



# Kawasaki Syndrome Case Report



Form Approved  
OMB 0920-0009

CDC CASE#     (1-4)

Please fill in the blank or check the answer for each question

## - PATIENT INFORMATION/DEMOGRAPHICS -

<b>Patient's Initials:</b> (First, Middle, Last) _____ (5-7)	<b>Residence:</b> <b>City:</b> _____ <b>County:</b> _____ <b>State:</b> _____ (8-10) (11-12)	<b>Age at Onset:</b> (Yrs) (Mo.) _____ (13-14) (15-16)	<b>Date of Birth:</b> (mm/dd/yyyy) _____/_____/_____ (17-18) (19-20) (21-24)
<b>1. Ethnicity:</b> (25) 0 <input type="checkbox"/> Not Hispanic/Latino 9 <input type="checkbox"/> Unk 1 <input type="checkbox"/> Hispanic/Latino	<b>2. Race:</b> (26) 1 <input type="checkbox"/> White 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 6 <input type="checkbox"/> Other 2 <input type="checkbox"/> Black or African American 5 <input type="checkbox"/> American Indian/Alaskan Native 9 <input type="checkbox"/> Unk	<b>3. Sex:</b> (27) 1 <input type="checkbox"/> Male 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> Female	

## - CLINICAL OUTCOMES -

<b>4. Date of Onset of Symptoms:</b> _____/_____/_____ (28-29) (30-31) (32-35) (mm/dd/yyyy)	<b>5. Was the patient hospitalized?</b> (36) 0 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 9 <input type="checkbox"/> Unk	<b>6. If YES, number of days hospitalized:</b> _____ (37-38)
<b>7. Outcome:</b> (39) 1 <input type="checkbox"/> Alive, no known sequelae 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> Dead 3 <input type="checkbox"/> Alive with sequelae (specify): _____	<b>8. DOES THE PATIENT HAVE RECURRENT KAWASAKI SYNDROME?</b> (40) 0 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 9 <input type="checkbox"/> Unk IF YES, list onset date of prior Kawasaki Syndrome episode: ____/____/____ (mm/dd/yyyy) (41-42) (43-44) (45-48)	

## - SIGNS, SYMPTOMS, AND DIAGNOSTIC CRITERIA -

**9. The criteria for a case are:**  
Fever ≥5 days unresponsive to antibiotics, and at least four of the five following physical findings with no other more reasonable explanation for the observed clinical findings:

1) bilateral conjunctival injection,	5) and cervical lymphadenopathy (at least one lymph node ≥1.5 cm in diameter).
2) oral changes,	
3) peripheral extremity changes,	If the fever disappears due to intravenous gamma globulin (IVGG) therapy before the fifth day of illness, a fever of <5 days duration fulfills fever criterion for case definition.
4) rash,	

	No	Yes	Unknown		No	Yes	Unknown
Fever	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (49)	2. Oral mucosal changes (erythema of lips or oropharynx, ... strawberry tongue, or drying or fissuring of the lips)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (62)
Date of fever onset: ____/____/____ (mm/dd/yyyy) (50-51) (52-53) (54-57)				3. Peripheral extremity changes (edema, erythema, ... or generalized or periungual desquamation)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (63)
Number of days febrile: _____ (58-59)				4. Rash	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (64)
Fever ≥5 days	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (60)	5. Cervical lymphadenopathy ≥1.5 cm diameter	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (65)
1. Bilateral conjunctival injection	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (61)				

## - CARDIAC STUDIES -

**10. Check the results for each study type (A-C), and list the number of weeks after illness onset that the study was done. If multiple studies were done, report the results that showed coronary artery aneurysm or dilatation for the first time.**

	Not done	Normal Results	Coronary Artery Aneurysms	Coronary Artery Dilatation	Other Abnormalities	Unknown Results	# Wks after illness onset	Date of first test showing coronary artery aneurysm or dilatation (mm/dd/yyyy)
A. EKG	0 <input type="checkbox"/> (66)	1 <input type="checkbox"/> (67)	2 <input type="checkbox"/> (68)	3 <input type="checkbox"/> (69)	4 <input type="checkbox"/> (70)	9 <input type="checkbox"/> (71)	____/____/____ (72-73)	____/____/____ (74-75) / ____/____/____ (76-77) / ____/____/____ (78-81)
B. ECHO	0 <input type="checkbox"/> (82)	1 <input type="checkbox"/> (83)	2 <input type="checkbox"/> (84)	3 <input type="checkbox"/> (85)	4 <input type="checkbox"/> (86)	9 <input type="checkbox"/> (87)	____/____/____ (88-89)	____/____/____ (90-91) / ____/____/____ (92-93) / ____/____/____ (94-97)
C. ANGIOGRAM	0 <input type="checkbox"/> (98)	1 <input type="checkbox"/> (99)	2 <input type="checkbox"/> (100)	3 <input type="checkbox"/> (101)	4 <input type="checkbox"/> (102)	9 <input type="checkbox"/> (103)	____/____/____ (104-105)	____/____/____ (106-107) / ____/____/____ (108-109) / ____/____/____ (110-113)

## COMPLICATIONS Check or list whether complications were associated with this illness.

	No	Yes	Unknown		No	Yes	Unknown
<b>11. CARDIAC</b>				<b>12. NONCARDIAC</b>			
Coronary artery aneurysms Specify diameter of aneurysm: _____ mm	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (114)	Arthralgia	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (125)
Other aneurysms (specify): _____	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (115)	Arthritis	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (126)
Coronary artery dilatation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (116)	Aseptic meningitis	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (127)
Aortic regurgitation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (117)	Gall bladder hydrops	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (128)
Arrhythmias	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (118)	Hearing loss	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (129)
Congestive heart failure	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (119)	Hepatitis or hepatomegaly	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (130)
Mitral regurgitation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (120)	Iritis or uveitis	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (131)
Myocardial infarction	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (121)	Meatitis or sterile pyuria	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (132)
Myocardial ischemia	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (122)	Myalgia or myositis	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (133)
Myocarditis	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (123)	Other (specify): _____	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (134)
Pericarditis or pericardial effusion	0 <input type="checkbox"/>	1 <input type="checkbox"/>	9 <input type="checkbox"/> (124)				

## TREATMENT:

## REPORTED BY:

## PLEASE MAIL COMPLETED FORM TO:

<b>13. WAS INTRAVENOUS GAMMA GLOBULIN (IVGG) GIVEN?</b> 0 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 9 <input type="checkbox"/> UNK (135)  IF YES, date of first IVGG treatment: ____/____/____ (mm/dd/yyyy) (136-137) (138-139) (140-143)  IF YES, was IVGG started before the fifth day of illness while the patient was still febrile? 0 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 9 <input type="checkbox"/> UNK (144)	Name: _____ Address: _____ Phone No. ( ) _____ Date: ____/____/____ (mm/dd/yyyy)	<b>Kawasaki Syndrome Surveillance</b> Division of Viral and Rickettsial Diseases Mailstop A-39 Centers for Disease Control and Prevention Atlanta, GA 30333
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