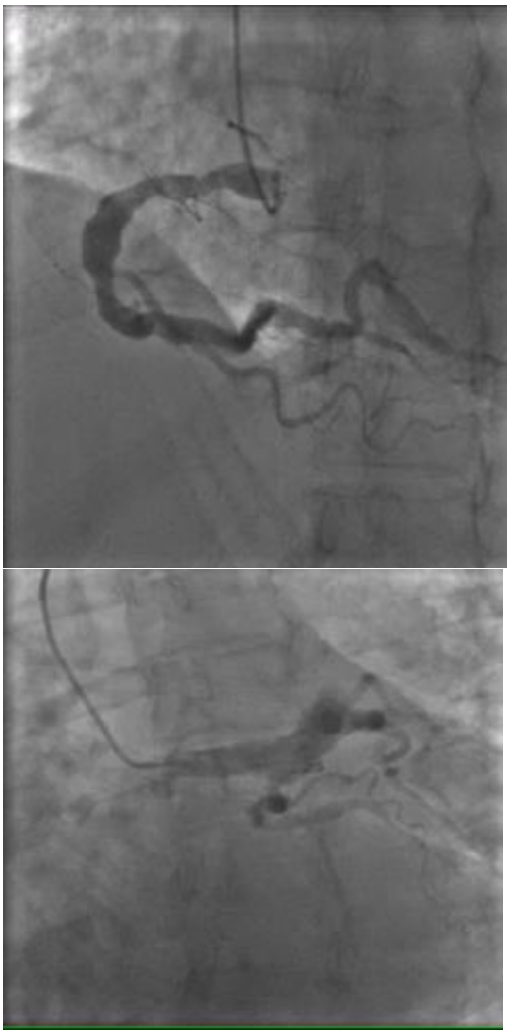
Subject: Clinical question of the week

March 27, 2015
David May, MD, PhD, FACC (dmay@cvscardio.com)

Good afternoon,

A 35 year old woman with a history of Kawasaki disease was admitted to our service with chest pain. Troponins are minimally elevated.
At angiography, there is no obstructive lesions, however the aneurysmal sections are now 2.0-2.5 cm in diameter including the left main. At diagnosis several years ago, they are noted to be about 1 cm. (We have no images, only the reports.)
The aneurysmal sections are multiple and diffuse in all three epicardial vessels.



ASA alone?
DAPT?
Beta blockers?

Statins?
Full AC?
Call the competing group and turf the patient?

Have a good weekend.

Dave

March 27, 2015
Hector Ventura, MD, FACC (hventura@ochsner.org)

Normal EF??? H

March 27, 2015
David May, MD, PhD, FACC (dcm1988@me.com)

Normal EF

March 27, 2015
Steven Lloyd, MD, PhD, FACC (sglloyd@uab.edu)

Dave,
The answer is: Yes.

Just kidding.
I vote for anticoagulation, though admittedly without much data to justify.
SL

March 27, 2015
Geetha Raghuveer, MD, FACC (graghuveer@cmh.edu)

Dear Dr. May

Dr. Gordon, BOG San Diego has a collection of such patients Best person to consult and am sure you will hear from him soon

Burnt out KD with coronary artery aneurysms are associated with dyslipidemia, you may have checked

Regards
Geetha Raghuveer

March 27, 2015
Timothy Dewhurst, MD, FACC (tdewhurst@comcast.net)

With an N of 3, I have used anti-coagulation (based on slow flow principles and seeing a 4 cm diameter RCA filled with clot as a STEMI), at least one anti-platelet agent and a statin. As one of my colleagues frequently says, I believe this to be "a data free zone."
Option 6 is always good on a Friday afternoon as well. :)
Tim

March 27, 2015
Hector Ventura, MD, FACC (hventura@ochsner.org)

David difficult question> Medical therapy is advisable Statins etc. Asprine is also. Some of these patients unfortunately they end up having a transplant. I am sure you do not need this but here is a paper. We transplanted 3 patients with K disease. 2 with low Ef 1 with normal and arrhytmias. H

March 27, 2015
John Messenger, MD, FACC (john.messenger@ucdener.edu)

David:

Have had several pts with this, including some kids. Our approach has been to use warfarin and aspirin 81 mg without data.

John M.

March 27, 2015
Anuj Gupta, MD, FACC (anujslink@gmail.com)

Seems that in a data free area, perhaps we have a gap where data needs to be collected. Perhaps a Kawasaki Disease coronary artery ectasia registry?

Anuj

March 27, 2015
Edward Fry, MD, FACC (fry5@comcast.net)

DAPT + Statin

March 27, 2015
Edward Toggart, MD, FACC (etogg1@mac.com)

Also with little data I vote for ASA, P2Y12 of your choice and a statin, then turf

Ed T

March 27, 2015
Frank Smart, MD, FACC (fsmart@lsuhsc.edu)

David I too have a few and have used warfarin and ASA. Also went to warfarin after a STEMI in RCA of patient number 1. That was 8 years ago and still going.

Frank

March 27, 2015
Daniel Humiston, MD, FACC (dhumiston@utahcardiology.com)

Dave,

I've only seen a handful of Kawasaki patients over the past 21 years, but my current therapeutic regimen is DAPT and statin. If we presume her chest pain is ischemic, then beta blocker would be appropriate as well. As others have pointed out, data on OMT for these patients is scarce. In addition, Dr. Jane Burns (John Gordon's wife) has likely forgotten more about Kawasaki disease than I'll ever know.

Thanks for the challenge,

Dan

March 27, 2015
Hadley Wilson, MD, FACC (Hadley.wilson@carolinashealthcare.org)

Interesting. I vote for 2,3&4.
Hadley Wilson

March 27, 2015
Richard Kovacs, MD, FACC (rikovacs@iu.edu)

Some interesting data - suggesting that these small aneurysms are not as bad as we might think....

I suggest Dr. May attend the next symposium in Hawaii.

Dick

March 27, 2015
Jeffrey Williams, MD, FACC (lcaep@hotmail.com)

Coumadin and ASA (if tolerated).

Jeff

March 27, 2015
Sunil Mankad, MD, FACC (mankad.sunil@mayo.edu)

I agree with the majority. Warfarin or NOAC and aspirin. Thanks David for the great question.

March 27, 2015
James Fasules, MD, FACC (jwfasules@gmail.com)

Small? Note 2.5 centimeters not millimeters. Be interesting to see if the contrast pooled and layered out on the angios. Last one I dealt with like this was a pre-teen out several years from his acute disease. The dye stayed layered out in the giant RCA aneurysm for 15 min. We got his function to improve and got him off the vent but he still needed transplant

John and Jane are the experts. See Gordon JACC 2009:54(21): 1911-1920. Classic article is Newberger Circ 2004: 110: 2747- 2771.

Unless Jane and John have new data the standard in kids with giant aneurysm has been ASA and warfarin. See Levin Cardiology 2014; 129:174-177.

Bypass has also been used since stenosis is often associated with the aneurysms but multiple serial giant aneurysms really screw up the flow dynamics.

Good luck.

Jim

March 27, 2015
Mladen Vidovich, MD, FACC (miv@uic.edu)

my 2 cents...

DAPT + high dose statin (...based on little evidence..)

I couldn't agree more with Dr. Gupta and have been thinking about this for a while...

...maybe create an "orphan" cardiac disease registry, led by ACC? it would be tremendously valuable for research and would give ACC members an opportunity to share experience/contribute cases, we could, in a matter of few years, have a very powerful dataset...

e.g., coronary anomaly, Kawasaki, non-compaction, and similar (we all see a few here and there, but lack knowledge how to treat/follow..)

March 27, 2015
Susan Farkas, MD, FACC (farkassu@aol.com)

Hi,
May be a little late to comment, but ..
1. I would like to know if she is ischemic or not ? PET scan which also would help with CFR.

2. Anticoagulation of course a yes, but despite recommandations came for NOAC, we have no dara as far as I know to support the effect of NOAC and coronary flows , it could be the same dose effect as with valvualr disease(which I think is the case)
3. This pts also can be grouped with Ehlers'Danlos type 4, may be 5 and also other elderly with large coronary aneurysms - the etiology at this point not as important. They also become calcified and thrombosed and grow.
If the pt symptomatic, aneurysms continue to grow, ischemic etc CABG was and can be done (I know the age bothers us but the goal is prolonged survival and asymptomatic pt.
hope it helps and also stimulates more very insightful conversations
I also recommend ACC listserv for orphan disease . Or ask the expert link...

Susan Farkas
North Dakota

March 28, 2015
Ursulo Juarez, MD, FACC (uuarez@webmedica.com.mx)

Hi:
Difficult case, scantly routinely experience
Rational: conitnuous thrombin generation then Full AC
Ischemic: Aspirin, Beta bliockers and statins
Future: Good scenario for Direct Anticoagulatns
Thanks Dr May.