KAWASAKI DISEASE

(Kawasaki's Syndrome, Mucocutaneous Lymph Node Syndrome)

REPORTING INFORMATION

- Class A(3)
- Report by the end of the work week
- Confidential Case Report Card (3812.11 rev.12/81) or Telephone
- The CDC Kawasaki Syndrome Case Reporting form (CDC 55.54, rev. 1-91) should be completed. To be submitted by the local health department to the Ohio Department of Health, Bureau of Infectious Disease Control, 246 N. High Street, PO Box 118, Columbus, OH 43266-0118.

AGENT

Unknown.

CASE DEFINITION

No definition is published in the CDC document "Case Definitions for Infectious Conditions Under Public Health Surveillance." The following definition is adapted from the CDC form "Kawasaki Syndrome, Case Reporting" (CDC 55.54 rev. 1-91).

Clinical description

Fever of ^5 days duration, unresponsive to antibiotics, with at least 4 of the 5 following physical findings with no other more reasonable explanation for the observed clinical findings:

1. Bilateral conjunctival injection
2. Oral mucosal changes (erythema of lips or oropharynx, strawberry tongue, or drying or fissuring of the lips)
3. Peripheral extremity changes (edema, erythema, or generalized or periungual desquamation)
4. Rash
5. Cervical lymphadenopathy ≥ 1.5 cm diameter

Laboratory criteria for diagnosis

None.

Case classification

Confirmed: a case that meets the clinical case definition.

Comment

If fever disappears after intravenous gamma globulin therapy is started, fever may be of <5 days duration and the clinical case definition may still be met.

SIGNS AND SYMPTOMS

Fever, mouth changes, rash, swelling and erythema of the hands and feet, and lymphadenopathy are seen during the first 8 to 12 days of illness. With the decline of fever, the other acute-phase symptoms rapidly resolve, and the patient looks much improved. Irritability, anorexia, and conjunctival injection persist into the subacute phase, which is marked by the desquamation of palms and soles and thrombocytosis. It is during this period when cardiac disease and arthritis are most likely to be encountered.

DIAGNOSIS

There is no single test diagnostic for KD. The diagnosis is established by fulfillment of clinical criteria (see case definition).

EPIDEMIOLOGY

Source

No specific organism or agent has been found to be causal for KD. Although various studies have

linked KD with mites, rickettsia, retroviruses and exposure to recently shampooed carpet, no single theory on the etiology of KD has been widely accepted to date.

Occurrence
KD is most common in children between six months and four years of age, and it occurs with slightly higher frequency in males. Children of Asian ancestry are at higher risk than white children, with blacks having an intermediate risk. KD occurs most commonly in the late winter and spring. Although most cases are sporadic, outbreaks have been observed.

Mode of Transmission
Unknown. KD is not transmitted person-to-person.

Period of Communicability
Unknown.

Incubation Period
Unknown.

PUBLIC HEALTH MANAGEMENT

Case

Treatment

Recent studies have demonstrated that high-dose immune globulin intravenous (IGIV) therapy initiated within 10 days of the onset of fever in conjunction with aspirin decreases the prevalence of coronary artery dilation and aneurysms. Aspirin is given initially in high dosage for its anti-inflammatory effect. After fever is controlled, aspirin dosage is decreased, but maintained for at least 2 months, to reduce the likelihood of spontaneous coronary thrombosis.

Isolation

Not necessary.

Contact
No measures needed.

Prevention and Control
None.