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Incomplete Kawasaki Disease: A Diagnostic Dilemma

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Dear Editor,

We read with great interest the recent report by Halimiasl et al. describing an interesting case of a child with a prolonged fever accompanied with coronary artery aneurysm and myocarditis published in your respected journal (1). This study has novelties and enhances the existing literature; however, the diagnostic approach of the authors may be questioned.

At the present time, there are two validated and generally accepted criteria for the diagnosis of Kawasaki disease (KD). This includes the 2004 American Heart Association (AHA) criteria (2), and the 2008 Japanese Circulation Society Joint Working Groups (JCS) criteria (3). In AHA criteria, prolonged fever lasting longer than 5 days together with at least four of the five major clinical characteristics of KD including diffuse mucosal inflammation, bilateral nonpurulent conjunctivitis, dysmorphic skin rashes, indurative angioedema over the hands and feet, and cervical lymphadenopathy are required for the diagnosis of KD (2). On the other hand, In JCS criteria, prolonged fever is considered as the sixth major clinical presentation, and five of the six mentioned major criteria are required for KD diagnosis (3). Patients who do not fully meet the criteria for KD should undergo echocardiogram study for detection of coronary artery abnormalities (CAA). The definitions of CAA in such cases are: maximum absolute internal diameter >3 mm in children lower than 5 years of age or > 4 mm in children 5 years and above, or a segmental diameter 1.5 times greater than that of an adjacent segment or the presence of luminal irregularity. These cases are considered as "incomplete or atypical" Kawasaki (2).

In the report by Halimiasl et al. no sufficient data about the major clinical characteristics of KD in their patient was provided. Out of six major criteria for KD, only prolonged fever was described in the paper. It is reported that the index case had coronary aneurysm and myocarditis in echocardiogram study. Nevertheless, the question is how the diagnosis of "incomplete KD" could be made based on only a prolonged fever that was accompanied with cardiac abnormalities but no other major criteria for KD. We were wondering if the authors could provide more data about the clinical/paraclinical characteristics of their patient for the readership, and discuss their diagnostic approach to KD in this patient in more details.

Authors' Contribution

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