Kawasaki disease (KD)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM

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REPORTING INFORMATION
(To be completed by CPSP staff)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Strict confidentiality of information will be assured.

CASE DEFINITION FOR KAWASAKI DISEASE

Report any new patient presenting before the age of 18 years with a definite or presumed diagnosis of KD:

1) **Complete Kawasaki disease** (KD), defined as fever persisting for five* days or more AND presence of **at least four** of the following clinical criteria:
   - Changes in the peripheral extremities
     - erythema of the palms and/or soles; edema of the hands and/or feet; periungual desquamation
   - Polymorphous rash
   - Bilateral bulbar conjunctival injection without exudate
   - Changes in the lips and oral cavity
     - erythema and/or cracking of the lips; strawberry tongue; diffuse erythema of the oropharynx
   - Cervical lymphadenopathy: >1.5 cm diameter, usually unilateral

   * Presumptive diagnosis and initiation of treatment may be made before the fifth day of fever.
2) **Incomplete KD,** defined as fever of five days or more and less than four clinical criteria.
3) **Other KD,** defined as KD not fulfilling criteria for complete or incomplete KD but presumed because of a feature on echocardiogram or follow-up (i.e., periungual desquamation) that has led the treating physician to recommend treatment and/or cardiac follow-up.

Month first seen: _____

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: ____ /____ /_____ (DD MM YYYY) 1.2 Sex: Male___ Female___

1.3 City / Province or territory of residence: _____ /_____

1.4 Postal code – First three digits only: ___ ___ ___

1.5 Ethnicity (check all that apply): First Nations___ Innu___ Inuit___ Métis ___ Black____
Caucasian___ Latin American___ Middle Eastern___ Asian (Oriental)___ South Asian____
Other, specify: _____

SECTION 2 – CLINICAL PRESENTATION

2.1 Date of admission: ____ /____ /_____ (DD MM YYYY) OR Patient was not admitted____

2.2 Date of diagnosis: ____ /____ /_____ (DD MM YYYY)

2.3 Duration of fever

2.3.1 Number of days of fever at diagnosis: _____

2.3.2 Total number of days of fever (start of fever until complete resolution): _____ Unknown ___

2.4 Is this a KD reoccurence? Yes___ No___ Unknown___ If yes, how long ago? _____ months _____ years

2.5 Diagnostic features

	Yes	No	Unknown
2.5.1 Changes in the peripheral extremities?	___	___	___
2.5.2 Polymorphous rash?	___	___	___
2.5.3 Bilateral bulbar conjunctival injection without exudate?	___	___	___
2.5.4 Changes in the lips and oral cavity?	___	___	___
2.5.5 Cervical lymphadenopathy >1.5 cm diameter?	___	___	___

2.6 Growth parameters (essential for evaluating echo findings): Height _____ cm Weight _____ kg

SECTION 2 – CLINICAL PRESENTATION (cont'd)

		Yes	No	Unknown
2.7	Documentation of an infection			
2.7.1	Positive microbiological studies?	___	___	___
	If yes, specify: site _____ organism / other test _____			
2.7.2	Positive viral studies?	___	___	___
	If yes, specify: _____			
2.7.3	Did the patient receive antibiotics at any point in the illness?	___	___	___
2.7.4	Has the patient received a vaccine in the 42 days prior to the onset of KD?	___	___	___
	If yes, specify which vaccine: _____			

SECTION 3 – TREATMENT

3.1 Was the patient treated with aspirin (ASA)? ___ ___ ___

3.1.1 If yes, dosage used at onset:

≥ 80 mg/kg/d ___ 20-80 mg/kg/d ___ 10-20 mg/kg/d ___ 3-10 mg/kg/d ___

Other, specify: _____

3.1.2 Time when switched to an anti-platelet dose (3-10 mg/kg/d):

Once afebrile___ 48 hrs after afebrile___ 2 weeks later___ Unknown___

Other, specify _____

3.2 Was the patient treated with intravenous immunoglobulin (IVIG)? ___ ___ ___

3.2.1 If yes, date of first infusion: ____ /____ /_____
DD MM YYYY

3.2.2 Dosage: 2g/kg ____ Other, specify: _____

3.2.3 Brand name of IVIG: Gammagard Liquid (10%)___ Privigen___

Gammunex___ Octagam___ Gammagard S/D (5%)___

Other, specify: _____ Unknown___

3.2.4 Number of doses given: ____ If >1 dose, was same brand used? ___ ___ ___

If no, specify brand: _____

3.3 Were there any side effects attributed to the IVIG treatment? ___ ___ ___

If no, proceed to question 3.4.

If yes, specify: allergic reaction___ mild-moderate headache___

suspected aseptic meningitis___ renal impairment___ thrombosis ___

hemolysis___ Other, specify: _____

If hemolysis was identified, specify:

3.3.1 Hemoglobin (Hgb) before first IVIG: _____ g/L

lowest Hgb after last IVIG: _____ g/L lowest Hgb after discharge: _____ g/L

3.3.2 Within 2 weeks of the last IVIG, was there any drop in Hgb of ≥20 g/l? ___ ___ ___

3.3.3 Other investigations (check all that apply and, if done, specify results)

- Peripheral blood smear ___
- Reticulocyte count ___ _____ (10^7 /L)
- LDH ___ _____ (U/L)
- Indirect bilirubin ___ _____ (µmol/L)
- Haptoglobin ___ _____ (g/L)
- Direct Coombs ___ If positive, anti-IgG: complement___ anti-complement___ unknown___
- Eluate ___ If positive, specify antibody specificity: _____
- Other (including specific antibodies), specify: _____

3.3.4 Were any treatments required for the anemia? Yes___ No___ Unknown___

If yes, specify: _____

3.3.5 Patient's blood group: A___ B___ AB___ O___ Unknown___

RhD + ___ RhD – ___ Unknown___

SECTION 3 – TREATMENT (cont'd)

		Yes	No	Unknown
3.4	Was the patient given any other treatments?			
3.4.1	Corticosteroids – oral ___ intravenous ___ both ___	___	___	___
3.4.2	Corticosteroids – after discharge	___	___	___
3.4.3	Infliximab	___	___	___
3.4.4	Anti-platelet agents or systemic anti-coagulants	___	___	___

If yes, specify: Clopidogrel___ Dipyrimidole___ Warfarin____
LMW Heparin___ Abciximab___ Other_____

3.4.5 Others (inotropes, diuretics, etc.) specify: _____

SECTION 4 – ECHOCARDIOGRAM (ECHO) FINDINGS

4.1 Was an ECHO done? ___ ___ ___

If no or unknown, proceed to Section 5. If yes, complete:

	First ECHO ____/____/_____ DD MM YYYY	**Worst ECHO** (within 3 months) ____/____/_____ DD MM YYYY	**Last ECHO** (if same date as first, or worst echo, complete the date only) ____/____/_____ DD MM YYYY
Presence of coronary aneurysm?	Y___ N___ U___ *	Y___ N___ U___	Y___ N___ U___
If yes, size of largest aneurysm?	_____ mm	_____ mm	_____ mm
Presence of coronary ectasia or dilatation?	Y___ N___ U___	Y___ N___ U___	Y___ N___ U___
If yes, size of largest dilatation?	_____ mm	_____ mm	_____ mm
Specify maximum diameter of:		Maximum diameter:	
Left main coronary artery		_____ mm or U ___	
Left anterior descending		_____ mm or U ___	
Circumflex		_____ mm or U ___	
Right coronary artery		_____ mm or U ___	

***** *Y = yes; N = no; U = unknown*

4.2 Other cardiac findings: myocarditis___ pericardial effusion___ valvular insufficiency___
Other, specify: _____

SECTION 5 – OUTCOME

5.1 Specify which definition applies to your patient:
Complete KD___ Complete KD, diagnosis made before the 5th day of fever___ Incomplete KD___ Other KD___

5.2 Date of discharge: ____ /____ /_____
DD MM YYYY

At the time of the patient's last assessment, was the patient:

- fully recovered___ or unknown___
- recovered with cardiac sequelae___ specify: _____
- recovered with other sequelae___ specify: _____
- deceased____ specify cause of death: _____ age at time of death: ____years ____ months

5.3 Provide any additional information that you think may be important:
_____

___ **I agree to be contacted by the CPSP for further information.**
___ **I do not wish to be contacted by the CPSP for further information.**

SECTION 6 – REPORTING PHYSICIAN

First name_____ Surname_____
Address_____
City_____ Province_____ Postal code_____
Telephone number_____ Fax number_____
E-mail_____ Date completed_____

Thank you for completing this form.