Apport de l'angio-TDM dans l'anévrysme coronaire géant thrombosé au cours de la maladie de Kawasaki réfractaire

Giant Thrombosed Coronary Artery Aneurysm in Refractory Kawasaki Disease: Diagnostic Value of CT Angiography

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Résumé

Un garçon de 4 ans atteint de maladie de Kawasaki a développé des atteintes coronariennes sévères malgré un traitement précoce. L'imagerie a montré un anévrysme coronaire géant de l'artère interventriculaire antérieure, partiellement thrombosé, nécessitant une anticoagulation. Ce cas illustre une forme réfractaire grave et souligne l'importance du diagnostic et du suivi précoce.

Mots-clés

Maladie de Kawasaki, maladie de Kawasaki réfractaire, anévrysme coronaire géant, vascularite pédiatrique, angio-TDM coronaire

Summary

A 4-year-old boy with Kawasaki disease developed coronary artery involvement despite early treatment with intravenous immunoglobulin, corticosteroids, and aspirin. Imaging revealed a giant partially thrombosed aneurysm of the left anterior descending artery, requiring anticoagulation. This case illustrates a severe refractory form of Kawasaki disease and highlights the importance of early diagnosis and cardiac imaging follow-up.

Keywords

Kawasaki disease, Refractory Kawasaki disease, Giant coronary aneurysm, Pediatric vasculitis, Coronary CT angiography

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INTRODUCTION

A previously healthy 4-year-old boy presented with a 20-day history of persistent fever and asthenia. He initially received amoxicillin, discontinued after the onset of a generalized rash suggestive of drug hypersensitivity. Subsequently, he developed bilateral non-purulent conjunctivitis and upper limb edema, prompting hospitalization.

On admission, clinical examination revealed cheilitis, bilateral conjunctival injection, polymorphous maculopapular rash, and periungual desquamation. Laboratory investigations showed anemia (Hb 9.5 g/dL), leukocytosis (19,160/mm^3), marked thrombocytosis (865,000/mm^3), elevated C-reactive protein (174 mg/L), and erythrocyte sedimentation rate (125 mm/h).

Echocardiography demonstrated coronary artery abnormalities, including dilatation of the left anterior descending artery and aneurysms. Despite prompt treatment with intravenous immunoglobulin, corticosteroids, and aspirin, follow-up imaging revealed progression. Coronary CT angiography identified a fusiform aneurysm of the left anterior descending artery, partially thrombosed, with pronounced irregular dilatation and luminal heterogeneity (Fig. 1). Anticoagulation therapy was initiated.

Kawasaki disease is an acute vasculitis with a predilection for coronary arteries (1). Although early treatment reduces the risk of complications, delayed diagnosis or refractory disease may result in giant aneurysms (2). This case illustrates a severe and uncommon evolution with a giant thrombosed coronary aneurysm, underscoring the importance of early recognition and multimodal imaging follow-up to prevent life-threatening complications (3).

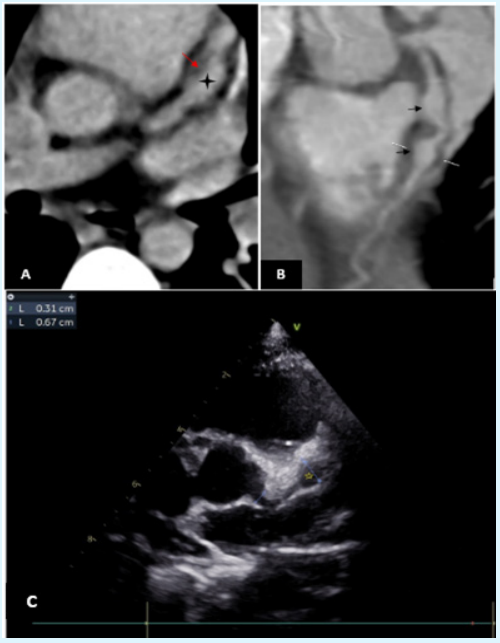

Figure 1. Left anterior descending (LAD) coronary artery aneurysm in Kawasaki disease

A- Axial CT coronary angiography image demonstrating a proximal left anterior descending (LAD) coronary artery aneurysm (✦) measuring 15 × 8 mm, with peripheral hypodense mural component consistent with partial thrombosis (↘), in the context of Kawasaki disease.

B- Curved planar reconstruction centered on the left anterior descending (LAD) artery on 1-month follow-up CT, showing resolution of the marginal thrombus and the presence of two adjacent aneurysms (→|), resulting in a beaded appearance of the LAD.

C- Echocardiography showing an aneurysm of segment II of the left anterior descending coronary artery measuring 6.7 mm in diameter (+9.92 Z score), associated with proximal arterial dilatation measuring 3 mm (+2.65 Z score).

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