Inclusion Criteria
- Patients suspected of having Kawasaki Disease (KD)
- ≥ 4 days since onset of fever

A respiratory viral infection should not be used to exclude a diagnosis of KD.

Principal Clinical Features
1. Mucositis – “strawberry tongue”
2. Nonpurulent conjunctivitis
3. Erythematous rash
4. Extremity changes – swelling/peeling
5. Cervical lymphadenopathy (≥ 1.5 cm diameter)

Not all features need to be present at the same time.

Evaluate for presence of principal clinical features

Laboratory Tests
- CBC + Diff
- CRP
- ESR
- Albumin
- ALT
- UA (microscopic)
- Red top tube to hold

Consider
- Blood culture
- Respiratory viral panel

For questions concerning this pathway, contact: KawasakiPathway@seattlechildrens.org
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Last Updated: December 2018
Next Expected Review: February 2023
**Inclusion Criteria**
- Complete KD or Incomplete KD diagnosis

**Echocardiogram** should be performed when the diagnosis of KD is considered, but unavailability or technical limitations should not delay treatment.

**PHASE II (MANAGEMENT)**

**Inclusion Criteria**
- Complete KD or Incomplete KD diagnosis

**Treatment**
- **High-dose IVIG:** 2 g/kg single infusion over 12 hours
- **Moderate-dose aspirin:** 30 to 50 mg/kg/day divided every 6 hours
- Verify Echocardiogram and Electrocardiogram have been done (repeat if abnormal per Cardiology)
- **Steroid use** as adjunct to primary treatment is controversial

**Monitor for 36 hours after IVIG completion**
(Fevers may be related to IVIG)

**Fever between hour 24 and hour 36 after IVIG completion?**

- **No**
  - Transition to Low-dose Aspirin
    - Whichever comes first: at discharge OR if not ready for discharge, when afebrile for 48 hours
    - 3 to 5 mg/kg once per day

- **Yes**
  - 12 hours without fever
  - Continue to monitor
  - Fever beyond 36 hours after IVIG completion
    - Fever defined as:
      - \( \geq 38.5 \, ^\circ C \) for 1 reading
      - \( \geq 38.0 \, ^\circ C \) for 2 readings at least 2 hours apart

**Discharge Criteria**
- Patient afebrile for at least 12 hours before discharge
- Patient received 6-week supply of low-dose aspirin
- Cardiology consult and Echocardiogram completed
- Cardiology follow-up and Echocardiogram scheduled in 2 weeks
- Patient received inactivated flu vaccine if in season
- Family received education materials regarding fever monitoring

**Repeat Laboratory Tests**
- CBC + Diff
- CRP

**Management Options**
- Reassess differential diagnosis
- Notify Cardiology and Rheumatology
- Second dose of IVIG (2 g/kg)
- Clinical judgment is needed to determine whether to consider additional/alternate therapies

**Off Pathway**
Principal Clinical Features

Not all features need to be present at the same time

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
Differential Diagnosis

The differential diagnosis includes other infectious and noninfectious conditions, including the following:

- Measles
- Other viral infections (eg, adenovirus, enterovirus)
- Staphylococcal and streptococcal toxin-mediated diseases (eg, scarlet fever and toxic shock syndrome)
- Drug hypersensitivity reactions, including Stevens Johnson syndrome
- Systemic onset juvenile idiopathic arthritis
- With epidemiologic risk factors:
  - Rocky Mountain spotted fever or other rickettsial infections
  - Leptospirosis
- Meningococcemia

Viral and bacterial infections can have symptoms that overlap with KD and should be considered and treated.

! A respiratory viral infection should not be used to exclude a diagnosis of KD
Special Consideration (> 10 days of fever)

If greater than 10 days since fever onset AND Presence of 2 to 5 principal clinical features THEN

- It is reasonable to administer IVIG to children presenting after the 10th day of illness (ie, in whom the diagnosis was missed earlier) if they have either persistent fever without other explanation or coronary artery abnormalities together with ongoing systemic inflammation, as manifested by elevation of ESR or CRP (CRP > 3.0 mg/dL) [LOE: Guideline: Class IIa, Level of Evidence B (McCrindle, 2017)]
- IVIG generally should not be administered to patients beyond the tenth day of illness in the absence of fever, significant elevation of inflammatory markers, or coronary artery abnormalities [LOE: Guideline: Class III, Level of Evidence C (McCrindle, 2017)]
Steroid Use

Steroid use as adjunct to primary treatment is controversial

Recommendations for adjunctive therapies for primary treatment:

- *Single-dose pulse methylprednisolone should not be administered with IVIG as routine primary therapy for patients with KD*  
  [LOE: Guideline: Class III, Level of Evidence B (McCrindle, 2017)]

- *Administration of a longer course of corticosteroids (e.g., tapering over 2–3 weeks), together with IVIG 2 g/kg and ASA, may be considered for treatment of high-risk patients with acute KD, when such high risk can be identified in patients before initiation of treatment*  
  [LOE: Guideline: Class IIb, Level of Evidence B (McCrindle, 2017)]

Careful consultation with Cardiology
Clinical judgment is needed to determine whether to consider additional/alternate therapies

- **[LOE: Guideline: Class IIb, Level of Evidence B (McCrindle, 2017)]**
  - High-dose pulse steroids (usually methylprednisolone +/- subsequent course and taper of oral prednisone)
  - Longer (eg, 2–3 weeks) tapering course of prednisolone or prednisone, together with IVIG 2 g/kg and ASA

- **[LOE: Guideline: Class IIb, Level of Evidence C (McCrindle, 2017)]**
  - Infliximab
  - Cyclosporine if second IVIG infusion, infliximab, or a course of steroids has failed
  - Monoclonal antibody therapy (except TNF-α blockers), cytotoxic agents, or (rarely) plasma exchange if second IVIG infusion, infliximab, or extended course of steroids has failed
Approved by the CSW Kawasaki Disease Pathway team for go-live on February 28, 2018

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Retrieval Website:  http://www.seattlechildrens.org/pdf/Kawasaki-Disease-Pathway.pdf


Return to Diagnosis Phase  Return to Management Phase
This pathway was developed through local consensus based on published evidence and expert opinion as part of Clinical Standard Work at Seattle Children’s. Pathway teams include representatives from Medical, Subspecialty, and/or Surgical Services, Nursing, Pharmacy, Clinical Effectiveness, and other services as appropriate.

When possible, we used the GRADE method of rating evidence quality. Evidence is first assessed as to whether it is from randomized trial or cohort studies. The rating is then adjusted in the following manner (from: Guyatt G et al. J Clin Epidemiol. 2011;4:383-94.):

- Quality ratings are *downgraded* if studies:
  - Have serious limitations
  - Have inconsistent results
  - If evidence does not directly address clinical questions
  - If estimates are imprecise OR
  - If it is felt that there is substantial publication bias

- Quality ratings are *upgraded* if it is felt that:
  - The effect size is large
  - If studies are designed in a way that confounding would likely underreport the magnitude of the effect OR
  - If a dose-response gradient is evident

Guideline – Recommendation is from a published guideline that used methodology deemed acceptable by the team.

Expert Opinion – Our expert opinion is based on available evidence that does not meet GRADE criteria (for example, case-control studies).

**Quality of Evidence:**
- ⭐⭐⭐⭐ High quality
- ⭐⭐⭐ Moderate quality
- ⭐⭐ Low quality
- ⭐ Low quality
- ⭐⭐⭐⭐⭐ Very low quality

Guideline
Expert Opinion

Return to Diagnosis Phase  Return to Management Phase  To Bibliography
Summary of Version Changes

- **Version 1.0 (2/28/2018):** Go live.
- **Version 2.0 (4/27/2018):** Changed warning in Management Phase to state, “Do not give ibuprofen or other NSAIDs while on aspirin.”
Medical Disclaimer

Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required.

The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication.

However, in view of the possibility of human error or changes in medical sciences, neither the authors nor Seattle Children’s Healthcare System nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or for the results obtained from the use of such information.

Readers should confirm the information contained herein with other sources and are encouraged to consult with their health care provider before making any health care decision.
Search Methods, Kawasaki Disease Pathway, Clinical Standard Work

Studies were identified by searching electronic databases using search strategies developed and executed by a medical librarian, Peggy Cruse. Searches were performed in July, 2017. Queries were run in the following databases: Medline (Ovid platform), Cochrane Database of Systematic Reviews (Ovid platform), Embase (embase.com), National Guideline Clearinghouse (guideline.gov), TRIP (tripdatabase.com), and Cincinnati Children’s Evidence-Based Care Recommendations (cincinnatichildrens.org/service//anderson-center/evidence-based-care/recommendations). Medline and Embase strategies used controlled subject headings, along with text words to capture literature on Kawasaki disease (Mucocutaneous Lymph Node Syndrome). A synthesis-level evidence filter was applied to Kawasaki results to capture higher-level evidence syntheses. All retrieval was limited to English language and papers published from 2000 to July 2017.

Peggy Cruse, MLIS
October 25, 2017

Identification

306 records identified through database searching
0 additional records identified through other sources

Screening

246 records after duplicates removed

246 records screened
233 records excluded

Eligibility

13 records assessed for eligibility

Included

4 full-text articles excluded, 1 did not answer clinical question, 2 did not meet quality threshold, 1 outdated relative to other included study
9 studies included in pathway

Flow diagram adapted from Moher D et al. BMJ 2009;339:bmj.b2535

Return to Diagnosis Phase  Return to Management Phase  To Bibliography, Pg 2


