Pediatric Rheumatology

Poster presentation

Peripheric arterial aneurisyms and monocytosis in intravenous immunoglobulin treatment resistant Kawasaki disease

E Baskin*[1], US Bayrakci[1], Konuksever Di[1], S Turkay[2], B Varan[1], H Ercoban[1] and Z Avci[1]

Address: [1]Baskent University, Ankara, Turkey and [2]Fatih University, Ankara, Turkey
* Corresponding author

from 15th Paediatric Rheumatology European Society (PreS) Congress
London, UK. 14–17 September 2008

Published: 15 September 2008

Pediatric Rheumatology 2008, **6**(Suppl 1):P274 doi:10.1186/1546-0096-6-S1-P274

This abstract is available from: http://www.ped-rheum.com/content/6/S1/P274

Kawasaki disease (KD) is an acute febrile illness caused by vasculitis, occurring in early childhood, and activation of monocytes/macrophages plays a central role during acute KD.

We described a 4 month-old boy diagnosed as KD with involvement of peripheral arteries as well as coronary arteries. He had diagnosed as KD in a local hospital because of fever lasting for 25 days, conjunctivitis, membranous desquamation from fingertips and rash. Patient was referred to our center because of resistant fever to IVIG treatment. Echocardiographic examination revealed right and left coronary artery aneurysms and leucocytosis (41000 mm3) with predominant monocytosis (25%) was observed on peripheral blood smear. Examination of bone morrow aspirate was normal while CD4/CD8 and CD14+CD16+ were high. Angiographic examination revealed aneurisms in subclavian arteries, mammarian arteries, right lumbal and renal arteries. IVIG was given for two more times without any improvement in his clinical condition. Thus, patient was treated with pulse methyl prednisolon. A dramatic decrease was observed in acute phase reactants as well monocytosis and CD4, CD14 and CD16 levels after treatment with steroids. During his follow-up lowe dose steroid was discontinued at the 2nd month and all these aneurysms regressed while aneurysms of coronary arteries unchanged at the end of a year.

Treatment with IVIG sometimes could be ineffective in patients with KD and treatment with pulse steroid should be considered in these patients. Increased number of peripheral blood CD14+CD16+ monocytes/macrophages in acute KD might be considered as a sign of disease severity and development of coronary artery lesions.