within the first 10 days of the illness and ideally in the first 7 days of illness. A single, large infusion of 2 g/kg over 10 to 12 hours is recommended. Retreatment with IVIG and/or other antiinflammatory drugs may be given to patients with an incomplete response to the initial IVIG (continued or recrudescent fever) or those with coronary artery dilation.

Aspirin is used in an antiinflammatory dose (80 to 100 mg/kg/day in divided doses every 6 hours) to control fever and symptoms of inflammation. However, after the fever has subsided, aspirin can be reduced to an antiplatelet dose (3 to 5 mg/kg/day). Low-dose aspirin is continued in patients without echocardiographic evidence of coronary abnormalities until the platelet count has returned to normal (6 to 8 weeks). If the child develops coronary abnormalities, salicylate therapy is continued indefinitely. Additional anticoagulation (e.g., clopidogrel [Plavix], enoxaparin [Lovenox], or warfarin) may be indicated in children who have medium-sized or giant coronary artery aneurysms.

Prognosis

Most children with Kawasaki disease recover fully after treatment. However, when cardiovascular complications occur, serious morbidity may result. The prognosis for patients is strongly related to the extent of coronary damage, with patients who have giant aneurysms being at the highest risk for complications and those with normal coronary dimensions having an excellent long-term prognosis.

Quality Patient Outcomes: Kawasaki Disease

- Early diagnosis and treatment
- Prevention of cardiovascular complications

Nursing Care Management

In the initial phase, the nurse must monitor the child's cardiac status carefully. Intake and output and daily weight measurements are recorded. Although the child may be reluctant to eat and