Kawasaki Disease Pathway

Diagnosis of Classic Kawasaki Disease (KD)

Fever (>38 °C, but usually >39°C or 102.2°F) for at least 5 days AND 4 of 5 principal clinical features:

1. Erythema and cracking of lips, strawberry tongue, and/or erythema of oral and pharyngeal mucosa
2. Bilateral bulbar conjunctival injection without exudate
3. Rash: maculopapular, diffuse erythroderma, or erythema multiforme-like
4. Erythema and edema of the hands and feet in acute phase and/or periungual desquamation in subacute phase
5. Cervical lymphadenopathy (≥ 1.5 cm diameter), usually unilateral

Initial Management (within first 10 days of fever):

- Admit for IVIG 2 g/kg infusion over 10-12 h (PICU or 1:1 nurse)
- Aspirin 30-50 mg/kg/day divided Q6hrs during acute phase
- Pediatric cardiology consultation & ECHO as soon as possible

Diagnosis of Incomplete Kawasaki Disease

- Children with fever ≥ 5 days AND 2 or 3 of 5 principal clinical criteria (see above) OR
- Infants ≤ 6 mo with fever for ≥ 7 days without other explanation

Differential diagnosis:
Sepsis, scarlet fever, viral infections (measles, roseola, adenovirus, etc), Stevens Johnson Syndrome, toxic shock, rickettsial diseases

Consider blood culture, viral respiratory PCR (although virus + does not exclude KD diagnosis)

NOT consistent with KD:
Exudative pharyngitis
Exudative conjunctivitis
Oral ulcerations
Bullous or vesicular rash
Petechiae
Splenomegaly

For hypotension (Kawasaki Shock Syndrome) or if SARS-CoV-2+: Recommend PICU consultation and transfer

Obtain screening labs (ESR, CRP, U/A (clean catch or bag), CBC, albumin, ALT)

CRP ≥ 3.0 mg/dL and ESR ≥ 40 mm/hr

Obtain ECHO

3 or more laboratory findings:

1. Anemia for age
2. Platelets ≥ 450,000 after day 7 of fever
3. Albumin ≤ 3.0 g/dL
4. Elevated ALT level
5. WBC count ≥ 15,000/mm^3
6. Urine ≥ 10 WBC/hpf

-OR- Positive echo

NO → Serial clinical and laboratory re-evaluation if fevers persist
Echo/re-echo if typical peeling of digits develops

YES → **Incomplete KD. Follow initial management as above for complete KD**

CRP < 3.0 mg/dL and ESR < 40 mm/hr

Reference: McCrindle et al. Diagnosis, Treatment, and Long-Term Management of Kawasaki Disease. Circulation 2017. http://circ.ahajournals.org/content/135/17/e927

For pediatric hospitalist consultation or transfer, call Community Referral Line at 406 327 4726

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