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When Kids Diseases Hit Grown-Ups: A Fresh Case of Kawasaki Disease in Adults

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Abstract | **Case Report**

Kawasaki disease is an acute systemic vasculitis predominantly affecting children, while adult-onset cases remain rare and poorly recognized. This rarity often leads to diagnostic delay and increases the risk of cardiovascular complications. We report the case of a previously healthy 19-year-old man admitted for persistent high-grade fever unresponsive to antibiotics, associated with conjunctival injection, mucocutaneous involvement, and inflammatory biological markers. Extensive infectious and autoimmune investigations were negative. Based on clinical features and exclusion of alternative diagnoses, adult-onset Kawasaki disease was diagnosed. The patient was treated with intravenous immunoglobulins and aspirin, resulting in rapid clinical and biological improvement. Cardiac investigations showed no coronary artery involvement during follow-up. This case highlights the importance of considering Kawasaki disease in adults presenting with prolonged fever and mucocutaneous manifestations, as early recognition and treatment are essential to prevent potentially severe cardiac complications.

Keywords: Adult-onset; Kawasaki disease; Prolonged fever; Vasculitis; Intravenous immunoglobulins; Coronary complications.

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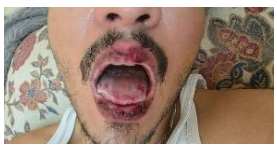
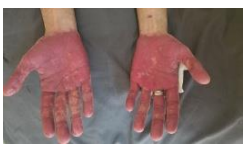
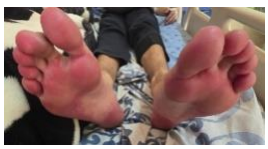
1. INTRODUCTION

Kawasaki disease (KD) is an acute vasculitis of medium-sized arteries, predominantly affecting children under the age of 5 years. Adult cases remain exceptional but are increasingly reported, often with atypical and misleading presentations [1–3]. Delayed diagnosis carries a major risk of coronary complications [4]. We present a case of KD in an immunocompetent adult that illustrates the need for early treatment.

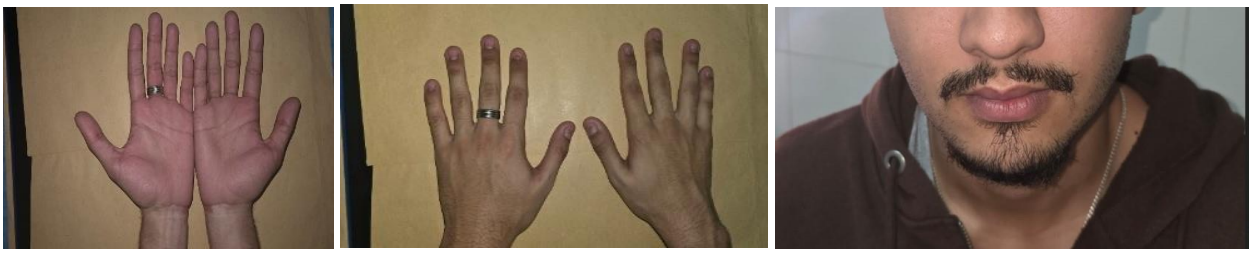
2. CASE REPORT

A 19-year-old chronic smoker at 1.4 pack-years, with no history of medication or toxic substance use, admitted to the internal medicine department for an acute condition characterized by fever for 5 days resistant to antipyretics and empirical antibiotic therapy, associated with diffuse arthralgias and myalgias. Clinical examination revealed pharyngitis, cracked cheilitis, a strawberry tongue, enanthem, painful edematous erythema on the palms and soles, bilateral superinfected conjunctivitis, and scrotal erythema. The patient did not show any lymphadenopathy, especially cervical, or digestive symptoms. Biologically, the patient presented an inflammatory syndrome with monocytosis at 1140/mm3, leukocytosis at 13000/mm^3, thrombocytosis at 543 000/mm^3; hepatic cytolysis with hyponatremia at 32 mmol/L and raised CRP at 64mg/L. All viral serology results were negative (HIV, EBV, CMV, Syphilis, hepatitis), as were the antinuclear antibodies. The initial echocardiography was normal. Figure 1 – 2 – 3 – 4.



Suggested the diagnosis of Kawasaki disease in adulthood. The patient was urgently treated with IV immunoglobulins, 2 g/kg in a single dose, plus aspirin, 160 mg/day. The outcome was very favorable, with defervescence in 24 hours, slower regression of cutaneous-mucosal lesions with periungual and palmoplantar desquamation, and progressive normalization of CRP and white blood cells. Follow-up cardiac ultrasounds did not reveal any coronary aneurysm. Figure 5 - 6 – 7



3. DISCUSSION

Classically, KD is an acute vasculitis of medium-sized arteries, affecting almost exclusively children. However, some cases in adults have been described, representing less than 1 to 3% of all the cases [1]. This rarity explains why adult KD remains poorly recognized, often diagnosed late, leading to an increased risk of cardiovascular complications, notably coronary ones [2]. Affected adults present partially similar clinical features, but with some particularities. The reported average age is between 20 and 40 years, with a slight male predominance [3]. Adult forms are more often incomplete, making diagnosis more difficult as compared with children [4].

The pathophysiology of KD remains poorly understood, but it involves an exaggerated immune response triggered by an infectious agent in genetically predisposed individuals [5]. The central mechanism involves necrotizing vasculitis of medium-sized arteries, leading to endothelial damage, inflammatory infiltration, and sometimes the formation of coronary aneurysms [6]. In adults, systemic inflammation sometimes appears more intense, explaining the increased arthralgias, hepatic cytolysis, and reported systemic involvement. Adult KD can present with the five classic criteria: prolonged fever, non-purulent conjunctivitis, polymorphous skin rash, mucous membrane changes, and cervical lymphadenopathy. However, several studies suggest that adult manifestations are often partial or atypical [1,3]. Arthralgias, arthritis, myalgias, abdominal pain, and liver abnormalities are significantly more frequent in adults than in children [7] as is the case for our patient.

This polymorphism often leads to initial misdiagnosis: viral infections, scarlet fever, drug eruptions, autoimmune diseases, or even staphylococcal or streptococcal toxic shock [8]. The diagnosis is therefore often one of exclusion, after infectious, autoimmune, and drug causes have been ruled out. In adults, pediatric criteria are used, but their sensitivity decreases [4]. Diagnostic delay is common and results from the lack of knowledge of the disease, its often incomplete presentation, and prior administration of antibiotics which partially alters the clinical picture. The biological markers of the inflammatory condition are inconsistent and nonspecific: increased CRP, leukocytosis, inflammatory anemia [6].

The most feared risk is coronary involvement that includes dilations, aneurysms, myocarditis, pericarditis, thromboses, and myocardial infarction [2]. Studies have documented that the risks of aneurysms are similar to those in children if treatment is instituted early, but much higher in cases of delayed diagnosis, a situation often seen in adults [9]. Transthoracic echocardiography is still performed first, but in adults, coronary CT or MRI is often more effective for evaluating arterial lumen [10].

The standard first-line treatment is the same as in children:

Intravenous immunoglobulins (IVIG) 2 g/kg in a single dose, High-dose aspirin in the acute phase followed by a low dose in the subacute phase [5], our patient had received a dose of 160 mg/day due to the risk of bleeding.

Early initiation (<10 days) significantly reduces the risk of coronary aneurysms [5]. The rapid response to IVIG and lack of coronary involvement in our case illustrate the benefit of early diagnosis. In case of failure, which happens in 15–20% of cases, rescue treatments are used: corticosteroids, infliximab, anakinra, or cyclosporine in serious or resistant forms [6].

Even when no coronary aneurysms are present at the outset, regular follow-up is recommended because abnormalities may sometimes appear later, even weeks after the acute phase [9]. Monitoring is based on : repeated echocardiograms, coronary CT scan or MRI depending on the initial abnormalities, and control of systemic inflammation.

4. CONCLUSION

Adult Kawasaki disease is a rare but important entity that is often underdiagnosed. The clinical polymorphism and the absence of specific signs explain the frequent diagnostic delays. This case illustrates that this traditionally pediatric disease can occur in adults,

and a high index of suspicion is necessary in any adult presenting with prolonged fever associated with cutaneous, mucosal, or conjunctival signs. Treatment with IVIG-aspirin remains the cornerstone of management and can permit favorable resolution without coronary complications when initiated in due time. However, cardiac monitoring during the long 962er mis required. This case points to the need for awareness among clinicians in knowing that Kawasaki disease remains a differential diagnosis for unexplained fevers in adults.

Competing Interests

The authors declare that they have no competing interests, and all authors confirm accuracy.

Authors' Contributions

All the authors made a substantial intellectual contribution, read and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

CONSENT

All authors declare that 'written informed consent was obtained from the patient (or other approved parties) for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editorial office/Chief Editor/Editorial Board members of this journal.

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