**Figure 1.** Algorithm outlining KD assessment and management. Optional investigations are in brackets.

**Patient diagnosed with Kawasaki disease**
Minimum tests to be completed: CBC + differential, CRP (ESR), creatinine, electrolytes, albumin, ALT (AST), urinalysis, blood culture, blood type

**Unstable**
- Shock
- Suspected MAS

**Stable**

Investigations to consider:
- Ferritin, LDH, triglyceride, INR, PTT, fibrinogen, d-dimer, troponin, NT-proBNP
- Echocardiogram, ECG, chest x-ray

Consider consultation with possible transfer to tertiary care centre:
- ICU
- Cardiology
- Rheumatology
- Thrombosis/Hematology

Treatments to be administered with subspecialty guidance:
- High-dose steroids
- IVIG 2 g/kg
- ASA (if platelets >80 x $10^9$/L) or antiplatelet/anticoagulant therapy depending on clinical situation

Any of the following:
- <12 months of age
- ≥10 days of fever
- COVID exposure within the last 8 weeks
- Coronary artery lesion on echocardiogram

**Yes**

**No**

Treatment: IVIG 2 g/kg
ASA (if platelets >80 x $10^9$/L)
Echocardiogram

Fever occurring 24-36 hours post-IVIG completion?

**Yes**

**No**

KD shock
- Close monitoring of hemodynamic status
- Judicious use of fluids

KD with MAS
- Close trending of MAS bloodwork

Rapid reassessment for other causes of fever. If no diagnosis aside from refractory KD is suspected, then

Assess for discharge and arrange follow-up

Assess for discharge, arrange follow-up with appropriate subspecialties

Subspecialty consultation for additional management considerations alongside first-line treatment with IVIG, echocardiography, and aspirin