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Commentary

Kawasaki Disease: A Major Risk for Children

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DESCRIPTION

The seasonality of incidence, widespread epidemics, and the self-limited character of the disease are suggestive of an infectious trigger even if the cause of Kawasaki disease is still unclear. One explanation for the illness is that one or more infectious organisms that are widely dispersed cause individuals who are genetically predisposed to develop an aberrant immune response. However, no specific cause has been found. A broad systemic vasculitis that affects blood is called Kawasaki disease.

Diagnosis

The four stages of the Kawasaki illness are acute febrile, subacute, convalescent, and chronic. The acute febrile phase is marked by fevers, which can reach 104°F (40°C) but are typically higher than 102°F (39°C). The main clinical characteristics of Kawasaki disease are visible during this phase, which lasts for 1 to 2 weeks without therapy. The subacute phase starts when the fever and other symptoms start to fade. The youngster is at the most risk of unexpected death during this time.

Treatment

Treatment for Kawasaki disease is divided into two phases: the acute phase and the chronic or long-term phase. Inhibiting platelet activation, reducing inflammation in the coronary artery wall, and preventing arterial thrombosis are the main goals of acute phase therapy. The avoidance of myocardial ischemia and infarction is the main goal of chronic or long-term care, which is based on coronary artery alterations.

High-dose intravenous therapy for Kawasaki disease is the first line of treatment.

Risk stratification

Long-term management and follow-up of Kawasaki disease depends on the severity and extent of coronary involvement. Periodic assessment and counseling about known cardiovascular risk factors is suggested for all families with children who have Kawasaki disease. For children with no coronary artery changes, management beyond the initial 6 to 8 weeks is nonexistent, but children with coronary artery aneurysms or obstruction will require life-long pharmacological therapy.

Effect after kawasaki disease

The Kawasaki disease recurrence rate, which is well known in Japan, is about 3%. Within 1 to 2 years of the disease's beginning, aneurysms in 50% to 67% of vessels with coronary arteries will shrink. Smaller aneurysm size, being less than one year old at the outset of the acute sickness, fusiform rather than saccular morphology, and position in a distal coronary segment are factors that are positively linked with aneurysm regression.

The most common underlying cause of congenital cardiac disease in children is Kawasaki illness. The primary symptoms of the illness, which can develop in up to 25% of untreated youngsters, are coronary artery aneurysms. All kids should receive a high-dose IVIG and aspirin treatment.

CONCLUSION

Although adult cases of Kawasaki disease have been documented, children are the disease's primary victims. Where it most frequently happens is among Asian people. The annual average incidence is 90–112 per 100,000 individuals. With a mean yearly incidence in the United States of 6-9 per 100,000 children under the age of 5, the incidence peaks in children between 1 and 2 years old. The annual incidence is, respectively, 3.6 and 3.7 per 100,000 people in Britain and Australia.

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