

Specific Changes Mark Atypical Kawasaki Disease

BY JEFF EVANS
Senior Writer

WASHINGTON — Atypical and incomplete Kawasaki disease may be distinguished from other common childhood febrile illnesses by characteristic changes to the extremities, mucosa, conjunctiva, and blood laboratory values, Dr. Fernanda Falcini reported at a poster session of the annual meeting of the American College of Rheumatology.

In a chart review of 1,499 children who were discharged from the hospital with a diagnosis of Kawasaki disease (KD), 225 (15%) did not fulfill the Centers for Disease Control and Prevention's case definition criteria of KD. The CDC identifies KD patients as those having four of the following five clinical signs: rash, cervical lymphadenopathy of at least 1.5 cm in diameter, bilateral conjunctival injection, oral mucosal changes, and peripheral extremity changes.

Of those 225 patients, 172 had incomplete KD (median age 21 months) and 53 had atypical disease (median age 50 months), according to Dr. Falcini of the rheumatology unit in the department of pediatrics at the University of Florence (Italy).

Patients with incomplete KD did not meet all of the CDC case definition criteria, whereas atypical disease referred to patients who also had a problem that generally is not seen in KD.

Lip and oral redness, skin extremity

changes, and nonexudative conjunctivitis occurred significantly more often among children with incomplete or atypical KD than in 55 children who had other febrile illnesses that mimic KD. These other illnesses were cytomegalovirus (in 21 children), adenovirus (16), systemic juvenile idiopathic arthritis (12), Epstein-Barr virus (5), and

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staphylococcal scalded skin syndrome (1).

The erythrocyte sedimentation rate and total platelet count of children with incomplete and atypical KD also were significantly higher than in children with other KD-mimicking illnesses. But children with febrile diseases other than KD were significantly more likely to have lymphadenopathy than were those with incomplete or atypical KD.

Coronary artery diseases, including dilatation and aneurysms, were detected only in patients with incomplete (47) or atypical KD (15), reported Dr. Falcini. ■



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Lyme Borreliosis Can Rest on Clinical Findings

LAS VEGAS — Patients who present with localized erythema near the site of a tick bite should not necessarily be referred for laboratory tests, Dr. Jana Hercogova said at a dermatology seminar sponsored by Skin Disease Education Foundation.

In fact, a tick bite followed by a local skin reaction should simply be examined in 1 week and, if the redness persists, treated with antibiotics, said Dr. Hercogova of Charles University, Prague.

In the absence of persistent redness, if tests come back positive for Lyme disease, she recommended treating the patient with doxycycline or penicillin, depending upon whether *Ehrlichia* coinfection is present.

Physicians should also be familiar with macular and annular erythema migrans, she noted, adding that patients with morphea should also be tested for *Borrelia* infection. However, she cautioned, "we should treat the patient without [serologic] evidence if we see a clinically clear case."

Dr. Hercogova added that physicians treating pregnant women should consider the gestational age when choosing treatment. In the first trimester, she advised using penicillin G 20 million U/day for 2 days, with oral antibiotics as an option for the following 2 weeks. If infection is suspected to have begun in the second or third trimester, she said she uses only oral antibiotics—mainly penicillin derivatives.

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—John R. Bell