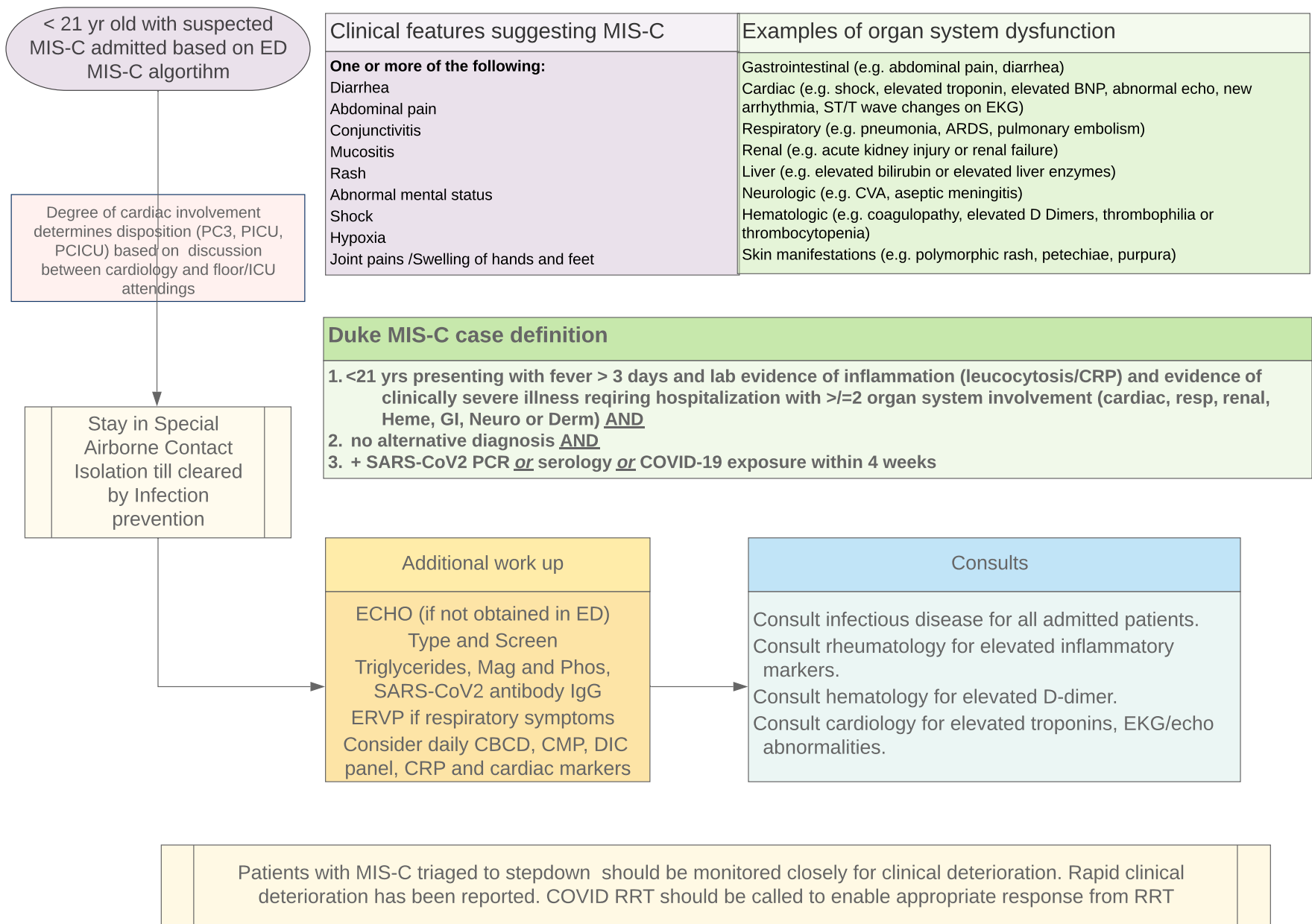


Inpatient Management of Multisystem Inflammatory Syndrome in Children (MIS-C)



Pathway developed by the Department of Pediatrics, Duke University: Revised [June 11, 2020]
 It is not a substitute for independent professional medical assessment, diagnosis, and treatment.

Incomplete/complete Kawasaki Disease	Myocarditis or depressed LV systolic function	Severe disease
1. IVIG 2 g/kg 2. Aspirin 30-50 mg/kg/d divided q6 hrs while febrile, decrease to 3-5mg/kg(max 81 mg) daily once patient defervesces 3. For high-risk KD patient (CAA at diagnosis, age < 6 months, IVIG resistance, CRP > 13 mg/dL), consider adding prednisone 1 mg/kg BID with a tapering course over ~3 weeks 4. Additional immunomodulators as needed in conjunction with Rheumatology, 5. Infectious Disease, and/or Immunology and based on response to initial IVIG therapy	1. Consider IVIG 1 g/kg daily x 2 days 2. For patients with moderate or greater systolic dysfunction, consider full anticoagulation with heparin, Lovenox, or warfarin in consultation with hematology 3. Consult with rheumatology and/or infectious disease regarding additional immunosuppression options: Anakinra (interleukin-1 inhibitor), corticosteroids, Tocilizumab (interleukin-6 inhibitor)	1. Consult hematology for recommendations on anticoagulation (aspirin, lovenox or heparin) 2. Consult Infectious Disease about use of antivirals (remdesivir) 3. Consult Rheumatology/Immunology about use of immunomodulating medications: Anakinra (interleukin-1 inhibitor), canakinumab (interleukin-1 inhibitor), IVIG, corticosteroids, Tocilizumab (interleukin-6 inhibitor)

For Acute COVID pediatric management guidelines please visit [customid.org](https://www.customid.org)

<https://www.customid.org/antimicrobial/guideline-therapeutic-management-pediatric-patients-confirmed-covid-19-peds>