**Kawasaki**

**Kawasaki disease (KD) Guidelines for patient management at Stony Brook Children’s Hospital**

The following guideline which includes a treatment algorithm was developed based on literature review and the clinical expertise of the faculty of the Divisions of Pediatric Cardiology, Pediatric Infectious Diseases and Pediatric Rheumatology here at Stony Brook. It is a guideline and individual patient factors should be considered as appropriate.

The algorithm categorizes patients into low risk and high risk. We have identified the following risk factors that would place someone in the high risk category if at least 2 are met.

Risk Factors:

Male

< 1 year of age

Hispanic ethnicity

CRP >100 mg/dL

Platelet counts <100,000/microliter of blood

The following subspecialists should be consulted as follows:

Consults:

**Pediatric Cardiology consult**: failed first IVIG, treatment of incomplete case or high risk/complex course

*Standard ECHO schedule*: ECHO at diagnosis and 2 weeks later (Baseline ECHOs can be done without a full consult for low risk patients)

*Repeat ECHOs ordered*: failed response to first IVIG or increased clinical concern.

**Pediatric Infectious Diseases consult**: consider on all KD cases but especially on incomplete KD cases

**Pediatric Rheumatology consult**: all atypical and high risk/complex cases including those that fail initial therapy; any case with infant <6 months of age

Hospital Discharge Instructions

Discharge generally occurs 24 hours after IVIG infusion if the patient remains afebrile over that time.

High dose aspirin therapy (with IVIG 2grams/kg) to be used as part of initial therapy for anti-inflammatory effect, transition to low dose for anti-platelet effect once afebrile ≥ 48 hours after completing IVIG.

Aspirin therapy:

High dose: 80-100mg/kg/day divided every 6 hours

Low dose: 3-5mg/kg/day once daily

Influenza vaccination as appropriate to the season (inactivated only – IIV) prior to discharge

Instruct family and primary care doctor that live vaccinations (MMR, varicella) have to be delayed 11 months after IVIG due to interference with immune response to immunization with live vaccines

Follow-up labs (CBC, CMP, ESR, CRP): to be done in conjunction with pediatric Infectious Diseases hospital follow-up visit

Follow-up with Pediatric Infectious Diseases 3-5 days after discharge

Follow-up with Pediatric Cardiology 2 weeks from start of illness

Follow-up with Rheumatology 1-2 weeks after hospitalization

**KAWASAKI DISEASE TREATMENT ALGORITHM**:

Diagram

Description automatically generated

References

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