BPSU Surveillance of Kawasaki Disease

Extension until February 2015

Kawasaki disease (KD) surveillance will continue for a further year until February 2015. 229 case reports have been received but there have been many case reports with fewer clinical criteria in addition to fever, and where cardiac involvement has been described. Here the clinicians are of the opinion that the case is KD and have been treated as such. Because of the strict surveillance definition applied with the survey, it has not been able to include/collect the data on these cases.

Kawasaki disease is the commonest cause of acquired heart disease in children in the UK and USA. The serious sequelae of KD make it important to diagnose this condition early in order to treat it effectively and therefore minimise complications and long term ill health within the Paediatric population. The last BPSU survey of KD was in 1990 and since that time there has been increased awareness of the condition and treatment protocols.

With approval from the BPSU and REC, the surveillance case definition has been widened to include **incomplete** or **atypical cases**. In addition, the current feeling of those in the research team is that the presence of streptococcal infection **does not** rule out KD and this should not be used as an exclusion criterion.

The latest study will examine incidence in terms of demographics and changes since 1990; clinical representation; clinical treatment and outcomes in particular the prevalence of non-cardiac complications within 30 days following Kawasaki disease in the UK and Ireland? And how are patients with diagnosed Kawasaki disease being followed up within the UK and Ireland?

Case definition: Any infant or child up to the **age of 16 years** presenting for the first time with Fever of 5 or more days duration ***plus* 4 of the following (complete);** OR ***plus* any two of the following and coronary artery changes (atypical);** OR **plus 2 or 3 of the following (incomplete)**:

1. Conjunctivitis	Bilateral, bulbar, non-suppurative
2. Lymphadenopathy	Cervical > 1.5cm
3. Rash	Widespread, polymorphous. *Not* vesicular.
4. Lips and mucosa	Red cracked lips, 'strawberry tongue', erythematous oral cavity
5. Changes of extremities	Erythema, oedema of palms and soles initially, then peeling of skin at later stage.

Exclusion: None (No longer are we excluding streptococcal infections)

Funding: Kawasaki disease parent support group – www.kssg.org.uk
Email: enquiries@kssg.org.uk

Ethics approval: This study has been approved by NRES Committee – South West (REC reference 11/SW/0310) and has been granted Section 251 permission under reference: ECC 6-02 (FT11)/2012

For further information about the study, please contact:
Professor Robert Tulloh, Department of Paediatric Cardiology, University Hospitals Bristol NHS Foundation Trust, Upper Maudlin Street, Bristol, BS2 8BJ

Email : Robert.Tulloh@UHBristol.nhs.uk
Pippa.Craggs@UHBristol.nhs.uk