Pathological Features of Coronary Arteries in Children With Kawasaki Disease in Which Coronary Arterial Aneurysm Was Absent at Autopsy

Quantitative Analysis

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Coronary arteries in six children who had Kawasaki disease but lacked coronary arterial aneurysms were examined. Four children died of myocarditis at the acute stage, and two children died of bacterial sepsis or as a result of an occurrence during cineangiography at the healed stage. Twenty-one children without Kawasaki disease were examined as controls. The six children with Kawasaki disease had no thrombi, recanalization, or stenosis greater than 50% in the major coronary arteries. Three patients had dilatation of the major coronary arteries at the acute stage. Two of the three patients died during the acute stage, and autopsy showed slight dilatation of coronary arteries and abnormal intimal thickening due to panvasculitis. In the third child, who died at the healed stage, dilatation of the coronary arteries detected by two-dimensional echocardiography at the acute stage had disappeared at the healed stage. No dilatation of the major coronary arteries was seen at autopsy. However, abnormal fibrous intimal thickening of the major coronary arteries without inflammatory changes was found. The other three patients had no dilatation of the major coronary arteries at the acute stage. Two patients died at the acute stage, and slight inflammation without abnormal intimal thickening was seen in the intima and the adventitial area. In the third patient, who died during the healed stage, two-dimensional echocardiography revealed no dilatation during the clinical course, and there was no inflammatory changes or abnormal intimal thickening at autopsy. We conclude that in Kawasaki disease, vasculitis of the major coronary arteries is present even in patients without coronary dilatation at the acute stage, and the abnormal intimal thickening may or may not remain at the healed stage. Kawasaki disease without coronary aneurysm has the same pathological entity as Kawasaki disease with coronary aneurysm. (Circulation 1988;78:345–350)

In patients with Kawasaki disease, the frequency of coronary arterial aneurysms is approximately 20%. According to previous autopsy studies, the coronary arteries show acute angitis in the acute stage, and scar tissue forms with marked intimal thickening in the healed stage. In patients with Kawasaki disease, the mortality was 0.3–0.4%, and almost all of the patients who died had coronary aneurysms of 6 mm or greater in diameter. Therefore, whether a coronary arterial lesion can develop in Kawasaki disease without coronary arterial aneurysms has not been reported. We studied the histological features of coronary arteries in patients with Kawasaki disease without coronary arterial aneurysms.

Patients and Methods

Patients

The patients were six Japanese children with Kawasaki disease in whom coronary arterial aneurysm was not noted at autopsy. Nakano et al. defined coronary arteries 4 mm or greater in diameter as coronary aneurysm clinically. In the present study, a coronary artery without aneurysm was defined as a coronary artery with elastic interna less than 4 mm in diameter. Dilatation of coronary artery was defined as the elastic interna with a
Maximal destruction of the elastic interna of each cavity were 1.2±0.3 mm.

As controls, 21 autopsied children without Kawasaki disease (12 boys and nine girls; aged 2 months to 4 years) were studied.

Methods

After fixation with 10% formalin, the three major coronary arteries were sectioned transversely at 2–3-mm intervals in their entirety from the ostia to periphery and were observed macroscopically. Then, all of the sections were embedded in paraffin and cut at 4-μm thickness by a microtome. They were stained with hematoxylin and eosin, elastic van Gieson’s stain, and Masson-trichrome. The specimens stained with elastic van Gieson were magnified at ×60–160, and the coronary arteries were traced on white paper for quantitative analysis. Thickness of intima, circumferences of the cavity (L1) and elastic interna (L2) of the coronary arteries, and length of destruction of the elastic interna (D) were measured with an image analyzer. Diameter of the coronary arterial cavity was calculated from circumference of the cavity (2πL1) to exclude factors of artificial deformity. Diameter of the elastic interna was also calculated from the circumference of the elastic interna (2πL2). Percent destruction of the elastic interna was calculated with the equation 100 × D/L2.

Stages of patients with Kawasaki disease were classified as stages 1–4 according to the duration of illness from the onset to death: stage 1, within 9 days of illness; stage 2, 12–25 days of illness; stage 3, 28–32 days of illness; and stage 4, over 40 days of illness. Acute stage was defined as stages 1–3, and healed stage was defined as stage 4.

Results

In 12 control patients between 2 and 11 months old, the mean±SD of maximal diameter of the coronary arterial cavity and maximal diameter of the elastic interna were 1.0±0.4 mm (maximum, 1.8 mm) and 1.1±0.4 mm (maximum, 1.9 mm), respectively. Maximal destruction of the elastic interna was 18±22% (maximum, 81%). Fibrous thickening of the intima was also seen partially or in the whole circumference, and maximal thickness of the intima of each specimen was 92±60 μm (maximum, 225 μm) (Figure 1A). In nine control patients between 1 and 4 years old, maximal diameter of the coronary arterial cavity and maximal diameter of the elastic interna were 1.2±0.3 mm (maximum, 2.0 mm) and 1.4±0.3 mm (maximum, 2.4 mm), respectively. Maximal destruction of the elastic interna was 28±23% (maximum, 82%). Fibrous thickening of the intima was seen, and maximal thickness of intima of each specimen was 150±72 μm (maximum, 290 μm) (Figure 1B).

Table 1 summarizes the results of the study of six children with Kawasaki disease. Macroscopically, there was no thrombi, stenosis greater than 50%, or recanalization noted in the coronary arteries in these patients. Patients 1–4, who died during the acute stage (stages 1–3), showed acute myocarditis at autopsy. Two of these four patients died suddenly, and the other two died of heart failure. In patient 1, who died on the 9th day of illness, acute inflammation was noted in the intimal and adventitial areas and was rare in the media. Inflammatory tissue was edematous and was infiltrated chiefly with neutrophils, eosinophils, and lymphocytes, some of which were atypical. Maximal destruction of the elastic interna, maximal thickness of the intima, and maximal diameter of the major coronary artery (cavity and elastic interna) were within normal limits. Patients 2 and 3 died at 18 (3-month-old boy) and 19 days of illness (1-year-old boy) with

Figure 1. Photomicrographs of coronary arteries in two children without Kawasaki disease. Panel A: Patient was a 10-month-old girl. Destruction of elastic interna was 19%. Maximal thickness of intima was 148 μm. Diameter of elastic interna was 1.4 mm (original magnification, ×40; elastic van Gieson’s stain). Panel B: Patient was a 3-year-old boy. Destruction of elastic interna was 43%. Maximal thickness of intima was 193 μm. Diameter of elastic interna was 1.5 mm (original magnification, ×25; elastic van Gieson’s stain). Arrowheads, elastic interna and endothelium at intima with maximal thickness; arrows, elastic externa.
severe panvasculitis and severe inflammation of the perivascular area (Figure 2A). infiltrating cells included neutrophils, eosinophils, lymphocytes, atypical lymphocytes, plasma cells, monocytes, fibroblasts, and fibrocytes. Slight dilatation of the major coronary artery was seen where panvasculitis was noted. In these two patients, maximal intimal thickness was abnormal. Maximal destruction of elastic interna was within the upper limit of controls. Patient 4 was a 3-month-old girl who died on the 22nd day of illness without any dilatation or aneurysm detected by two-dimensional echocardiography during her clinical course. Microscopically, slight mononuclear cell infiltration in the coronary arteries was localized in the intima and adventitial areas (Figure 2B). Maximal destruction of the elastic interna, maximal thickness of intima, and maximal diameter of the major coronary artery were within normal limits.

Patients 5 and 6 died during the healed stage of Kawasaki disease (stage 4). Patient 5 was a 10-month-old boy who developed a fever and rash 30 days after the onset of Kawasaki disease (i.e., after the acute signs and symptoms of Kawasaki disease had disappeared). Culture of blood revealed *Staphylococcus aureus*. He died of complicated pneumonia on the 46th day after the onset of Kawasaki disease. There was no dilatation or aneurysm of coronary arteries as determined by serial two-dimensional echocardiography during his clinical course. Microscopic examination of coronary arteries revealed no inflammatory cell infiltration (Figure 3A). Maximal destruction of the elastic interna, maximal thickness of intima, and maximal diameter of the major coronary artery were within normal limits.

Patient 6 was 2 years and 5 months old when he developed Kawasaki disease. With two-dimensional echocardiography, dilatation of coronary arteries was noted during the acute stage but disappeared after 1 year. Although the patient was well until he was 4 years and 7 months old, marked spasm of the left anterior descending coronary artery followed by acute myocardial infarction occurred during cineangiography. He died 2 days after the onset of spasm. Microscopic examination revealed no inflammatory cell infiltration in the coronary arteries (Figure 3B). Maximal destruction of the elastic interna and maximal diameter of the coronary arterial cavity were within normal limits. Maximal diameter of elastic interna was at the upper limit of controls. However, abnormal and fibrous intimal thickening of coronary artery of 800 μm was detected. In addition, autopsy revealed acute anteroseptal myocardial infarction.

**Discussion**

We previously reported that lesions of the major coronary arteries in patients with Kawasaki disease change dynamically with time: acute inflammatory changes are seen in the intima and the adventitial area in stage 1 (within 9 days), and inflammation progresses into the media and becomes panvascular in stage 2 (12–25 days). Subsequently, coronary
Eighty percent of myocarditis have been reported. The disease usually begins with a viral infection, and the heart is involved in the acute stage. Children with myocarditis often die of sepsis, a bacterial infection that can cause inflammation and damage to the heart muscle. In Kawasaki disease, the coronary arteries can become inflamed, leading to the formation of aneurysms, or bulges in the walls of the arteries.

Aneurysms with thrombi appear. Granulation tissue is observed in stage 3 (28–32 days), and scar formation consisting of marked fibrous intimal thickening, recanalization, thrombi, or severe stenosis emerge in stage 4 (more than 40 days). These characteristics were obtained from the autopsied children with coronary aneurysm, and coronary arterial lesion of Kawasaki disease was defined as acute vasculitis.2

The present study revealed that the six children without coronary aneurysm did not have macroscopic thrombi, severe stenosis, or recanalization. They died of myocarditis at the acute stage or a bacterial sepsis or an accident at the healed stage. This finding supports our hypothesis that only children with coronary aneurysm die of coronary heart disease as sequela of Kawasaki disease.

Even in babies without cardiac disease,9–11 the destruction of the elastic interna and intimal thickening have been reported in the coronary arteries. Eighty percent destruction of the elastic interna was noted in our controls. Hence, the destruction we observed in the elastic interna in patients with Kawasaki disease without aneurysm was within the upper limits. However, in three patients with dilatation of the major coronary arteries during the acute stage, intimal thickening over the upper limits of controls was seen due to panvasculitis at the acute stage and fibrous thickening at the healed stage. In the three patients lacking coronary dilatation at the acute stage, inflammation of coronary arteries was slight during the acute stage and disappeared without abnormal intimal thickening during the healed stage. These findings suggest that dilatation or lack of dilatation depends on the severity of the inflammation in the major coronary arteries; the healing process for each situation is different. Probably, the abnormal fibrous intimal thickening is involved in the regression of coronary arterial dilatation as seen in patient 6. However, the following discrepancy is noted between pathology of the coronary arteries and clinical data: clinical signs

FIGURE 2. Photomicrograph of coronary arteries of patients with Kawasaki disease without aneurysm at acute stage. Panel A: Histology of major coronary artery with dilatation. Note presence of severe panvasculitis and perivascular inflammation. Inflammatory tissue was edematous and infiltrated chiefly with neutrophils, eosinophils, lymphocytes, atypical lymphocytes, plasma cells, monocytes, fibroblasts, and fibrocytes. Photograph was obtained from patient 2 (original magnification, ×100; hematoxylin and eosin stain). Panel B: Histology of major coronary artery without dilatation. Slight inflammatory changes are seen in intima and adventitial area. Note infiltrate of slight mononuclear cell infiltration. Photograph was obtained from patient 4 (original magnification, ×200; hematoxylin and eosin stain). Arrowheads, elastic interna; arrows, elastic externa.
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References


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