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)

OFFER RECRUITMENT TO **RECOVERY** trial
DO NOT DELAY TREATMENT IN ACUTELY UNWELL CHILD

SHOCKED?

NO

IVIg 2g/kg based on ideal body weight

IV methylprednisolone 10mg/kg once daily for 3 days
- if features of severe disease
- OR ongoing fever 24 hours after IVIg

YES

Fluid resus (APLS)
Inform Critical care/NWTS if >40ml/kg fluid bolus and persistent hypotension

IV methylprednisolone 10mg/kg once daily for 3 days (up to 30mg/kg max. 1 gram in severe cases on advice of paediatric rheumatologist)
AND IVIg 2g/kg based on ideal body weight

SEVERE DISEASE:
Persistent hypotension
Persistent tachycardia
>40ml/kg fluid boluses
O2 sats <92 % in room air
CRP >150
High troponin/BNP
High ferritin
High D dimer
High LDH
Abnormal ECG
Coronary aneurysms
Left ventricular failure

Consider 2nd dose of IVIg if persistent inflammation 36 – 48 hours after 1st dose, following approval of PIMS-TS MDT + consideration of eligibility for RECOVERY trial

Apyrexial, clinically improving

Persistent pyrexia/high CRP/signs of sHLH/MAS

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