YOU