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Infant with suspected septic shock not responding to antibiotics

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Sepsis in infants is a well-recognized entity with clear-cut treatment. However, what if the presenting infant does not respond to antibiotics and fluid treatment? What if the symptoms persist? When does one start thinking about alternative diagnoses? A pediatric team at a small DGH faced this problem. With this case report we would like to share our thought process and the challenges our team faced considering the atypical presentation of Kawasaki disease. Kawasaki disease is an acute febrile systemic vasculitis. Being the most common cause of acquired heart disease in the UK, early diagnosis and treatment is essential. Kawasaki disease remains a clinical diagnosis based on clinical criteria. Some patients do not fully meet these criteria, forming an incomplete form of the disease. This subtype still poses a significant risk of cardiac consequences; hence forming a challenging group of patients. In our case, a five month old boy initially seemed to present with septic shock. Despite appropriate antibiotic treatment his temperature did not settle. In addition the inflammatory markers only increased. He remained extremely irritable and had an extensive maculopapular rash. On day five of his illness, he was suspected to have incomplete Kawasaki disease. ECHO confirmed the presence of cardiac sequelae. This clinically septic child responded remarkably well to intravenous immunoglobulins and high dose aspirin.

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Benign presentation of a potentially fatal disease

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Anomalous origin of the left coronary artery from the pulmonary artery (ALCAPA) is a rare congenital cardiovascular defect that can range from being fatal early in life to presenting in adulthood asymptomatically. We present the case of a teenager whose diagnosis was incidental during examination for sports practice. The echocardiogram raised the suspicion of an anomalous flow in the coronary arteries and showed mitral valve prolapse with mild regurgitation. Magnetic resonance imaging revealed a very ectasia right coronary artery and low signal intensity in the usual location of the left anterior descending artery. The diagnostic hallmark of ALCAPA syndrome is the visualization of the left coronary artery originating from the main pulmonary artery, which was only possible in this case with coronary angiography, that showed an aneurismatic right coronary artery with retrograde filling from the left coronary artery, ending in the pulmonary artery and multiple vascular connections between the right and left coronary system. Surgical techniques can be broadly divided into one-coronary and two-coronary-system repairs. Surgery allows correction of chronic subendocardial ischemia, improvement of ventricular function, and minimizes the risk for malignant dysrhythmias and sudden death. Two-coronary-system repairs are preferred and include coronary button transfer, the Takeuchi procedure, or placement of a coronary artery bypass graft with ligation of the origin of the left coronary artery. This patient was submitted to coronary artery button transfer with excellent result.

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