Asia-Pacific Kawasaki Disease Association

Educational Seminar 2022

Program Schedule

Register Here

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Organizer

Japanese Society of KD
Asia-Pacific KD Association

Co-sponsored by

Japan KD Research Center

September 3rd, 2022

Tokyo time 9:00-11:00 p.m. (GMT +9 hrs)

Any question?
Please contact

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Greetings

Welcome to the educational seminar organized by the APKDA/JSKD. Kawasaki Disease (KD) is very common among Asian descents. With a mission to keep the health of all Asian children, we established the Asian Kawasaki Disease Clinical Research Network (AKDCRN) in 2016 with pediatricians who worked for KD in Asia, to discuss the care of children with this disease.

A discussion was held by some of the members during the International KD Symposium in 2021, and the Asia-Pacific Kawasaki Disease Association (APKDA) was eventually founded with the purpose of developing AKDCRN activities and building a more sustainable organization. Representatives of all Asian regions will be invited by this group to a meeting to discuss potential future cooperation.

If you are interested in this organization, please feel free to use this opportunity to get in touch with us.

This educational seminar is what we have planned as the initial step in APKDA activities. It is being organized by the Japan Branch of APKDA and the Japanese Society of Kawasaki Disease (JSKD). We are very honored for the opportunity of having Professor Mamoru Ayusawa and Professor Etsuko Tsuda, two of Japan's top experts in KD care and research, as our guest speakers who will share their idea and experiences about KD diagnosis and its long-term management.

We hope that medical professionals from various parts of Asia, especially young medical professionals, will attend this seminar and apply the knowledge in their clinical practice from now on.

Sincerely,

August 1 st, 2022

APKDA Japan Branch

Hiromichi Hamada, MD, PhD

Asia-Pacific Kawasaki Disease Association

Educational Seminar 2022 Program

9:00-9:10 p.m. Opening remarks

Yoshihide Mitani, MD, PhD
President of Japanese Society of KD

9:10-10:00 **Session 1**

Diagnosis of Kawasaki Disease – History and Contemporary Style in Japan

Moderator: Kenji Furuno, MD, PhD
Fukuoka Children's Hospital

Speaker: Mamoru Ayusawa, MD, PhD
Nihon University School of Medicine

Q&A

10:00-10:50 **Session 2**

Management in patients with coronary artery lesions caused by KD

Moderator: Kazuyuki Ikeda, MD, PhD
Kyoto Prefectural University of Medicine

Speaker: Etsuko Tsuda, MD, PhD
National Cerebral and Cardiovascular Center

Q&A

10:50 **Closing remarks**

Hiromichi Hamada, MD, PhD
Committee member of APKDA

Session 1

Diagnosis of Kawasaki Disease

History and Contemporary Style in Japan

Mamoru Ayusawa, MD. PhD.

Professor, Department of Development and Nutrition, the Faculty of Health and Medical Science

Kanagawa Institute of Technology

Visiting Professor, Department of Pediatrics and Child Health, Nihon University School of Medicine

Diagnosis of Kawasaki disease (KD) depends on characteristic clinical signs, which were noticed and summarized by Dr. Tomisaku Kawasaki in 1967.

In Japan, through the experience of accumulating 400,000 patients, we have been making efforts to diagnose KD as early as possible, because the earlier initiation of intravenous immunoglobulin treatment (IVIG) resulted in better prevention of coronary artery complications. There have been many discussions on diagnosing incomplete KD and treating IVIG unresponsiveness as essential strategies.

With an overview of the history of revision of Japanese diagnostic guidelines, our efforts for an earlier diagnosis of KD will be announced.

Session 2

Management of patients with coronary artery lesions caused by Kawasaki disease

Etsuko Tsuda, MD, PhD.
Department of Pediatric Cardiology
National cerebral and cardiovascular center, Japan.

Giant aneurysms typically occlude coronary arteries within the first year after onset of Kawasaki disease (KD) and can cause acute myocardial infarction. Bilateral giant aneurysms are major risk factors for sudden death after KD and lead to myocardial infarction, decreased left ventricular ejection fraction, multifocal premature ventricular contractions, and asymptomatic non-sustained ventricular tachycardia. Prevention of myocardial infarction and left ventricular dysfunction depends on careful follow-up, anticoagulation therapy, and coronary revascularization.

The culprit lesions are complicated with giant aneurysms and severe calcification, and their morphology varies with each lesion. The age of coronary revascularization in patients with coronary artery lesions (CALs) caused by KD ranges from children to adults. Thrombolysis should be performed in either small children who cannot undergo percutaneous coronary intervention (PCI) or in the situation of early PCI unable to be performed. The optimal time for performing coronary artery bypass grafting (CABG) should be decided with the understanding of the characteristics of CALs due to KD and their natural history. Once good flow in the internal thoracic artery graft 1 year after surgery is confirmed, graft patency will persist for more than 20 years. The post-CABG left ventricular ejection fraction is related to the outcome in this population. At a minimum, good coronary revascularization to the left coronary artery can avoid a poor prognosis in this population. Good coronary revascularization would improve the quality of life.

Sudden death can occur more than 20 years after acute KD in patients with low left ventricular ejection fraction. The use of angiotensin-converting enzyme inhibitors (ACEI) and beta-blockers help to reduce the occurrence of adverse effects. Such patients may also benefit from antiarrhythmic treatment with amiodarone or sotalol. The indication of cardiac resynchronization therapy for chronic heart failure can be discussed. If critical ventricular tachycardia is detected, either catheter ablation or an implantable cardioverter defibrillator (ICD) would be useful to prevent sudden death from fatal ventricular arrhythmia. In this population, the goal is to maintain quality of life for long life. The effectiveness, risk of complications, quality, and degree of success of the procedure must be discussed. We select the best procedure for each patient on this basis and derived the accumulation of evidence from the latest to the earliest results.

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