Original Research Paper

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Paediatrics

KAWASAKI DISEASE PRESENTING AS ACUTE FLACCID PARALYSIS - A RARE CLINICAL MANIFESTATION

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KEYWORDS :

INTRODUCTION: Kawasaki disease (KD) is an acute, self limiting febrile illness with medium vessel vasculitis and has a predilection for coronary arteries.It was first described by Jomisoku kawasaki.It is the most common cause of paediatric vasculitis and paediatric myocardial infarction.It is a disease of early childhood.

BACKGROUND : The etiology of KD is still an enigma with many proposed hypotheses, none is conclusively proven.But it is an immunological reaction elicited in a genetically susceptible host following exposure to KD triggers widespread in the environment.An infective etiology is suggested by occurrence in defined age group infancy and young children, occurrence of epidemics and clinical features like fever, rash, lymphadenopathy.

KD remains a clinical diagnosis with no confirmatory laboratory lab test.The classical clinical criteria are

1. Fever persisting for at least 5 days
2. Presence of at least 4 factors : Erythema of palms and soles ,edema of hands and feet with periungual peeling of fingers and toes,Polymorphous rash,Bilateral bulbar conjunctival congestion,Lip cracking, erythematous oral mucosa,Unilateral cervical lymphadenopathy
3. Exclusion of other causes

It has got varied clinical presentation with some atypical presentations like aseptic meningitis, inflammatory polymyositis, transient sensory neural hearing loss, anterior uveitis, sterile pyuria etc.AFP is defined by a clinical syndrome of rapid onset weakness sometime with bulbar and respiratory muscle weakness in children <15 years or any age when polio is suspected.

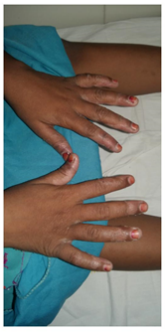
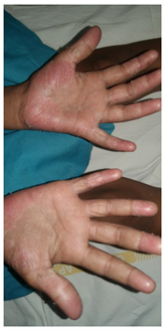
CASE : A 5 year old female child brought with weakness of both lowerlimbs for 2days ,sudden in onset, progressed within few hours, associated with pain with history of rash maculopapular type more on extremities with skin peeling of both the hands and congestion of both the eyes.Clinical examination showed erythema of oralcavity,left cervical lymphnode enlargement,acral skin peeling with erythema.Neurologically child had symmetrical motor weakness in both lowerlimbs with power 2/5,sluggish deep tendon reflexes and sensorium,cranial nerves,sensory system,bladder bowel being normal without any meningeal signs.Respiratory and cardiac examination was normal.

Lab investigations showed elevated ESR,CRP with hemogram showing microcytic hypochromic anemia with normal platelet count.Serum electrolytes:normal,CSF analysis was normal.Cardiac evaluation(ECG,ECHO normal.CPK levels(1810 IU/l) were elevated. Diagnosis of kawasaki disease with myositis was made with the evidence of clinical criteria and supporting lab findings.

After initial stabilization,the child was managed in PICU.The workup for AFP surveillance was done.Child was treated with IVIG (2gm/kg/day),aspirin 30mg/kg/day for 48 hours followed by 5mg/kg/day and supportive treatment.

There was a dramatic improvement neurologically within 36hours and she became afebrile in 48hours.She was able to walk with no residual neurological deficit.Parents were counselled regarding the need for followup for cardiovascular risk assesment and a repeat cardiac evaluation 3 weeks later was normal.The child is kept under followup.

CONCLUSION: KD is a self-limiting disease assosciated with complications like coronary aneurysms(in 25% cases if untreated), aseptic meningitis, inflammatory polymyositis, Sensory neural hearing loss.Cardiac complications are more dreadful complications and hence to be kept under followup for cardiac monitorng. KD can also be presented as AFP, however a detailed history ,clinical examination, lab investigations should be done to ruleout other causes.

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