algorithm for the evaluation and treatment of patients in whom incomplete or atypical Kawasaki disease is suspected (refer to "Criteria for Treatment of Kawasaki Disease" later in this statement and Fig 1). We attempt to summarize the current state of knowledge of the management of patients with Kawasaki disease. The recommendations are evidence based

and derived from published data wherever possible. The levels of evidence on which recommendations are based are classified as follows: level A (highest), multiple randomized clinical trials; level B (intermediate), limited number of randomized trials, nonrandomized studies, and observational registries; and level C (lowest), primarily expert consensus.

## Evaluation of Suspected Incomplete Kawasaki Disease (KD)<sup>1</sup>

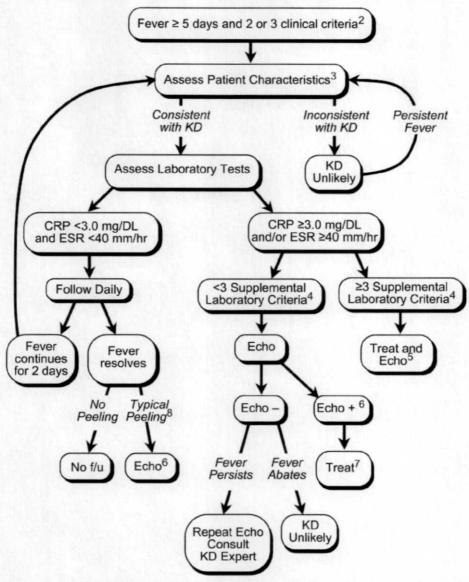


Fig 1. Evaluation of suspected incomplete Kawasaki disease. (1) In the absence of gold standard for diagnosis, this algorithm cannot be evidence based but rather represents the informed opinion of the expert committee. Consultation with an expert should be sought anytime assistance is needed. (2) Infants ≤6 months old on day ≥7 of fever without other explanation should undergo laboratory testing and, if evidence of systemic inflammation is found, an echocardiogram, even if the infants have no clinical criteria. (3) Patient characteristics suggesting Kawasaki disease are listed in Table 1. Characteristics suggesting disease other than Kawasaki disease include exudative conjunctivitis, exudative pharyngitis, discrete intraoral lesions, bullous or vesicular rash, or generalized adenopathy. Consider alternative diagnoses (see Table 2). (4) Supplemental laboratory criteria include albumin ≤3.0 g/dL, anemia for age, elevation of alanine aminotransferase, platelets after 7 days ≥450 000/mm³, white blood cell count ≥15 000/mm³, and urine ≥10 white blood cells/high-power field. (5) Can treat before performing echocardiogram. (6) Echocardiogram is considered positive for purposes of this algorithm if any of 3 conditions are met: z score of LAD or RCA ≥2.5, coronary arteries meet Japanese Ministry of Health criteria for aneurysms, or ≥3 other suggestive features exist, including perivascular brightness, lack of tapering, decreased LV function, mitral regurgitation, pericardial effusion, or z scores in LAD or RCA of 2–2.5. (7) If the echocardiogram is positive, treatment should be given to children within 10 days of fever onset and those beyond day 10 with clinical and laboratory signs (CRP, ESR) of ongoing inflammation. (8) Typical peeling begins under nail bed of fingers and then toes.