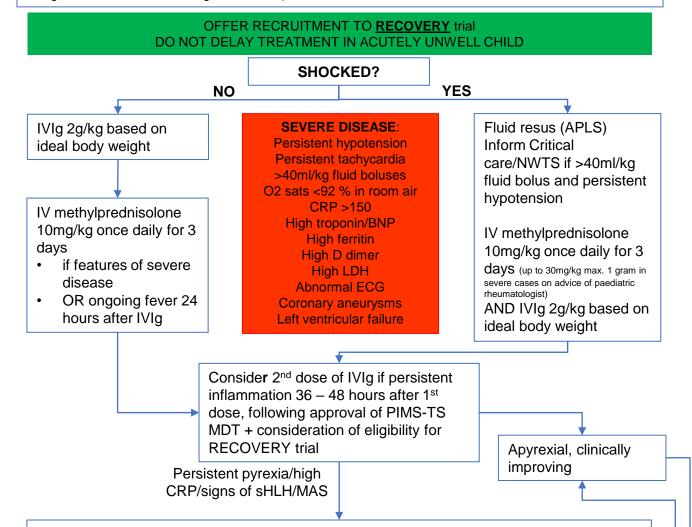
Diagnosis PIMS-TS:

- A. Kawasaki disease-like PIMS-TS
- B. Non-specific PIMS-TS with evidence of persistent fever, inflammation (neutrophilia, elevated CRP and lymphopenia) and evidence of single or multi-organ dysfunction (shock, cardiac, respiratory, renal, gastrointestinal or neurological disorder)



Biologics - must be agreed by PIMS-TS MDT

- If in RECOVERY offer 2nd stage randomization: tocilizumab vs anakinra vs standard care
- Kawasaki disease-like, NOT in RECOVERY give infliximab
- Non-specific type, NOT in RECOVERY give anakinra OR infliximab as per PIMS-TS MDT decision
- Oral prednisolone 1 2mg/kg once daily, wean over 2 3 weeks
- Aspirin 3 5 mg/kg once daily for minimum 6 weeks
- PPI for gastric protection
- Criteria for discharge: afebrile >48 hrs, haemodynamically stable, CRP improving

ANTIBIOTICS

- IV broad spectrum antibiotics in ALL
- Add CLINDAMYCIN if meets criteria for Toxic Shock Syndrome
- Initial infection screen does NOT have to be negative before commencing IVIg/corticosteroids

ASPIRIN AND ANTICOAGULATION

- High dose aspirin as per Trust KD guideline if PIMS-TS Kawasaki disease-like + no contraindications. Step-down to low dose aspirin once child apyrexial.
- Avoid high dose aspirin if platelets low/coagulation deranged/significant GI symptoms
- Low dose Aspirin 3 5 mg/kg for ALL for a minimum of 6 weeks (until cardiac review)
- TEDS for all >12 years
- Consider prophylactic enoxaparin (Clexane) 0.5mg/kg (max 20mg) BD based on individual child's risk factors for thrombosis and any contraindications – decision to be made by PIMS-TS MDT