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STANDARD OF MEDICAL CARE

KAWASAKI DISEASE

2026

General part

Diagnosis name: Kawasaki disease

Condition or disease codes according to NC 025:2021 "Classifier of diseases and related health problems":

M30.3 Mucocutaneous lymph node syndrome (Kawasaki)

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List of abbreviations

AKA	coronary artery aneurysm
ACE	angiotensin converting enzyme
ASL-O	antistreptolysin O titer
ASK	acetylsalicylic acid intravenous human
INFLUENCE	immunoglobulin intravenous
in/in	
GGT	gamma-glutamyltransferase
GCS	glucocorticosteroids
DNA	deoxyribonucleic acid
ECG	electrocardiogram
Echocardiography	echocardiography (transthoracic)
ZAK	complete blood count
Health care	healthcare facility
IM	myocardial infarction
IMzp-ST	ST-segment elevation myocardial infarction
ELISA	enzyme immunoassay
KA	coronary artery / coronary arteries
IMP	clinical patient pathway
CT	computed tomography computed
KTA	tomography angiography
EOM	international normalized ratio low
LMH	molecular weight heparins
NSAIDs	nonsteroidal anti-inflammatory
OCT	drugs optical coherence
PCR	tomography polymerase chain
POAC	reaction direct oral anticoagulants
RA	agglutination reaction
RNGA	indirect hemagglutination reaction
p/w	subcutaneously
SRB	C-reactive protein
ESR	erythrocyte sedimentation rate
PCI	percutaneous coronary intervention
HC	Kawasaki disease
CD25	soluble interleukin-2 receptor α cardiovascular
SMRT	magnetic resonance imaging 2019 coronavirus
COVID-19	infection
IgM	Immunoglobulin M
LAD	left anterior descending coronary artery
MIS-s	multisystem inflammatory syndrome in COVID-19
NFAT	nuclear factor of activated T cells
TNF	tumor necrosis factor
SARS-CoV-2	coronavirus 2 associated with severe acute respiratory syndrome
WBC	leukocytes

Form No. 025/o	form of primary accounting documentation No. 025/o "Medical card of an outpatient patient No. ___" and instructions for filling it out, approved by order of the Ministry of Health of Ukraine dated February 14, 2012 No. 110, registered with the Ministry of Justice of Ukraine on April 28, 2012 under No. 661/20974
Form No. 003/o	form of primary accounting documentation No. 003/o "Medical card of inpatient patient No. _" and instructions for filling it out, approved by order of the Ministry of Health of Ukraine dated February 14, 2012 No. 110, registered with the Ministry of Justice of Ukraine on April 28, 2012 under No. 661/20974

The Standard of Medical Care "Kawasaki Disease" (hereinafter referred to as the SCD) was developed in accordance with the Methodology for the Development and Implementation of Medical Standards of Medical and Rehabilitation Care on the Principles of Evidence-Based Medicine, approved by the Order of the Ministry of Health of Ukraine dated September 28, 2012 No. 751 "On the Creation and Implementation of Medical and Technological Documents for the Standardization of Medical and Rehabilitation Care in the System of the Ministry of Health of Ukraine", registered with the Ministry of Justice of Ukraine on November 29, 2012 under No. 2001/22313. The MDS was developed on the basis of the Evidence-Based Clinical Guideline “Kawasaki Disease”, which is based on the principles of evidence-based medicine, taking into account modern international recommendations, which lists all possible methods and means of treatment and further management of patients with Kawasaki disease, the effectiveness of which has been proven, which can be found at https://www.dec.gov.ua/cat_mtd/galuzevi-standartitaklinichni-nastanovi/.

At the time of development of this SDM, the instructions for medical use of some medicinal products approved by the Ministry of Health of Ukraine do not contain indications for the treatment of patients with Kawasaki disease (hereinafter referred to as "KD") or there are restrictions on their use in children.

According to Article 44_1 of the Law of Ukraine "Fundamentals of Ukrainian Legislation on Healthcare", unregistered medicinal products or registered medicinal products for indications not specified in the instructions for medical use or the summary of product characteristics may be used in the interests of curing a person only upon receipt of the written consent of the patient or his legal representative.

In relation to a person under the age of 14 (a minor), the specified medicinal products may be used with the written consent of his/her parents (one of the parents) or other legal representatives (legal representative), and in relation to a person aged 14 to 18 - with his/her written consent and the written consent of his/her parents (one of the parents) or other legal representatives (legal representative). When obtaining consent to the use of such medicinal products, the person and/or his/her legal representative must be provided with full information about the purposes, methods, side effects, possible risks and expected results from the use of these medicinal products, the presence or absence of alternative treatment options.

Section I. Organization of medical care in the treatment of children with Kawasaki disease

1. Provisions of the standard of medical care

Doctors of various specialties should be aware of the initial symptoms of CD in children in order to detect it early and prescribe treatment immediately.

Medical care for children with HC is provided in health care facilities (hereinafter referred to as – Health care facilities) that provide specialized medical care to children require interdisciplinary cooperation and integrated patient management by a multidisciplinary team of specialists, preferably with experience in diagnosing and treating CD. The multidisciplinary team may include: a pediatrician, a pediatric infectious disease specialist, a pediatric immunologist, a pediatric cardiologist, a pediatric cardiorheumatologist, an ultrasound diagnostician, and doctors of other specialties, as needed.

Further monitoring of patients with CD is carried out by pediatricians, general practitioners - family doctors, pediatric cardiologists, pediatric cardiorheumatologists, and cardiologists.

2. Justification

Chronic obstructive pulmonary disease (COPD) is an acute systemic inflammatory disease, a vasculitis, that affects mainly children under 5 years of age and is characterized by inflammation of medium-sized vessels, particularly the coronary arteries (CA). COPD is the leading cause of acquired heart disease in children in developed countries, surpassing rheumatic fever. The disease has a potentially severe course with a risk of developing coronary artery aneurysms (CAAs), which increases the risk of myocardial infarction (MI), ischemic heart disease, and premature death in childhood or adulthood.

Early detection, diagnosis, and initiation of treatment for HC, including administration of intravenous human immunoglobulin (IVIG) within the first 10 days of fever onset, are critical to reducing the risk of complications. Delay in diagnosis, especially in cases of incomplete or atypical HC, significantly increases the likelihood of coronary pathology.

Well-established interdisciplinary interaction between specialists, as well as access to modern diagnostic methods and healthcare facilities that provide specialized medical care, are necessary prerequisites for optimal management of patients with CD.

Educational campaigns aimed at increasing awareness among healthcare professionals about CD contribute to better recognition of the disease, reducing the time to diagnosis and timely treatment, and generally improving the quality of medical care.

Monitoring the course of coronary artery disease is based on the assessment of clinical dynamics, laboratory indicators of inflammation, echocardiographic (hereinafter referred to as EchoCG) examination of the state of the coronary arteries of patients, including the analysis of Z-scores, which allows for timely detection and prevention of the development of coronary complications.

3. Criteria for the quality of medical care for Kawasaki disease

Mandatory:

1) there are locally agreed written documents – clinical itineraries patients (hereinafter referred to as the CMP), which regulate the interaction between all levels of medical care and ensure timely identification, referral, diagnosis, treatment and follow-up of patients with CD;

2) an individual medical care plan is developed for children with HC, agreed with parents or legal representatives and available to the multidisciplinary team. An individual plan, based on information on the clinical diagnosis and EchoCG results, should include the prescribed treatment, measures to prevent complications and an algorithm for further monitoring, taking into account the results of the assessment of the Z-scores of the CA;

3) the child's parents or legal representatives are provided with affordable form with information about the diagnosis, justification of treatment goals, need for observation and control of the cardiovascular system. Information is provided on recognizing alarming symptoms, the importance of adhering to an individual plan, as well as contacts for urgent or scheduled consultation;

4) before discharge, the child's parents or legal representatives receive information on the features of immunoprophylaxis after administration of a high dose of IVLIG;

5) healthcare providers post information materials regarding about HC, its clinical manifestations, complications, and the importance of early diagnosis in accessible places in healthcare facilities, as well as on official healthcare facility websites and social media pages.

Section II. Diagnosis of HC in children

1. Provisions of the standard of medical care

Diagnostic measures are aimed at timely detection by a general practitioner - family doctor, pediatrician, pediatric infectious disease specialist, pediatric immunologist or other specialistcharacteristic initial clinical signs and symptoms of CD, especially in children in the first 5 years of lifefor immediate referral of the child to an inpatient department of a health care facility that provides specialized medical care to childrenfor further examination and appropriate treatment.

HC remains a clinical diagnosis for which there is no pathognomonic diagnostic test and is established on the basis of a combination of clinical signs, laboratory parameters, and the results of instrumental examinations to assess the condition of the heart and coronary vessels.

If criteria for complete or incomplete Kawasaki disease are present, priority should be given to initiating treatment rather than waiting for diagnostic results for other diseases with which differential diagnosis is being performed.

2. Justification

Without treatment, approximately 25% of patients develop dilatation of the coronary artery or coronary artery. It is essential to establish the diagnosis of CH within 10 days of the onset of fever—preferably on the 4th–5th day of illness in patients with complete CH and as early as possible (but no later than 10 days) in patients with suspected incomplete CH. Treatment initiated within the first 10 days of the onset of fever is critical to prevent irreversible coronary damage.

Incomplete forms are most common in infants <6 months of age and in older children/adolescents. These patients are at increased risk for coronary lesions due to delayed diagnosis. Risk groups for developing coronary artery disease in patients with CD include children ≤6 months of age, children with coronary artery disease Z-scores ≥2.5 (proximal regions) at diagnosis by day 10 of fever, and patients with very high inflammatory markers (e.g., CRP ≥130 mg/L) or certain ethnic risk factors (e.g., Asian). Identifying patients at high risk for developing coronary artery disease at diagnosis is important and allows for increased initial anti-inflammatory therapy, which may improve outcomes.

Echocardiography is the primary imaging modality for coronary artery disease in children with CHD. It is a noninvasive, high-resolution, and rapid imaging test that provides high-resolution, high-resolution images of proximal CA abnormalities using CA Z-scores that compare the diameter of the artery in a child with CHD with that expected in healthy children of the same age, sex, and body size. Z-scores greater than 2.5 indicate that the child has CA.

Patients with CHD and ACA are at high risk of MI, especially during the first 2–3 months after disease onset. Although the risk of MI decreases after two years from disease onset, patients with large or giant ACAs remain at constant risk of ischemia throughout their lives. Symptoms of acute coronary syndrome in patients with CHD may differ from the classic manifestations of MI in adults with atherosclerosis. In infants and young children, symptoms are often nonspecific: poorly localized pain, incomprehensible crying, anxiety, unusual pallor, sweating. In older children, pain in the chest, arm, or abdomen, shortness of breath, vomiting, and skin discoloration may occur. Laboratory and instrumental studies are performed for diagnosis.

3. Criteria for the quality of medical care

Mandatory:

1) the diagnosis of CD may be suspected in the presence of febrile fever for at least 4-5 days (or earlier), especially in children under 5 years of age, with the following clinical signs detected during physical examination:

full (classical) form of HC-≥ 4 of 5 major clinical features: bilateral non-exudative conjunctivitis (conjunctival vascular injection, sclera without purulent discharge), usually bulbar with peripheral luminal opacity around the limbus;

changes in the mucous membrane of the mouth and lips: bright diffuse erythema of the oropharynx, cracked, dry bright red lips (sometimes with a "cherry" tint), "strawberry" tongue (hyperemia of the tongue with pronounced hypertrophy of the papillae);

polymorphic rash on the body (predominantly maculopapular, often most pronounced in the groin area; usually without vesicles, bullae, or ulcers);

changes in the extremities: redness (erythema) of the palms and soles, swelling of the hands and feet, induration (hardening) of the palms/soles in the acute period; in the subacute period (2–3 weeks after the onset of fever, sometimes earlier) – characteristic peeling of the skin around the nails;

Cervical lymphadenopathy: enlargement of ≥1 lymph node in the neck with a diameter of ≥1.5 cm, most often unilateral (without pronounced suppuration or severe pain.

The assessment and management of patients with the full (classic) form of CD is provided in Appendix 1 to this Standard;

2) patient assessment at**incomplete (atypical) form of CRC**conduct in accordance with Appendix 2 to this Standard;

3) in case of suspicion of HC, a set of laboratory tests is performed: a complete

blood count with determination of the erythrocyte sedimentation rate (hereinafter – ESR) and CRP (quantitative determination);

biochemical blood test (albumin, alanine aminotransferase, gamma-glutamyltransferase (hereinafter - GGT);

general urine analysis;

3) conduct instrumental examinations:

electrocardiography (hereinafter referred to as ECG);

transthoracic echocardiography: no later than the 10th day from the onset of the disease (preferably – at the time of diagnosis/suspected diagnosis, before starting treatment (IVLIG) to assess the status of the CA. However, the absence of positive EchoCG results should not be an obstacle to treatment in case of persistent signs of CH;

Echocardiography can be performed more than 2 times a week if ACA (Z-scores ≥ 2.5) are detected in the acute period before the process stabilizes. All Echocardiography results (Z-scores of ACA, presence/absence of ACA) must be documented in the form of primary accounting documentation No. 003/o;

if necessary, repeated echocardiograms are performed 1–2 days after the previous one, even if the first result is within normal limits, but the suspicion of HC remains high;

a repeat echocardiogram should be performed approximately 2 weeks after the first one, still during the acute/subacute period;

in case of recurrent fever within a week after the patient is discharged from the inpatient department of the health care facility, an EchoCG should be performed urgently if there is no clear alternative diagnosis;

In children of the first years of life, sedation may be used during transthoracic echocardiography with the involvement of a pediatric anesthesiologist if visualization of the heart and coronary vessels is difficult due to the child's restlessness;

Imaging standards for Echocardiography during patient preparation, technical standards for the assessment of CA, and quantitative assessment of echocardiographic findings are provided in Appendix 3 to this Standard;

4) during the examination of children with suspected HC, a differential diagnosis is performed diagnosis with other childhood diseases accompanied by fever and having similar clinical manifestations in accordance with Appendix 4 to this Standard;

5) determining the risk category of patients for CA damage and The classification of ACA formations is based on the calculation of Z-scores. The same Z-score calculator should be used for the first and subsequent echocardiograms to interpret CA damage. Accurate measurements of the patient's weight and height are critical to avoid over- or underestimation of CA Z-scores;

6) in the event of a sharp deterioration in the child's condition, exclude the possibility development of shock, acute MI, macrophage activation syndrome (secondary hemophagocytic lymphohistiocytosis, the signs of which are given in Appendix 5 to this Standard);

7) in complex cases, a multidisciplinary diagnosis is performed a consultation with the participation of: a pediatric immunologist, a pediatric infectious disease specialist, a rheumatologist, a pediatric cardiologist, a surgeon, an intensive care unit doctor, and other specialists.

Section III. Treatment of Kawasaki disease in the acute period 1. Provisions of the standard of medical care

Treatment of children with acute phase of CH is carried out in the conditions of an inpatient department in a health care facility (pediatric, infectious, other department depending on where the hospitalized patient is, given the wide clinical manifestation of the disease), which provides specialized medical care to children. The goal of therapy is to quickly suppress the inflammatory process and prevent damage to the coronary arteries.

2. Justification

Treatment of coronary artery disease begins with identifying patients at standard and high risk of coronary artery disease at the time of diagnosis.

There are: initial therapy of the acute phase of HC, treatment in case of resistance to IVLIG, intensification of initial therapy in high-risk patients and additional approaches to treatment in patients with refractory HC. The use of IVLIG in the acute period can reduce the incidence of aneurysms by several times.

Standard-risk patients receive IVLIG and acetylsalicylic acid (ASA). Patients with HC and high risk of AKA (baseline AKA Z-scores ≥2.5 by day 10 of fever, infants <6 months of age, CRP >130 mg/L**)**or severe course require intensification of treatment with additional anti-inflammatory therapy and the use of glucocorticosteroids (hereinafter referred to as GCS) to reduce the risk of developing AKA in refractory UC.

GCS in HC are used in two main situations: primarily in patients at high risk of severe disease and secondarily in cases of resistance to IVLIG.

The best result is achieved with early diagnosis of HC (on the 4th–5th day of fever) and immediate initiation of therapy, but no later than the 10th day of fever. If for various reasons the diagnosis is established later (after the 10th day), IVLIG is still prescribed if the process is active (fever, increased CRP quantitative value/ ESR), especially when there are coronary changes. The absence of fever and normal inflammatory indicators after the 10th day indicate the extinction of the acute process. In such cases, IVLIG can be omitted, however, the decision to use IVLIG is made individually.

Symptomatic and pathogenetic therapy (e.g., anticoagulant therapy, treatment of dehydration, myocarditis, etc.) is also used to treat children with CD, according to the patient's risk category.

Treatment of resistant forms of CD includes second-line therapy: repeated IVLI, high-dose corticosteroids and/or infliximab, the choice depends on the clinical situation.

3. Criteria for the quality of medical care

Mandatory:

1) initial therapy in the acute phase of HC involves the administration of the first dose 2 g/kg IVLIG, over 8–12 hours no later than day 10 of illness, immediately after diagnosis (if possible, on day 4–7 of fever). It should be noted that ESR increases after IVLIG infusion, so this indicator is not a reliable marker of active inflammation after infusion;

2) in the acute period of HC, ASA is also prescribed in a dose of (30 - 80 mg/kg/day divided into 4 doses per day) as anti-inflammatory and antipyretic therapy until body temperature normalizes within 48–72 hours. After that, switch to low doses of ASA (3–5 mg/kg/1 g per day) to ensure antiplatelet effect after fever decreases and continue taking for up to 6–8 weeks from the onset of the disease even in the absence of changes in blood pressure;

3) if through≥ 36 hours after IVLIG administration, body temperature did not normalized, inflammatory markers and clinical manifestations of HC persist - IVLIG is reintroduced and/or other/additional anti-inflammatory therapy is prescribed. Such patients have an increased risk of developing AKA compared to those who responded to IVLIG treatment. For the treatment of resistance, glucocorticosteroids (intravenous administration of prednisolone or methylprednisolone) are used in addition to IVLIG: prednisolone IV, 2 mg/kg per day, divided every 8 hours for 5 days (maximum 60 mg/day) during hospitalization, then oral prednisolone 2 mg/kg per day, divided every 8 hours; slow dose reduction over 15 days (maximum 30 mg/dose) after normalization of CRP levels;

4) for patients with high-risk CD (CA Z-scores ≥2.5 at initial examination by the 10th day of fever, infants <6 months of age,

patients with CRP above 130 mg/l) intensification of initial therapy (dual therapy) by adding another anti-inflammatory therapy may be beneficial;

5) management of patients depending on the size of the aneurysm should be carried out in accordance with Appendix 6 to this Standard;

6) HC accompanied by low blood pressure, inadequate myocardial perfusion or dysfunction, is described as shock syndrome in HC. This form is characterized by a higher frequency of elevated CRP, hypoalbuminemia, and thrombocytopenia compared with HC without shock. Hemodynamic instability usually improves rapidly after the administration of IVLI. Given the increased risk of resistance to IVLI and CA damage, it is advisable to consider intensification of initial IVLI therapy by adding a second anti-inflammatory agent. Lines of anti-inflammatory therapy in HC are given in Appendix 7 to this Standard;

7) discontinue ASA in the first 6-8 weeks without the recommendation of a cardiologist children's is not recommended (except for complications, for example, Reye's syndrome);

8) in case of a sharp deterioration in the child's condition (increased size of the ACA, the appearance of new symptoms or signs of ischemia, shock, macrophage activation syndrome/secondary hemophagocytic lymphohistiocytosis), the detection of symptoms of MI - the patient is consulted by a cardiac surgeon or interventional cardiologist;

9) all children ≥ 6 months who receive ASA should receive it during flu season influenza vaccine (inactivated), preferably before discharge from the hospital;

10) live vaccines - against measles, mumps, rubella and chickenpox - should postpone for 11 months after the administration of IPV, as passively administered antibodies may reduce the effectiveness of these live vaccinations;

11) discharge from the inpatient health care facility is carried out under the following conditions: absence fever, stable hemodynamics, and signs of stabilization or normalization of EchoCG indicators.

Section IV. Treatment of complications of Kawasaki disease. Features of the management of patients with transient, stable and progressive aneurysms

1. Provisions of the standard of medical care

Treatment of complications of CH is aimed at preventing thrombosis, preventing ischemic complications, reducing the progression of ACA, and improving the long-term prognosis and quality of life of patients.

The management of patients is determined by the type of ACA (transient, stable or progressive) and the degree of risk according to the classification of risk categories given in Appendix 8 to this Standard.

2. Justification

Coronary artery aneurysms are the main complication of coronary artery disease, which determines the risk of thrombosis, stenosis, MI, and sudden death. The appearance and progression of ACA can occur in the acute/subacute period or after some time after the disease.

Long-term antiplatelet or anticoagulant treatment reduces the risk of coronary thrombosis and related mortality.

Progressive and giant ACAs have a high risk of thrombosis even when the clinical condition is normalized. Early intensification of antithrombotic therapy, monitoring of the condition of the ACA (echocardiography, CTA or MR angiography) and individual selection of treatment ensure a reduction in the number of adverse events.

3. Criteria for the quality of medical care

Mandatory:

1) with rapid expansion of large/giant ACA, it should be prescribed simultaneous ASA and anticoagulant during the first 6-8 weeks of the disease. Monitoring of the effectiveness of anticoagulant therapy should be carried out at least once a week at the initial stage and subsequently at least once a month in accordance with Appendix 9 to this Standard;

2) 6-8 weeks after the onset of the disease and in the absence of AKA, cancel low-dose ASA (after conducting a control echocardiogram in 4–6 weeks);

3) frequency of observations and long-term treatment are given in Appendix 9 to this Standard.

Preferred:

4) consider the use of direct oral anticoagulants (apixaban) in older children instead of warfarin if there is experience with their use;

5) adolescents and young adults should be checked at least once every 2 years lipid profile and glucose levels to promptly correct dyslipidemia or other risk factors;

6) Whenever possible, patients with ACA >5 mm should be prescribed statins in adolescence/adulthood to improve endothelial function and prevent atherosclerosis.

Section V. Further observation and control of the heart and vascular condition after undergoing HC

1. Provisions of the standard of medical care

Vascular changes due to HC can lead to severe complications: ischemic heart disease, arrhythmias, MI, and sudden death in children and young patients.

Therefore, for all children who have undergone HC with any lesions of the coronary arteries (including those that have completely regressed), long-term observation is necessary, which is carried out by a pediatric cardiologist or cardiologist.

Management of children with severe cardiac lesions after CHD should be carried out in specialized cardiac centers with the possibility of involving a multidisciplinary team for patients with giant aneurysms, which includes: a cardiologist, a pediatric cardiologist, a cardiac surgeon, an interventional cardiologist, imaging specialists, an intensive care physician, and rehabilitation specialists.

The main goals of long-term follow-up are prevention of thrombosis and MI. Examination methods may include low-dose CT angiography, MRI, or invasive angiography.

2. Justification

The frequency of clinical examinations by a cardiologist and instrumental examinations of patients with CH is determined by the risk category and stage of the disease.

The duration of observation depends on the degree of damage to the CA, taking into account the maximum Z-scores at the time of examination. The main criterion for assigning a patient to a certain risk category and determining further observation tactics (risk stratification according to Echocardiography) is the maximum value of Z-scores achieved during the disease. In some patients, an increase in the diameter of the CA can last up to 6 weeks after the disease, and in especially severe cases (rarely) even more than 2 months.

3. Criteria for the quality of medical care

Mandatory:

1) for each patient with HC and coronary changes, the risk category must be reviewed at each control inspection in accordance with Annexes 8, 9 to this Standard;

2) daily ECG monitoring in all patients after MI or in the event of ventricular arrhythmias, to determine the need for antiarrhythmic therapy or implantation of a cardioverter-defibrillator;

3) in case of new symptoms or positive results non-invasive tests, invasive coronary angiography should be performed immediately to decide on interventional treatment;

4) patients with AKA (risk categories 4–5) during the first year after disease, an expanded assessment of the coronary bed is performed using invasive low-dose CT angiography or MRI angiography, for optimal planning of further follow-up and treatment;

5) invasive control of the coronary artery should be performed every 2–3 years in in the event of significant residual changes;

6) provide the patient's parents or legal representatives with a plan observation with a detailed explanation of the importance of regular check-ups and adherence to prescribed therapy.

MEDICAL CARE QUALITY INDICATORS

List of indicators of quality of medical care

1. Availability of specialized medical care in health care facilities pediatric patients with Kawasaki disease clinical patient pathway (hereinafter referred to as KMP).

2. Percentage of children with newly diagnosed HC who were prescribed INFECTION until the 7-10th day from the onset of the disease.

Passports of medical care quality indicators

1. Availability of specialized medical care in health care facilities pediatric patients with Kawasaki disease KMP.

The indicator's relationship to approved guidelines, standards, and medical care protocols (hereinafter referred to as GCPs).

The indicator is based on the provisions of this SDM. Notes
on the interpretation and analysis of the indicator.

This indicator characterizes the organizational aspect of the introduction of modern medical and technological documents (MDT) in the region. The quality of medical care for children with CH, compliance of medical care with the requirements of the MDT, compliance of the MDT with the current MDT cannot be covered by this indicator, but to analyze these aspects, mandatory introduction of the MDT in health care facilities is necessary.

Desired indicator value level: 2025 –
70%
2026 – 90%
2027 and subsequent periods – 100%.

Instructions for calculating the indicator.

Organization that should calculate the indicator: structural units for health care of local state administrations.

Data are provided by health care facilities that provide specialized medical care to children with CH located in the service area to the structural units for health care of local state administrations.

Data is provided by mail, including e-mail.

Indicator calculation method: calculation by manual or automated processing.

The indicator is calculated by the structural units for health care of local state administrations after receiving information from all health care facilities that provide specialized medical care to children with CH registered in the service area. The value of the indicator is calculated as the ratio of the numerator to the denominator.

The denominator of the indicator is the total number of health care facilities providing specialized medical care to children with chronic diseases registered in the service area. The source of information is the report of the structural units on health care of local state administrations, which contains information

regarding the number of health care facilities providing specialized medical care to children with CH registered in the service area.

The numerator of the indicator is the total number of health care facilities providing specialized medical care to children with HC, registered in the service area, for which the fact of the presence of a CMC with HC is documented. The source of information is the CMC provided by a doctor providing specialized medical care to children with HC.

The indicator value is given in percentage.

2. Percentage of children with newly diagnosed HC who were prescribed INFECTION until the 7-10th day from the onset of the disease.

Linking the indicator to approved guidelines, standards, and medical care protocols.

The indicator is based on the provisions of this SDM. Notes

on the interpretation and analysis of the indicator.

When analyzing the indicator, it is necessary to take into account the inadmissibility of formal and unjustified inclusion in the indicator numerator of those patients with CD who were referred to the health care facility for the second time during the reporting period.

The primary medical documentation must document the facts of the patient's medical examination, the performance of mandatory diagnostic procedures specified in the Medical Documentation, in particular, EchoCG, as well as the presence or absence of recurrent manifestations and complications of the disease. Patients for whom such records are missing in the medical documentation are not included in the indicator numerator.

The target (desired) level of the indicator value at the stage of introducing the SMP is not determined in order to prevent distortion of the real situation due to administrative pressure.

Instructions for calculating the indicator.

Health care institution that should calculate the indicator: doctor providing medical care to children with HC; structural units for health care of local state administrations. Data are provided by doctors providing medical care to children with HC, registered in the service area, to structural units for health care of local state administrations.

Data is provided by mail, including e-mail.

Indicator calculation method: calculation by manual or automated processing.

The indicator is calculated by the health care structural units of local state administrations after receiving information from all doctors who provide medical care to children with HC registered in the service area.

The indicator value is calculated as the ratio of the numerator to the denominator.

The denominator of the indicator is the total number of children with newly diagnosed CD who were treated in a healthcare facility during the reporting period and who were prescribed IVLIH treatment.

The source of information is: form No. 025/o, No. 003/o.

The numerator of the indicator is the number of children with newly diagnosed CD who were treated in a healthcare facility during the reporting period and who were prescribed IVLIG by the 8th-10th day from the onset of the disease.

The source of information is: form No. 025/o, form No. 003/o.

The indicator value is given in percentages.

List of sources and regulatory legal acts used in the development of the medical care standard

1. Electronic document “Evidence-based clinical guideline "Kawasaki Disease", 2025, https://www.dec.gov.ua/cat_mtd/galuzevi-standartita-klinichni-nastanovi/.

2.OrderMinistrieshealth careUkrainefrom 14February2012year No.110"Aboutapprovalformsprimaryaccountingdocumentationand instructions regardingïxfilling,Whatare usedininstitutionssecurityhealth regardlessfromforms of ownershipandsubordination", registeredin Ministry justiceUkraineApril 282012yearbyNo.661/20974.

3.Ministry OrdersecurityhealthUkrainefromSeptember 282012year No. 751"On the creation ofandimplementation of medical and technological documentsfrom standardizationmedical and rehabilitation assistance insystem Ministries securityHealth of Ukraine", registeredinMinistryjusticeUkraine 29 November2012yearby number2001/22313.

4. Order of the Ministry of Health of Ukraine dated July 28, 2014 No. 527 "On approval of forms of primary accounting documentation and instructions for their completion, used in healthcare institutions that provide outpatient and polyclinic care to the population, regardless of subordination and form of ownership", registered with the Ministry of Justice of Ukraine on August 13, 2014 under No. 959/25736.

5. Order of the Ministry of Health of Ukraine dated November 9 2020 No. 2559 "On some issues of improving the work of anesthesiology and intensive care departments of healthcare institutions,registered in MinistryjusticeUkraineDecember 18, 2020 under No. 1259/35542.

6. Order of the Ministry of Health of Ukraine dated June 13, 2025 No. 971 "On approval of the seventeenth edition of the State Formulary of Medicinal Products and ensuring its availability."

Acting Director of the Department
of Medical Services **Valeria SORUCHAN**

Appendix 1
to the Standard of Medical Care
"Kawasaki Disease"
(subparagraph 1, paragraph 3 of section II)

A. LABORATORY EXAMINATIONS
- Complete blood count with formula
- ESR, CRP
- Biochemical profile, ALT, GGT, total bilirubin
- Urinalysis (from collected urine or catheterized) + microscopy

B. CARDIOLOGICAL ASSESSMENT
- ECG and EchoCG

C. DIAGNOSTIC CRITERIA FOR FULL-SIZED CH
- Fever for at least 4 days (day of onset = day 1 of fever) + at least 4/5 of the following core clinical features at any time during the illness (does not necessarily have to occur simultaneously):

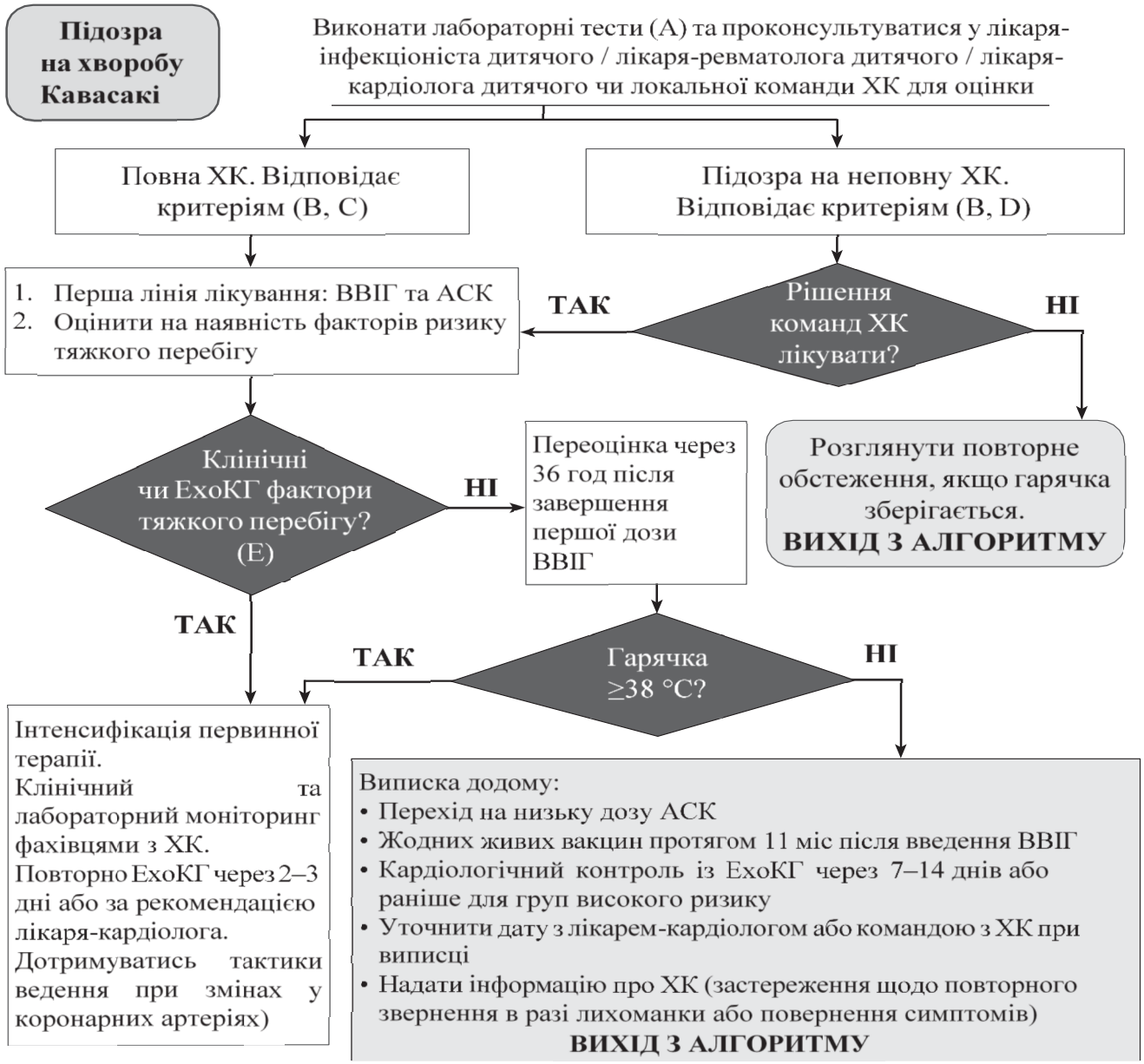
- Polymorphic rash
- Bulbar vascular injections without exudate, bilateral
- Changes in the oral cavity: redness and cracks in the lips, a crimson tongue or erythema of the oral and pharyngeal mucosa, or all signs together
- Erythema of the palms and soles: usually accompanied by edema; later — peeling of the skin in the subacute phase of the disease
- Cervical lymphadenopathy: usually unilateral, lymph node mass >1.5 cm in diameter
- Lack of alternative diagnosis

D. SUSPECTED INCOMPLETE KAWASAKI DISEASE

Prolonged unexplained fever ≥3 days + 2–3 of 5 clinical signs or, in infants, unexplained fever >7 days with inflammatory laboratory or echocardiographic criteria:
- CRP ≥30 mg/L or ESR ≥40 mm/h or both + 3 or more of the following:
  - anemia for age
  - platelets ≥450,000/mm³
  - albumin ≤30 g/l
  - elevated ALT
  - leukocytosis ≥15,000/mm³
  - urine: leukocytes ≥10/field of view
- LAD or RCA Z-scores ≥2.5
- OR ≥6 or more non-selective echo signs:
  - decreased LV function
  - mitral regurgitation
  - pericardial effusion
- Z-score e LAD or RCA in the range of 2.0–2.5

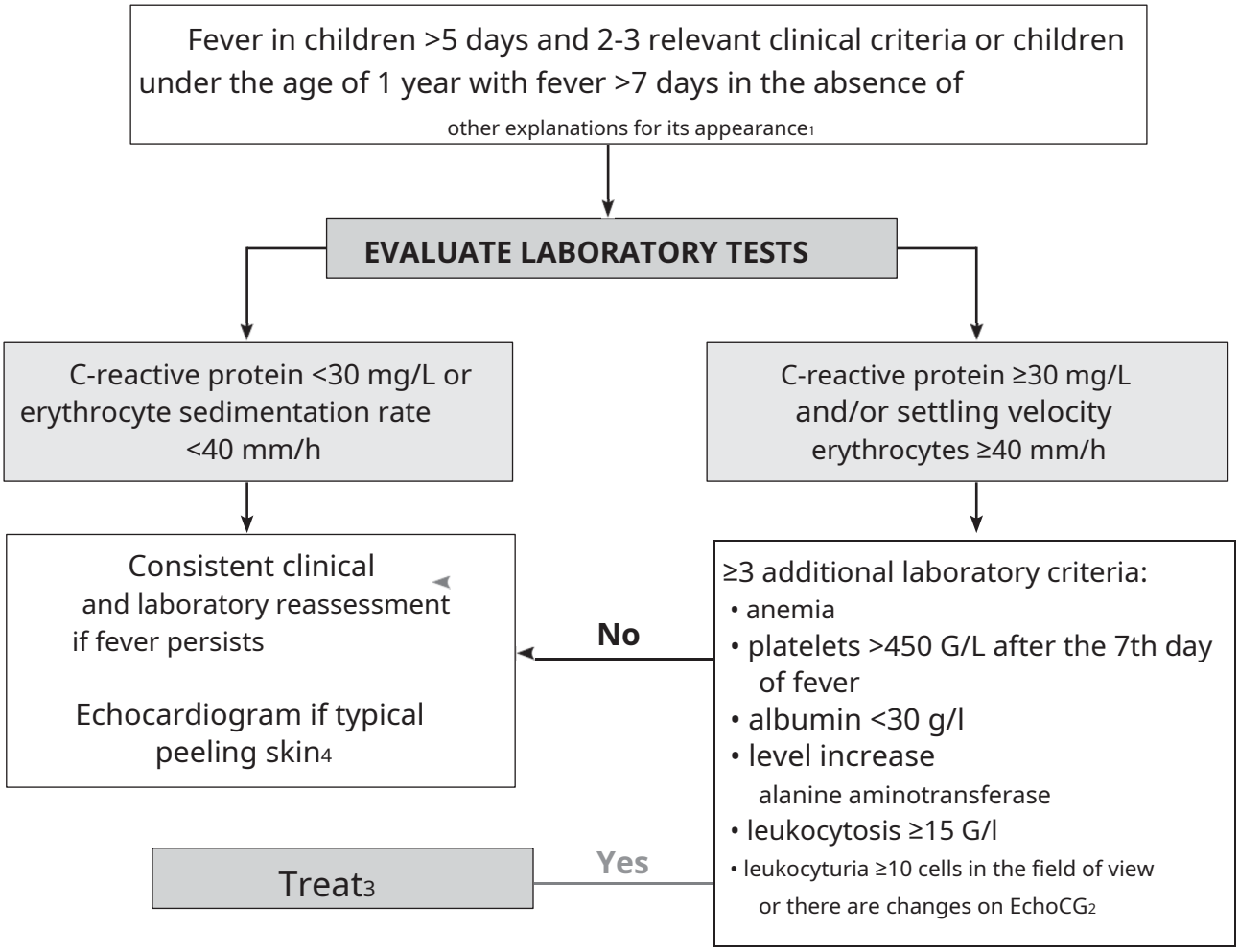
E. HIGH RISK CRITERIA
- Age ≤6 months
- Z-score LAD or RCA ≥2.5 already at the initial EchoCG

KAWASAKI DISEASE: assessment and management tactics



Appendix 2
to the Standard of Medical Care
"Kawasaki Disease"
(subparagraph 2 of paragraph 3 of section II)

Evaluation of the patient for suspected incomplete CC



Notes:

1Clinical features not typical of CD include exudative conjunctivitis, exudative pharyngitis, oral ulceration, bullous or vesicular rash, generalized lymphadenopathy, or splenomegaly. If these features are present, alternative diagnoses should be considered. Children younger than 6 months may have a prolonged fever without other criteria for CD. These children are at particularly high risk for coronary vascular anomalies;

2Echocardiography results are considered positive if one of the following 3 conditions is present: Z-scores (standardized score) are >2.5 for the left anterior descending artery or right CA; CA aneurysms are present; or >3 of the following are present: decreased left ventricular function, mitral regurgitation, pericardial effusion, or Z-scores of the right or left anterior descending CA or right CA are 2-2.5;

3if the EchoCG results are “positive”, treatment should be carried out until the 10th day from the onset of fever or after 10 days if fever and signs of systemic inflammation (C-reactive protein, erythrocyte sedimentation rate) persist;

4typical is peeling skin that begins below the nail bed of the fingers and toes.

Appendix 3
to the Standard of Medical Care
"Kawasaki Disease"
(subparagraph 3 of paragraph 3 of section II)

Echocardiographic imaging standards for patients with CD

Patient preparation	**Technical aspects of the assessment coronary arteries**	**High quality rating**	**Quantitative assessment**
Equipment 1. Usage sensor with maximum possible frequency 2. Dynamic recording video or digital digital cine	Left main coronary artery (LMCA): imaging techniques 1. Short axis at the level of the aortic valve (PSAX — *parasternal short axis* on a level AoV) 2. Parasternal long section of the left ventricle with an upper tangential slope (PLAX — *parasternal long axis of the left ventricle*) 3. Subcostal long axial section of the ventricles (*subcostal ventricular long axis*)	Availability aneurysm or thrombosis KA	CA damage by Z-scores (normalized to body surface area – BSA) 1. No lesion: Zscores <2 in all segments 2. Dilation only: Z-scores from 2 to <2.5 3. Small aneurysm:Z-scores ≥2.5 to <5 4. Medium aneurysm: Z-scores ≥5 to <10 and absolute size <8 mm 5. Large or giant aneurysm: Z-scores ≥10 or absolute size ≥8 mm It is advisable to repeat echocardiography more frequently in the acute phase in patients with CA lesions until their size stabilizes or before discharge - especially in patients with high-risk factors (age <6 months or baseline Z-scores ≥2.5).
Sedation should be considered in the following cases: 1. Children aged <3 years 2. Non-contact or excited children who are not cooperative under examination time	Front descending branch left coronary artery (LAD): 1. Short axis at the level of the aortic valve (AoV) and the left ventricle (LV); distal part LAD passes ahead valve pulmonary artery (PV) 2. Parasternal long left ventricular out superior tangential slope (PLAX)	Violation regionally y short-lived myocardial infarction	Ventricular function 1. LV ejection fraction or measurement in M-mode (decrease systolic LV functions turns out approximately 20% of patients at presentation and is associated with CA involvement [33]. 2. End-diastolic volume or LV dimensions 3. End-systolic volume or LV dimensions 4. Diastolic function LV/RP 5. LV deformity
	Circumferential branch of the left coronary artery: 1. Short axis at the level of the aortic valve (PSAX) 2. Apical four-chamber view (apical 4-chamber) — lower view in the left atrioventricular groove		Availability or degree atrioventricular regurgitation
	Right coronary artery (RCA), proximal segment:		Availability and dimensions pericardial effusion

	1. Short axis at the level of the aortic valve (PSAX) 2. Parasternal long slice of the left ventricle with a lower tangential slope (PLAX) 3. Subcostal coronal section in the right ventricular outflow tract (RVOT) region 4. Subcostal short-axis section at the level of the atrioventricular groove (SAX)		
	PCA, middle segment: 1. Parasternal long slice of the left ventricle with a lower tangential slope (PLAX) 2. Apical four-chamber view (apical 4-chamber) 3. Subcostal long axial section of the left ventricle 4. Subcostal short-axis section at the level of the atrioventricular groove (SAX)		Aortic root dimensions (in more than 10% of patients with the disease Kawasaki observed Z-scores aortic root >2)
	PCA, distal segment: 1. Apical four-chamber view (apical 4-chamber), lower view 2. Subcostal long axial section of the atria, lower view		
	Posterior descending artery: 1. Apical 4-chamber view, inferior view 2. Subcostal long axial section of the atria, lower view 3. Parasternal long slice with lower tangential inclination (PLAX) 4. Section in the plane of the posterior interventricular sulcus		

Appendix 4
Standard of medical care
"Kawasaki disease"
(subparagraph 4 of paragraph 3 of section II)

Differential diagnosis of Kawasaki disease with other diseases*

	Measles	Parvovirus infection	Scarlet fever	Infection, caused *Arcanobacterium haemolyticum*	Yersiniosis	Infection, caused by M. pneumoniae-associated mucositis (MPAM)	Idiopathic juvenile arthritis
Typical age	Any	7-10 years	> 7 years	10-30 years	Any	Any	< 16 years old
Fever	Above 38.3°C unanswered on antibiotics	Short-lived, usually subfebrile	Yes	Yes	Yes	Yes	Yes
Qatar upper respiratory ways	Bright expressed, exudative and	Possible, weakly expressed	Pharyngitis, typical purulent angina	Pharyngitis, typical purulent tonsillitis	Possible	Yes (100%)	Not characteristically
Rash	Spotted-papular, appearance – on 5- and day diseases I, characteristic phasedness	Generalized spotted, appears on background of disappearance fevers, typically on the face Possible "syndrome gloves and socks"	Generalized on the spotted dot wow, from the first days fever, necessarily on the face	Spotted, scarlet fever and rash (75%) from the first days fevers	Scarlatinopods BNA, papular, urticarial, Hemorrhagic Typical hyperemia face, neck, hands and feet	Minimal skin manifestations (31%)	Possible, spotted-papular, with any localization

Changes mucous oral cavities	Stains Koplika	Not typical	Pharyngitis, crimson tongue	Pharyngitis, raspberry tongue	Raspberry tongue	Bright hyperemia, soreness, chapped lips, aphthae and ulcers on the inside cheeks, tongue, gums	Not characteristically
Pharyngitis	Not characteristic	Not typical	Characteristic, from catarrhal about to purulent sore throat	Catarrhal (97-100%), purulent angina (70%)	Characteristic	Not typical	Not characteristic
Conjuncts vit	Double-sided, exudative and	Not typical	Not typical	Not typical	Possible	Typical (97%)	Not characteristic
Cervical lymphadenitis	Not characteristic	Not typical	Double-sided	Bilateral, 41-48%	Possible, additionally – others groups	Not typical	Not characteristic
Changes palms and stop	Not typical	Not typical	Peeling on 2-3 weeks	Peeling for 2-3 weeks	Erythema, peeling for 2-3 weeks	Possible	Not typical
Damage joints	Not typical	Possible arthritis and arthropathy after disappearance fevers	Possible as late complication	Not typical	Possible in 2-3%	Not typical	Characteristically
Diarrhea	Possible	Not typical	Not typical	Not typical	Characteristic	Not typical	Not typical
Changes in laboratory their indicators	Typical for viral infections	Typical for viral infections, possible anemia, thrombocytopenia	Leukocytosis with a shift formulas left ↑ ESR, ↑ SRB	Leukocytosis with by shifting the formula left ↑ ESR, ↑ CRP	Leukocytosis with by shifting the formula left ↑ ESR, ↑ CRP	Nonspecific	Leukocytosis with landslide formulas left ↑ ESR, ↑ CRP

Opportunities laboratory oh verifications	Virological not the same PCR research in the first 7 days diseases, serological research from 4 days ago appearances rashes Specification vaccination status	Virological, PCR, serological research for specification etiology	Selection pathogen from oropharynx - S. pyogenes, increase ASLO titer	Selection pathogen from oropharynx	Serological research (RA, RNGA, ELISA)	PCR and/or IgM to M. pneumoniae	

Note: * if criteria for complete or incomplete Kawasaki disease are present, priority should be given to initiating treatment rather than waiting for diagnostic results for other diseases.

Differential diagnosis of MIS-c and HC (most distinctive features between the two conditions)

The criterion is whether sign	Kawasaki disease	MIS-c (Multisystem Inflammatory Syndrome in Children). Multisystem inflammatory childhood syndrome
Etiology	The exact cause is unknown. It is likely an immune response to an infectious or other trigger in genetically susceptible children.	Post-infectious hyperinflammatory state clearly associated with with a previous SARS-CoV-2 infection (develops 2–6 (up to 8) weeks after COVID-19). A link must be proven
Age	Mostly children under 5 years of age. Average age: children 2-3 years old, very rare in those older than 8 years. Highest incidence in children of East Asian origin	Average age 7–9 years. Highest incidence among children Latino and African Americans
Fever	≥4-5 days, usually >38–39°C, resistant to antipyretics	≥38°C ≥24 hours Often >39°C, often with chills
Conjunctivitis	Without exudate, bilateral. Classically, a limbal bright zone (absence of redness around the iris) is observed – up to 90% of cases	In about 40% of cases, limbal areas are involved
Oral changes cavities	Hyperemia of the oropharyngeal mucosa, dry, red and cracked lips, "Strawberry" tongue - very characteristic signs	Less common: lip lesions (20–30% of cases), "strawberry" tongue – rare (up to 4–5%)
Changes to limbs	Erythema and edema of the palms and feet in the acute phase; pain in the extremities. In the subacute phase, lamellar peeling of the skin on the tips of the fingers and toes.	Quite rare: Swelling or redness of the hands/feet is uncommon in MIS-s. Skin peeling is uncharacteristic
Lymphadenopathy iya	Usually unilateral – size of lymph node ≥1.5 cm (occurs in about 25–50% of patients with UC). Other groups of lymph nodes are not enlarged.	Cervical lymphadenopathy occurs in 4-5% of cases
Gastro-intestinal symptoms	In about 20% of cases (moderate abdominal pain, nausea, diarrhea, sometimes a rare clinical picture of acute abdomen)	Very common (50-90% of cases): abdominal pain (often severe), vomiting, diarrhea
Damage hearts	Hypotension/shock – very rare (≈2 –3% of cases, coronary shock syndrome). Heart failure – usually not, although minimal left ventricular dysfunction is possible. Myocarditis is possible but usually mild. Troponin is normal or	Hypotension in almost all in severe cases. Shock often develops – most hospitalized MIS-C patients have signs of perfusion failure (cardiogenic or mixed genesis).

	slightly elevated, NT-proBNP often <1000 pg/mL. Systolic cardiac function is usually preserved (LVEF normal or slightly decreased)	Almost all patients: noted myocarditis/LV dysfunction of varying degrees. Often LVEF <55%, arrhythmias may be present (extrasystole, blockades). Troponin is elevated in most cases, NT-proBNP is very high (hundreds–thousands of pg/ml), which reflects severe heart damage
Coronary arteries	Without treatment, about 20-25% of patients develop aneurysms (sometimes giant). Aneurysms can persist, causing the risk of thrombosis, myocardial infarction in the long term	Dilatation or small aneurysms of the coronary arteries (10-15% of cases). Typically – transient, disappear within 1–3 months. Cases of giant aneurysms are casuistic. The risk of myocardial infarction is minimal
Laboratory markers inflammation	Elevated: CRP usually 30–100 mg/L. Marks of inflammation are pronounced, but rarely reach extreme values	Severely elevated: CRP often >100–200 mg/L. Elevated levels of inflammatory markers often greater than in UC
Leukocytes, differential	Leukocytosis with neutrophilia is characteristic. Lymphopenia is usually absent.	Often leukopenia or normal leukocytes on the background of lymphopenia
Platelets	Thrombocytosis after 7–10 days of illness (>450×10*9/L). May be normal in the acute period.	Thrombocytopenia is common. Thrombocytosis is not typical.
Coagulopathy (D-dimer)	Usually normal or moderately elevated. D-dimer values in UC rarely exceed 1000–2000 ng/mL.	Very high D-dimer is an almost constant sign of MIS-C (reflects hypercoagulability). Often >3000 ng/mL, sometimes >5000–8000 ng/mL
Ferritin	Moderate increase: usually <300–500 ng/ml, values >1000 ng/ml are uncharacteristic (if present, should be suspect macrophage activation syndrome)	Significant increase: often 500–1000 or more ng/ml, not infrequently > 2000 ng/ml in severe cases. Hyperferritinemia reflects massive activation of the immune system
Other flammable mediators	Clinically, incomplete MAS (macrophage activation syndrome) may develop in <2% of patients	Cytokine “storm”. Often there are signs of MAS-like hyperinflammation (very high ferritin, triglycerides, cytopenias)
PCR/serology SARS-CoV-2	Negative results (no connection with COVID-19). The presence of coronavirus infection is not typical; if a child with signs of HC tests positive for COVID-19, it is necessary to differentiate from MIS-c	Positive in most cases: ≥95% of patients have either a positive PCR or antigen or IgG antibodies to SARS-CoV-2 nucleocapsid (N) protein, or known recent contact
Treatment (first line)	IV infusion 2 g/kg IV	IVIG 2 g/kg + glucocorticoids

	(+ in the presence of risk factors, intensification of therapy)	
Treatment (resistant cases)	If fever persists >36 hours – repeat dose of IVLIG 2 g/kg or pulse therapy with methylprednisolone, or infliximab 5 mg/kg IV (see the algorithm for treatment of chronic obstructive pulmonary disease)	If there is no response after 24–36 hours: re-administration of IVLI is not recommended. Instead, increase the dose of GCS or anakinra. Possible tocilizumab or infliximab
Forecast, consequences	With timely treatment, the prognosis is excellent. Mortality <0.1%. Fever and acute inflammatory manifestations resolve within 1–2 days after IVLIG. ACAs form in 3–5% (with treatment); most of them regress within 1–2 years, but lesions may remain (especially giant ones). Requires observation by a cardiologist (risk of thrombosis, coronary artery disease). Children without aneurysms recover completely without long-term consequences	The prognosis is generally favorable with appropriate treatment. Mortality rate ~1–2% (mostly from refractory shock or multiorgan failure). Cardiac function normalizes in > 80% of cases within 1–4 weeks; 10–20% may have mild residual changes (moderate LV dysfunction)

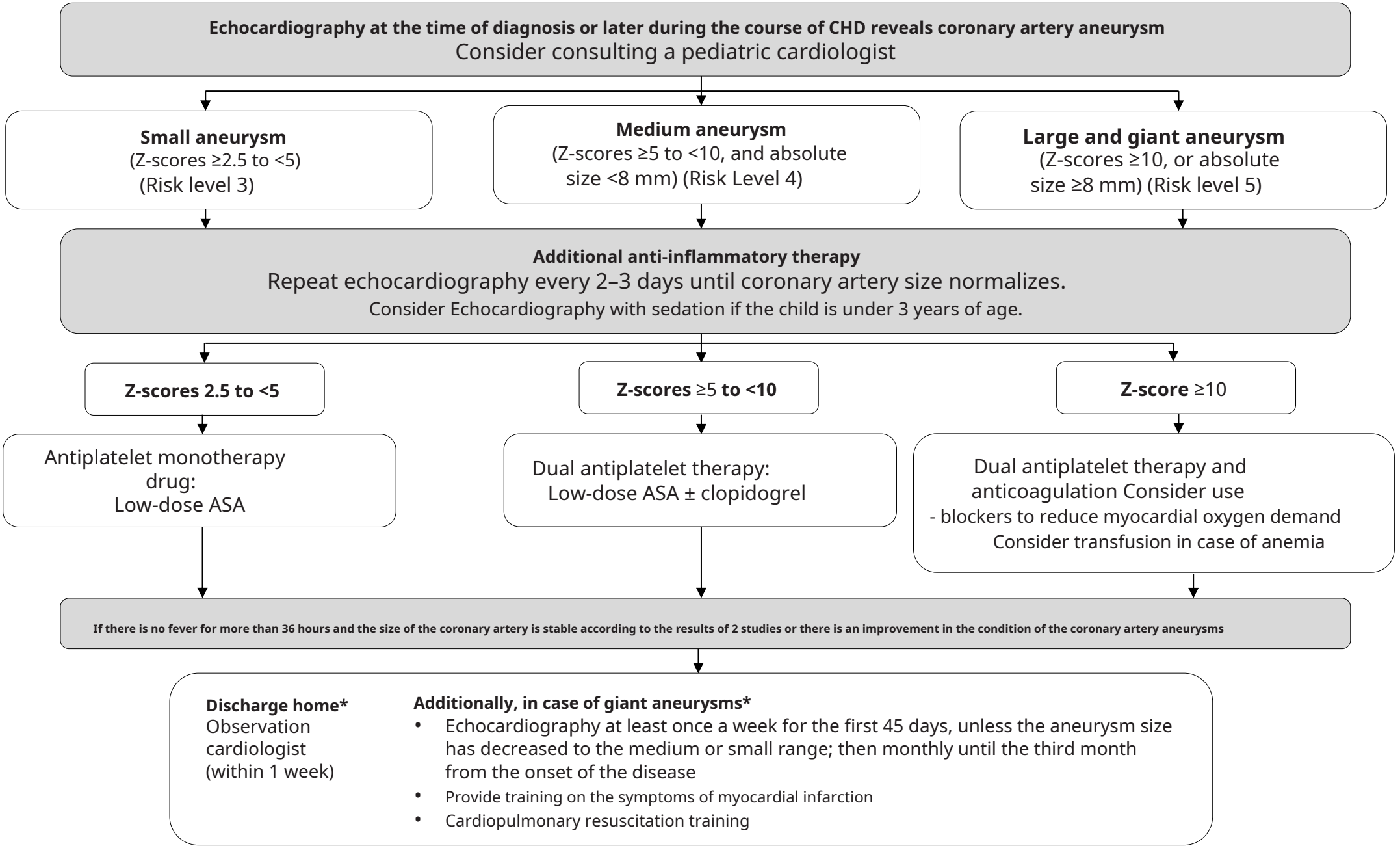
Appendix 5
to the Standard of Medical Care
"Kawasaki Disease"
(subparagraph 6 of paragraph 3 of section II)

Clinical and laboratory features of secondary hemophagocytic lymphohistiocytosis (HLH)

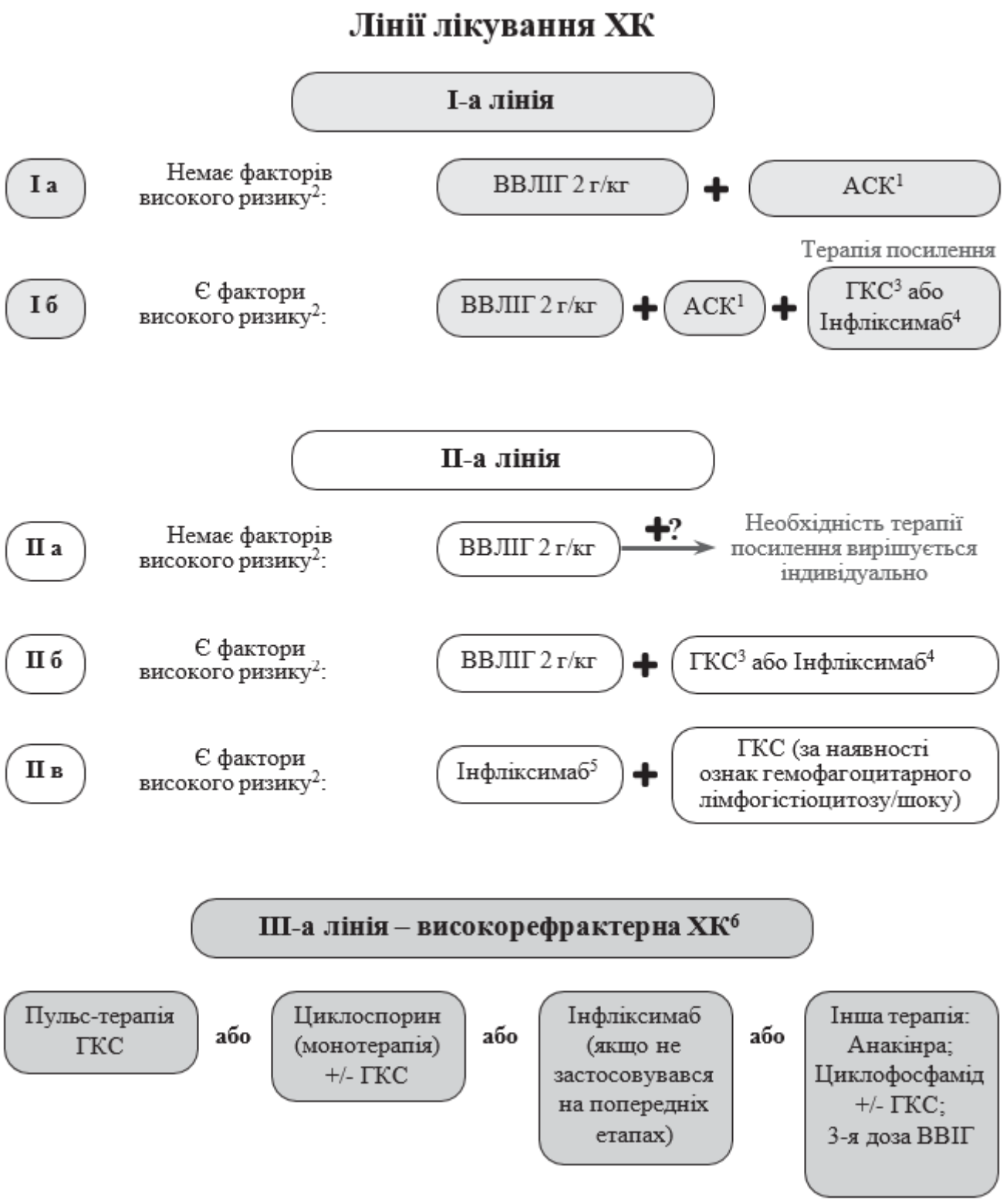
	Sign	Threshold value
1.	Fever	≥38.5°C
2.	Splenomegaly	≥2 cm below the costal margin
3.	Cytopenia	≥2 of the following cell lines
	Hemoglobin	<90 g/l (in newborns <100 g/l)
	Platelets	$<100 \times 10^9$/l
	Neutrophils	$<10^9$/l
4.	Hypofibrinogenemia or hypertriglyceridemia	Fibrinogen≤1.5 g/l or triglycerides ≥3.0 mmol/l
5.	Hyperferritinemia	≥500 μg/L
6.	Hemophagocytosis	Bone marrow, other tissues
7.	Increased level soluble CD25	≥2400 U/ml

Note: At least five of the eight criteria must be confirmed to make the diagnosis.

Appendix 6
to the Standard of Medical Care
"Kawasaki Disease"
(subparagraph 5, paragraph 3, section III)



Appendix 7
to the Standard of Medical Care
"Kawasaki Disease"
(subparagraph 6, paragraph 3, section III)



Notes:

[1]ASA is continued regardless of the line of HC therapy;
[2]high-risk factors: age ≤6 months, Z-scores ≥2.5, CRP ≥130 mg/l, Asian origin, shock, etc.;
[3]consider pulse glucocorticosteroid therapy in severe cases of CD, with signs of hemophagocytic lymphohistiocytosis or shock;
[4]The recommended dose of infliximab is 5 mg/kg IV (may be increased to 10 mg/kg in severe cases, signs of shock, or hemophagocytic lymphohistiocytosis). If necessary, infliximab should be used in the setting of

hyperrefractory HC in its absence or in the presence of contraindications, consider etanercept as an alternative (0.8 mg/kg subcutaneously once a week, duration 2–3 administrations);

[5] if IVLIG is contraindicated in the 2nd line of therapy;

[6] The decision regarding treatment is made individually by a multidisciplinary team.

Appendix 8
to the Standard of Medical Care
"Kawasaki Disease"
(Section IV, paragraph 1)

Risk categories for coronary artery disease during follow-up

Classification	Description
1	Absence of lesion at any stage (Z-scores always <2)
2	Dilation only (Z-scores 2 to <2.5)
3	Small aneurysm (Z-scores ≥2.5 to <5)
3.1	Present at the time of examination or persistent
3.2	Reduced to dilated or normal lumen diameter
4	Medium aneurysm (Z-scores ≥5 to <10 and absolute diameter <8 mm)
4.1	Present at the time of examination or persistent
4.2	Reduced to a small aneurysm
4.3	Reduced to dilated or normal lumen diameter
5	Large or giant aneurysm (Z-scores ≥10 or absolute diameter ≥8 mm)
5.1	Present at the time of examination or persistent
5.2	Reduced to a medium aneurysm
5.3	Reduced to a small aneurysm
5.4	Reduced to dilated or normal lumen diameter

Appendix 9
to the Standard of Medical Care
"Kawasaki Disease"
(subparagraph 1 of paragraph 3 of section IV)

Long-term treatment, thromboprophylaxis, and drug therapy for Kawasaki disease

Classifier action **equal risk**	Description **coronary** their **arteries**	Frequency **observations after** stabilization of the spacecraft in **patient or normalization sizes at** discharge: medical history; **physical examination; ECG;** Echocardiography	Diagnosis **tika** inducible another myocardium **all** ischemia* **(stress** and tests)	**Extended coronary** visualization **I**	**Antitrom bocitary therapy**	**Antico agustin on therapy**	**Consult** actions **with** questions **physical activity** those
1 (Z-scores always <2)	Absence b damage KA in any which moment	1–2 weeks (consider possibility observation after 4–6 weeks, if visualization KA suboptimal or laboratory inflammatory markers are abnormal because 1–2 weeks); possible termination observation between 4 weeks and 1 year	Not shown	Not shown	Low ASA dose throughout 6 weeks, then to stop	Not shown at	Consultation tion during each visit
2 (Z-scores 2–2.5)	If watched is only expanded nya – it disappears for 6 weeks - 1 year	1–2 weeks (consider visit after 6 weeks if abnormal results stored through 1-2 weeks); 1 year; possible termination observation after 1 year, if symptoms disappear; spend reviews every 2–5 years, if disease stored	Not shown	Not shown	Low ASA dose throughout 6 weeks; if KA leave within the limits norms, through 6 weeks, to stop	Not shown at	Consultation tion during each visit
3 (Z-scores 2.5–<5)	**3.1**Small aneurysm current or I persist cha	If during 1 week observed progressive expansion, then recommended thorough observation 1. once a week until the CA stabilizes;	Will examine ntion every 3–5 years	Consider coronary KTA in 1 year as basic; can consider every 3–5 years	Low ASA dose	Not shown at	Consultation tion during each visit

		6 weeks; 6 months; 12 months; annually					
	3.2 Small aneurysm Regresive only expanded or to norms	Within 1 week; 6 weeks; 1 year; 5 years, possible termination observation by conditions, what is stress-test and coronary CTA is normal	Will examine ntion every 5 years	Consider coronary KTA in 1 year as base indicator; can consider, if there is induced ischemia	Reception low doses of ASA I will continue. they go to normalization its size	Not shown at	Consultation tion during each visit
4† (Z-scores 5–<10 or absolutely th size <8 mm)	**4.1:** Medium aneurysm current or I persist cha	Within 1 week (if progressive expansion, then recommended thorough observation 1 time per week to stabilization of the spacecraft); 6 weeks; 3 months; 6 months; 12 months; annually	Will examine ntion every 2–5 years	Consider coronary KTA in 1 year as base level; can consider every 2–5 years	Low ASA dose plus clopidogrel l	Not shown at	Consultation tion during everyone; consider and limited I activities ; self-contained marriage
	4.2: Medium aneurysm regress la to small aneurysms	Within 1 week; 6 weeks; 6 months; 12 months; annually	Will examine ntion every 3–5 years	Consider coronary KTA in 1 year as base level; can to consider every 3–5 years	Low ASA dose	Not shown at	Consultation tion during each visit
	4.3: Medium aneurysm regress la to norms or only expanded no	Within 1 week; 6 weeks; 6 months; 12 months; every 2 years	Will examine ntion every 4–5 years	Coronary KTA in 1 year is possible consider as a weekend indicator, if available induced ischemia	Low ASA dose	Not shown at	Consultation tion during each visit
5† (Z-scores ≥10 **or absolutely th size > 8 mm)**	**5.1**: Big or gigantic aneurysm current or I persist cha	Within 1 week (if the extension progresses, recommended thorough observation 1 time per week to stabilization of the spacecraft); 6 weeks; 3 months; 6 months; 9 months; 12 months, then every 6–12 months	Will examine ntion every 6–12 months	Consider possibility carrying out initial coronary KTA within 2–6 miss.; can to consider every 1–5 years, or carrying out invasive coronary angiography	Low ASA dose; double antithrombus ocytic therapy with clopidogrel lem can be considered	Barbarians n, LMH or POAC	Consult tation during each visit; limited I activities ; self-contained marriage
	5.2: Big	Within 1 week (if the extension	Will examine ntion	Consider coronary	Low ASA dose;	Can examined	Consult tation

	or gigantic aneurysm Regresive la to average aneurysms	progresses, then recommended thorough observation 1 time per week to stabilization of the spacecraft); 6 weeks; 3 months; 6 months; 9 months; 12 months, then every 6–12 months	every 2–5 years	KTA in 1 year, as basic and repeat and every 2–5 years	double antithrombus ocytic therapy with clopidogrel lem can be considered	uti version applied anny warfarins Well, LMH or POAC‡	during each visit; limited I activities ; self-contained marriage
	5.3: Big or gigantic aneurysm regress la to small aneurysms	Within 1 week (if the extension, progresses then recommended thorough observation 1 time per week to stabilization of the spacecraft); 6 weeks; 3 months; 6 months; 9 months; 12 months, then annually	Will examine ntion every 3–5 years	Consider coronary KTA in 1 year as basic and repeat and every 3–5 years	Low ASA dose; double antithrombus ocytic therapy with clopidogrel lem can be considered	Not shown at	Consult tation during each visit; limited I activities ; self-contained marriage
	5.4: Big or gigantic aneurysm regressed ala to norms or only dilations	During 1 week (if dilation, progresses then recommended thorough observation 1 time per week to stabilization of the spacecraft); 6 weeks; 3 months; 6 months; 9 months; 12 months, then every 1–2 years	Will examine ntion every 3–5 years	Consider coronary KTA in 1 year as base indicator, and repeat and every 3–5 years	Low ASA dose	Not shown at	Consult under time each visit; limited I activities self-contained marriage