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Case Report

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KAWASAKI DISEASE – A CASE REPORT OF AN ADOLESCENTMALE WITH FEVER, JAUNDICE AND EOSINOPHILIA

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ABSTRACT

Kawasaki disease is the most common acute, self-limiting small to medium vessel vasculitis predominantly in infants and children but can occur in adults also. Typically present with fever conjunctivitis, pharyngitis and skin erythema's progressing to desquamating rashes on soles and palms. Our case highlights an adolescent presenting with Kawasaki disease fever jaundice and eosinophilia.

KEYWORDS Kawasaki disease, Eosinophilia, Jaundice.

INTRODUCTION

Kawasaki disease is an acute febrile, systemic vasculitic syndrome of unknown etiology, occurring predominantly in infants and children younger than 5 years of age but can also occur in adults also.The highest incidence is in Asia with almost 1 in 100 children suffering with Kawasaki disease.[1] The disease is self-limiting and usually resolves without treatment within about 12 days.[2] However, Kawasaki disease can result in coronary aneurysms, patients who suffer coronary artery damage may develop thrombosis or stenotic lesions associated with the aneurysms. The case report is a rare presentation in an adolescent.

CASE REPORT

A 13 years old male adolescent was a known case of Asthma on Meter Dose inhalers (salbutamol and budesonide) presented with high grade (103^0F), continuous fever had 4-5 spikes/day associated with chills and rigor which partially responded to broad spectrum antibiotics and antipyretics. Fever was associated with jaundice which was first noticed by mother as yellowish discoloration of eyes. Jaundice was progressively increasing, associated with pruritus, high colored urine and clay colored stool. On clinical examination patient had bipedal edema, pallor and hepatomegaly. On laboratory evaluation there was hyperbilirubinemia (predominantly conjugated), transaminitis, anemia, thrombocytosis,peripheral eosinophilia. Blood and urine culture were sterile, ESR was raised with high CRP titer. USG whole abdomen revealed hepatosplenomegaly. Hewas evaluated on line of pyrexia of unknown origin. There was no evidence of tropical infection, infective endocarditis, parasitic/viral/bacterial infection. During the course of his illness, he developed new onset arthralgia and erythematous rashes over left forearm. After ruling out infective etiology possibility of eosinophilic leukemia was kept. Bone marrow examination showed no evidence of leukemia, however there was interstitial increase in eosinophils and precursor. As there was no evidence of leukemia on one marrow, high eosinophil count with history of asthma, possibility of eosinophilic granulomatous with polyangiitis was kept and was planned for immunosuppression, however rash became more extensive and vanishing desquamating (Figure 1,2). 2D Echo was done which revealed coronary aneurysm and the confirmation was done by CT coronary angiography (figure 3). Final diagnosis of Kawasaki disease was made in view of fever, evanescent rash, and coronary aneurysms. Patient was managed conservatively with immunosuppression.

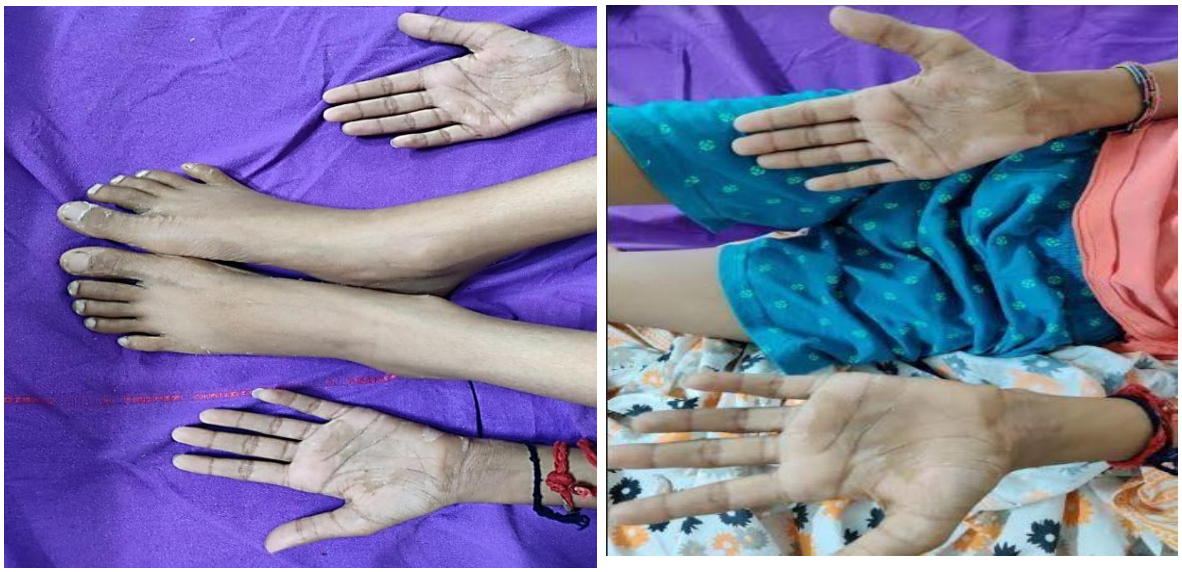

Figure 1-2: Vanishing desquamating rash of extremities.

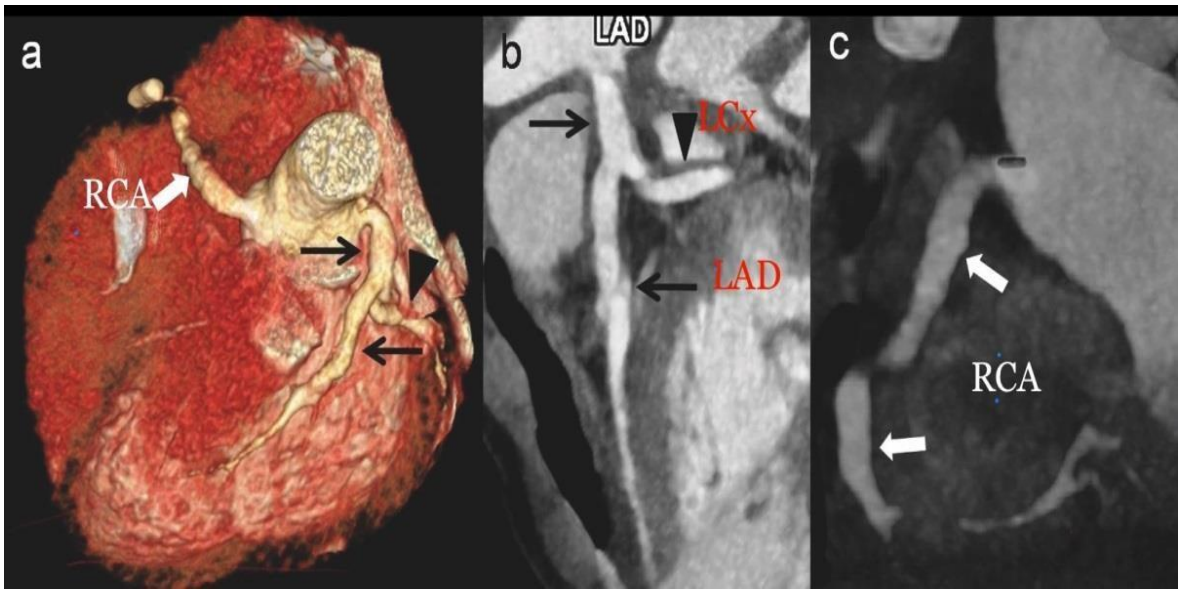

Figure 3: CT coronary angiography showing coronary aneurysms findings in the patient.

DISCUSSION

Kawasaki disease occurs primarily in young children, with 80% of patients are under the age of 4 years and with the peak incidence occurring at 9 to 11 months of age.[3] In addition to the coronary artery abnormalities hepatic dysfunction is also a common complication during an acute episode of Kawasaki disease.[4] Early diagnosis and treatment of Kawasaki disease is of the utmost importance because of the dreadful complications that can occur during the acute illness. In Kawasaki disease the drug of choice in such situations will be a single dose of IVIG (2 g/kg) and then aspirin (100 mg/kg/day) for 14 days, followed by 3–5 mg/kg/day for 6 weeks.[5]

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