Lupus-like onset of recurrent Kawasaki disease in an adolescent boy

Sirs.

A 15-year-old boy was admitted to our hospital for fever and rash. Five days before admission he had had fever and sore throat treated with clarithromycin without clinical improvement. At admission he was still febrile but his general condition was fair. A butterfly rash on his face was evident (Fig. 1), and he referred diffuse arthralgias, muscle weakness, headache and asthenia. Lymphadenopathy was not present. Laboratory tests showed an elevated erythrocyte sedimentation rate (ESR), C reactive protein (CRP), fibrinogen, white blood cell number, and neutrophilia. Renal function was normal. Blood and urine cultures were negative. Rapid diagnostic test for group A β-haemolytic Streptococcus was negative. Serological tests for detection of antibodies IgM against Epstein-Barr virus, measles, mumps, chickenpox, herpes virus - B, and B, cytomegalovirus, Mycoplasma pneumonia, Leishmania and blood culture were negative. Antinuclear autoantibodies (ANA), antineutrophil cytoplasmic antibody (ANCA) and anti-DNA titres were negative; antinuclearin autoantibodies (ACl) IgM values were positive (50 MPL). IgG were absent. Chest radiograph was negative. During the 4 following days, the patient presented high grade fever and developed chills, strawberry tongue, bilateral non-exudative conjunctivitis with hemorrhages in the left eye and diffuse maculopapular rash. Kawasaki disease (KD) was then suspected. Electrocardiogram (ECG), echocardiography and abdominal ultrasound scan were normal. The child was treated with intravenous immunoglobulin and acetil salicylic acid. Fever as well as systemic manifestations led us to consider systemic lupus erythematosus (SLE) diagnosis. However, the ACR diagnostic criteria were not satisfied. Otherwise, according to the revised diagnostic criteria for KD, the presence of bilateral non-exudative conjunctivitis, chills, strawberry tongue and maculopapular rash suggested KD (9). The diagnosis was eventually confirmed by rapid improvement after IV Ig therapy and subsequentextremity peeling. Positive IgM but negative IgG ACL are also reported in KD (10), possibly due to polyclonal B-lymphocyte activation. To our knowledge an adolescent with KD mimicking the onset of SLE has not been described so far. The diagnosis of KD in adolescents may be difficult, since the signs and symptoms are often atypical and can mimic other disease including SLE. A timely diagnosis is mandatory to reduce possible complications.

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A case of Kawasaki disease accompanied by Henoch-Schönlein purpura

Sirs.

Cases of vasculitis occasionally have overlapping features with other forms of vasculitis (1); however, there have been few reports of such occurrences in Kawasaki disease (KD), a childhood form of vasculitis (2,3). We describe a patient who concurrently showed features of KD and Henoch-Schönlein purpura (HSP).

A 3-year-old boy was admitted with a history of 7-day fever, injected conjunctivae, red lips, a non-purpuric exantheme, puffy hands, and right cervical lymphadenopathy (1.8 cm in diameter). Laboratory data revealed leukocytosis (15.600/µl), mild thrombocytosis (445,000/µl), and an elevated C-reactive-protein level (CRP, 15.6 mg/dl). A diagnosis of typical KD was made, and in-

Letters to the Editor