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SCIENTIFIC LETTER

Acute Anterior Uveitis as the Presenting Feature of Kawasaki Disease

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To the Editor: While ocular manifestations like conjunctival injection are well described in Kawasaki disease (KD) [1], acute anterior uveitis as the initial manifestation is distinctly uncommon. We describe a girl who presented to the eye clinic with red eyes and was later diagnosed with KD.

A 9-y-old girl presented with fever for 15 d, red eyes and photophobia. She developed an erythematous macular rash 4 d after fever. There was no eye discharge, pain or blurred vision. Both eyes showed keratic precipitates, cells and flare in the aqueous suggesting anterior uveitis. As she had fever and systemic manifestations, she was referred for a pediatric consultation. Examination revealed fissured lips, red tongue, bilateral conjunctival injection and swollen hands. Investigations showed hemoglobin of 106 g/L, total leucocyte count 12.47×10^9/L (76 % neutrophils and 20 % lymphocytes), platelets 4.57×10^9/L, C-reactive protein 55.15 mg/L and erythrocyte sedimentation rate 20 mm in the first hour (Westergren). Blood culture was sterile. Echocardiogram was normal. A clinical diagnosis of KD was made. Intravenous immunoglobulin (2 g/kg) was given along with prednisolone, aspirin, topical atropine and betamethasone. Redness improved dramatically. Eye examination after 3 mo was normal.

Bilateral nonexudative bulbar conjunctivitis typically sparing the limbus is seen in more than 85 % children with KD and is one of the major diagnostic criteria of KD [1]. Other ocular manifestations like superficial punctate keratitis, vitreous opacities, choroidal and retinal changes, papilledema and subconjunctival hemorrhage are less commonly described [2]. Anterior uveitis has been seen in upto 66 % of patients with KD a mean of 8.6 d after the onset of fever [3]. It commonly manifests as redness and photophobia and has a good prognosis [4]. Photophobia and redness of eyes were so prominent in this case that this child was first taken to an ophthalmologist who in turn sent the child for pediatric review because of underlying systemic features. Both ophthalmologists and pediatricians should be aware of this clinical presentation as delayed diagnosis could be responsible for delay in treatment and consequently for adverse cardiovascular outcomes.

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