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Clinical profile of Kawasaki disease (KD) in children admitted at Dhaka Shishu (children) Hospital

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Statement of the Problem: Kawasaki disease (KD) is an acute, febrile, self-limiting vasculitis of the medium-and small-sized arteries of unknown etiology. The aim of this study was to evaluate its presenting symptoms, clinical course, laboratory tests, and treatment in children with complete and incomplete KD.

Methodology & Theoretical Orientation: Medical records of 20 children with KD admitted in Dhaka Shishu Hospital, between January 2011 and December 2014, were reviewed for demographic features, diagnostic clinical features of KD, and additional clinical findings including arthritis and/or arthralgia, gastrointestinal symptoms, respiratory symptoms and central nervous system symptoms. Besides, available laboratory findings collected on admission before Intravenous Immunoglobulin (IVIG) administration were reviewed. The diagnosis of complete and incomplete KD was made using the American Heart Association (AHA) recommendations. The diagnosis was confirmed by echocardiographic findings of coronary artery abnormalities.

Findings: About two-thirds of the children (65%) were 30 – 60 months, 20% were < 30 months and 15% were 60 or above 60 months old with mean age being 42 months. Sixty percent had fulfilled the criteria of complete KD. Of the five principal signs, polymorphous skin rash was predominant (90%), followed by changes in oral mucosa or lip (85%), conjunctival hyperemia (75%), cervical lymphadenopathy (70%) and changes in distal extremities and gastrointestinal symptoms (each 65%). Majority of the children had raised WBC (75%), raised ESR (95%), increased platelet count (70%) and elevated CRP (75%). Uveitis was a predominant complication (45%), followed by facial paralysis (30%) and neurosensory hypoacusia (20%). Cardiovascular complications like coronary artery aneurysm were found in 30% cases. However, cervical lymphadenopathy and changes in distal extremity were significantly common in complete KD than those in incomplete KD ($p = 0.019$ and $p = 0.05$ respectively).

Conclusion & Significance: Unexplained febrile children with elevated acute-phase reactants and thrombocytosis require echocardiographic assessment for exclusion of a diagnosis of incomplete KD.

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