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Clinical Image
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Severe Desquamation in Kawasaki Disease: Is it Somehow Protective?

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Clinical Image

A previously healthy 12-year-old boy was first treated in the primary care for a possible pharyngitis because of fever, conjunctivitis and a non-desquamating skin rash. The fever continued for 10 days then remitted, while other symptoms resolved. Two weeks later, he started to have desquamation, which rapidly progressed to a full thickness, over his palms and soles when he presented to our center (Figure 1). His blood tests revealed: Platelets 804 x 10^9/L (reference: 150-450 x10^9/L), Erythrocyte sedimentation rate (ESR) 61 mm/h (reference: 0-10 mm/h), C-reactive protein (CRP) 7.09 mg/L (reference: <3.5 mg/L) and Lactate Dehydrogenase (LDH) 281 g/L (reference: 125-220 U/L). Urinalysis, Throat culture, and Anti-streptolysin-O titer were unremarkable. An echocardiogram was normal. He was started on oral Aspirin 81 mg daily and was followed in clinic when he developed onycholysis over all fingernails. A repeat blood test in 6 weeks was normal. The echocardiogram was repeated 3 times and showed no coronary abnormality; hence, Aspirin was discontinued.

Desquamation is very common in Kawasaki disease (KD). In the original report on KD from Japan, 49 out of 50 had desquamation and was also above 90% in two different series from the United States, [1-4]. Although a lower rate was reported in Chinese (83%), [5]. Full-thickness epidermal peeling is a hallmark of KD and often prompts the diagnosis in missed cases. The sensitivity and specificity of desquamation in KD is unknown. However, patients who did not peel were more likely to develop aneurysms interestingly suggesting somehow a protective role of skin peeling [4].

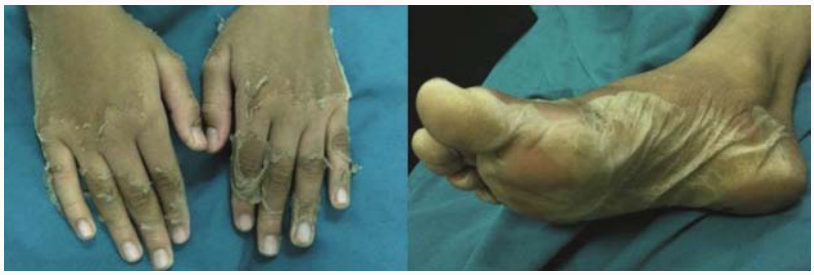

Figure 1: Sever desquamation of the patient's hands and soles.

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