



Multisystem Inflammatory Syndrome in Children- A Case Study from a Tertiary Care Centre in Maharashtra, India

Original Research Article

ABSTRACT

Background: A multisystem inflammatory syndrome in children (MIS-C) is associated with coronavirus disease 2019. Understanding the epidemiology and clinical course of multisystem inflammatory syndrome in children (MIS-C) and its association with Covid-19 is important, given the clinical and public health implications of the syndrome.

Materials and Methods: This was a prospective observational study carried out in the Department of Paediatrics, Krishna Institute Of Medical Sciences, Karad, Maharashtra, India, over a period of 12 months. Thirty three children, between the ages of 1 month-14 years were studied.

Results: Out of the 67 patients admitted to our paediatrics ward during this period with suspected MIS-C, 33 patients were confirmed to have MIS-C on laboratory investigations. Involvement of a minimum of two systems was noted. The main clinical manifestations were gastrointestinal (abdominal pain, nausea and vomiting and diarrhoea) and dermatological (rash). Fever was present in all 33 cases. The laboratory investigations were indicative of a pro inflammatory state seen in MIS-C. Positive findings on echocardiography were found in majority of cases.

Conclusion: Multisystem inflammatory syndrome in children associated with SARS-CoV-2 has become serious public health problem in the paediatric population, with haemodynamic instability and cardiac dysfunction being the main signs, and rapid resolution with anti-inflammatory therapy.

Keywords: Anti-inflammatory; syndrome; coronavirus.

1. INTRODUCTION

When the COVID-19 pandemic was first reported in Asia and initially spread throughout the globe, paediatricians were grateful that children were afflicted with mild symptoms in majority of the cases [1-2]. Then, an alarming warning came from the National Health Service in England in April 2020 about cases of older school-aged children and adolescents presenting to the ER with fever, hypotension, severe abdominal pain and cardiac dysfunction, resembling a Kawasaki like illness, who tested positive for SARS-CoV-2 infection either by nasopharyngeal RT-PCR assay or by antibody testing [3]. These children had laboratory findings of cytokine storm, including high serum IL-6 levels, and generally required inotropic support to increase cardiac output. Even though most of these children no

longer required intensive care after only a few days and completely recovered, the health authorities were alerted to the possibility of an unusual presentation of SARS-CoV2 in the paediatric population. We describe the demographic characteristics, presenting symptoms, clinical course, laboratory findings, therapy received, and outcomes among children and adolescents meeting the case definition of MIS-C.

Physicians have noted some clinical similarities between MIS-C and Kawasaki disease (KD), a febrile illness of young childhood involving inflammation of the blood vessels that can result in coronary artery aneurysms. Patients with MIS-C may have some of the clinical features of KD, including fever, dilation of conjunctival blood vessels, rash and redness of the oropharynx [4].

However, these clinical signs can be observed in many infectious diseases in childhood and are not specific for any one diagnosis. The question has therefore arisen as to whether MIS-C and KD are the same entity.

2. MATERIALS AND METHODS

2.2 Case Definition [5]

CDC case definition

All 4 criteria must be met:

Age <21 years

Clinical presentation consistent with MIS-C, including **all** of the following:

Fever:

Documented fever >38.0°C (100.4°F) for ≥24 hours

or

Report of subjective fever lasting ≥24 hours

Laboratory evidence of inflammation

Including, but not limited to, **any** of the following:

Elevated CRP

Elevated ESR

Elevated fibrinogen

Elevated procalcitonin

Elevated D-dimer

Elevated ferritin

Elevated LDH

Elevated IL-6 level

Neutrophilia

Lymphocytopenia

Hypoalbuminemia

Multisystem involvement

2 or more organ systems involved:

Cardiovascular (eg, shock, elevated troponin, elevated BNP, abnormal echocardiogram, arrhythmia)

Respiratory (eg, pneumonia, ARDS, pulmonary embolism)

Renal (eg, AKI, kidney failure)

Neurologic (eg, seizure, stroke, aseptic meningitis)

Hematologic (eg, coagulopathy)

Gastrointestinal (eg, abdominal pain, vomiting, diarrhea, elevated liver enzymes, ileus, gastrointestinal bleeding)

Dermatologic (eg, erythroderma, mucositis, other rash)

Severe illness requiring hospitalization

No alternative plausible diagnoses

Recent or current SARS-CoV-2 infection or exposure

Any of the following:

Positive SARS-CoV-2 RT-PCR

Positive serology

Positive antigen test

COVID-19 exposure within the 4 weeks prior to the onset of symptoms

2.1 Study Design and Patients

This was a prospective observational study carried out in the Department of Paediatrics, Krishna Institute of Medical Sciences, Karad, Maharashtra, India, over a period of 12 months (May-2020 to May-2021).

2.3 Reference Range used for Laboratory Investigations

Parameter	Reference Range
Haematology	
White blood cell count(10 ³ /ul)	4.0-12.0
Lymphocyte(%)	25-33
Neutrophil (%)	54-62
Hemoglobin (g/dL)	11.5-14.5
Platelets (10 ³ /mL)	150-450
Liver and renal function	
Albumin (g/dL)	4.0-5.3
Creatinine (mg/dL)	0.22-0.59
Alanine transaminase (U/L)	5-45
Aspartate aminotransferase (U/L)	15-50
Inflammatory Markers	
C-reactive protein (mg/L)	Male 0.6-7.9 Female 0.5-10.0
Ferritin (ng/mL)	10-60
Procalcitonin (ng/mL)	<0.15
Lactate dehydrogenase (U/L)	150-500
Interleukin-6 (pg/mL)	<1.8
Creatine kinase (U/L)	5-13
Coagulation	
D-dimer(mg/ml)	<0.4
Erythrocyte Sedimentation Rate(mm/hr)	0-20
Cardiac	
Troponin (ng/L)	<10
Prohormone of brain natriuretic peptide (ng/L)	0-450

Reference (Ref.) ranges were obtained from Nelson Textbook of Pediatrics (we chose eight years as the age category provided the overall mean of included patients).

3. RESULTS

3.1 Case Testing and Demographic Characteristics: (Table 1)

Out of the 67 patients admitted to our paediatrics ward during this period with suspected MIS-C, 33 patients were confirmed to have MIS-C on laboratory investigations, Majority of the cases (70%) were diagnosed on antibody testing (IgG, IgM antibodies). Only 30% of the cases

were diagnosed on the basis of RT-PCR and Rapid Antigen Test. (Table 1)

The median age of children affected in our study is 8.6 years. No specific sex predilection was seen. Children in the age group of 0-5 years comprised 39% of the population and those in the age bracket of 6-14 years of age were 61%. In our study population, 51% of males were affected and 49% females were affected (Table 1).

The mean duration of hospital stay was 8 days. There was no significant differences between the duration of hospital stay in both groups of children.

Table 1. Clinical characteristics of the patients at hospital admission, according to age group

Characteristic	Overall(33)	0-5 years(13)	6-14 years(20)
Sex predilection			
Male	12	5	7
Female	11	6	5
Positivity for SARS-CoV-2 -no.			
On RT-PCR assay	11	4	7
On serologic assay for IgG antibodies	22	13	9

Symptoms at admission — no.			
Constitutional: fever or chills	33	9	24
Cardiovascular: chest pain	3	1	2
Duration of hospital stay (days)	8	7-10	8-10
Gastrointestinal			
Abdominal pain	23	10	13
Nausea or vomiting	24	9	15
Diarrhoea	21	13	8
Dermatologic			
Rash	26	15	11
Swollen hands or feet	4	2	2
Mucocutaneous			
Conjunctivitis	16	9	7
Mucosal changes	14	6	8
Neurologic			
Headache	6	2	4
Altered mental status or confusion	1	0	1
Lymphadenopathy	5	3	2
Musculoskeletal			
Muscle aches or myalgias	8	2	6
Joint pain	3	1	2
Upper respiratory			
Congestion	12	8	4
Sore throat	7	3	4
Lower respiratory			
Cough	18	8	10
Shortness of breath	7	3	4
Wheezing	1	1	0

Table 2. Vital signs and laboratory values of the patients at hospital admission, according to age group

Characteristic	Overall(33)	0-5 years(13)	6-14 years(20)
Vital signs			
Median heart rate (IQR) — beats/min	133 (120–148)	140 (130–158)	128 (123–153)
Tachycardia — no.	32	11	20
Hypotension	23	6	17
Temperature $\geq 38.0^{\circ}\text{C}$ — no.	33	9	24
Median oxygen saturation (IQR)	98 (97–100)	98 (96–99)	99 (97–100)
Oxygen saturation $< 92\%$	4	3	1
Laboratory values			
Median white-cell count (IQR) $\times 10^{-3}/\mu\text{l}$	10.1(6.6–13.5)	11.8 (7.4–14.8)	9.7 (6.4–13.7)
Lymphopenia — no. /total no.	23/33	7/13	16/20
Neutropenia — no./total no.	0/33	0/13	0/20
Platelet count $< 80 \times 10^{-3}/\mu\text{l}$	7/33	5/33	2/33
Elevated proBNP level — no. /total no.	26/33	9/13	17/20
Elevated troponin level — no. /total no.	15/33	6/13	9/20
Elevated C-reactive protein level	31/33	12/13	18/20
D-dimer level > 0.55 mg/liter — no./total no.	28/33	11/13	17/20
Ferritin level > 300 ng/ml — no./total no.	22/33	12/13	10/20
LDH level ≥ 500 U/liter — no./total no.	3/33	1/13	2/20
Interleukin-6 level ≥ 5.0 pg/ml — no./total no.	12/33	7/13	6/20
ESR ≥ 40 mm/hr — no./total no. (%)	24/33	8/13	16/20
Echocardiography:			
Left Ventricular dysfunction	12	4	8
Pericardial Effusion	6	1	5
Coronary artery aneurysms	1	0	1

Table 3. Clinical course and outcomes, according to age group

Characteristic	Overall(33)	0-5 years(13)	6-14 years(20)
Median time from symptom onset to hospital admission (IQR) — days	4 (3–6)	4 (3–6)	4 (3–6)
ICU admission — no.	24	12	12
Median length of stay (IQR) — days	6.0 (4.0–9.0)	6.0 (3.0–8.0)	6.0 (4.0–10.0)
Therapy — no.			
CPAP	13	6	7
Mechanical Ventilation	4	3	1
Vasopressor support	12	4	8
Systemic glucocorticoids	30	11	19
IVIG	28	16	12
Clinical Outcomes-No.			
Shock	12	6	7
Myocarditis	10	4	6
Acute kidney injury	11	7	4
Death	2	1	1

3.2 Clinical Features and Involvement: (Table 1)

Most patients (78%) had involvement of at least two organ systems (Table 1). The most commonly involved organ systems were the gastrointestinal (69%), cardiovascular(57%); dermatological(68%). Fever with/without chills was present in 100% of cases. The main manifestations in clinical symptomatology were gastrointestinal and dermatological. Headache was the primary neurological symptom noted, seen in 0.2% of the cases. Lower respiratory symptoms primarily consisted of cough which was present in 54% of the overall cases.

3.3 Vital Signs: (Table 2)

Median heart rate was noted to be 133 beats per minute, with tachycardia being noted at the time of admission in the majority of cases (96%). Hypotension was defined according to age appropriate criteria and it was seen in 70% of overall cases. Temperature, recorded with a digital thermometer in the right axilla, was found to be elevated (>38 degree Celsius) in 100% of the cases. The median oxygen saturation was found to be 98% (interquartile range 97-100%), with oxygen saturation <92% found only in 0.1 % of the cases.

3.4 Laboratory Investigations: (Table 2)

On admission, among patients with suspected or confirmed MIS-C, the median white-cell count was 10,100 per microliter, and 23 of 33 (69%) had lymphopenia; 26 of 33 (78%) had elevated proBNP levels, 15 of 33 (45%) had elevated

troponin levels, 31 of 33 (93%) had elevated C-reactive protein levels, and 28 of 33 (84%) had elevated d-dimer levels (Table 2). During hospitalization, at least one echocardiogram was obtained for 19 patients (57%); 12 (63%) had some degree of ventricular dysfunction, 6 (31%) had pericardial effusion, and 1 (0.05%) had a documented coronary-artery aneurysm. Additional clinical and laboratory findings on admission, according to age group, are provided in Table 2.

3.5 Clinical Course and Outcomes: (Table 3)

The median time from symptom onset to hospital admission was 4 days, with 24 of 33 (72%) patients requiring ICU admission. A total of 28 patients (84%) received intravenous immune globulin (IVIG), 63 (90%) received systemic glucocorticoids, and 12 (36%) received vasopressor support; 28 (84%) received both systemic glucocorticoids and IVIG. Additional outcomes have been described in Table 3.

4. DISCUSSION

We describe 33 patients younger than 14 years of age who met the criteria for MIS-C associated with SARS-CoV-2 infection. The majority of patients (70%) had laboratory-confirmed antecedent or concurrent SARS-CoV-2 infection, and most had no documented underlying conditions. Cardiovascular involvement was common, with almost half receiving vasopressor or vasoactive support and 1 in 12 having coronary-artery aneurysms. Most patients were cared for in an intensive care unit, and 20%

received invasive mechanical ventilator support. Although most discharged patients survived, 2 patients (0.05%) died, both of whom had previously been healthy.

In the remaining 34 patients, alternate diagnosis of bronchopneumonia, acute gastroenteritis and Kawasaki disease was considered and the patients were treated accordingly.

Evidence supporting a causal link with SARS-CoV-2 includes a strong temporal association with Covid-19 activity, confirmation of SARS-CoV-2 infection through nucleic acid or antibody testing in the majority of patients, and hyperinflammatory manifestations similar to those in adults with Covid-19 [6-8]. Almost one third of the patients tested negative for SARS-CoV-2 by RT-PCR but had detectable antibodies.

We found variations in presenting symptoms and manifestations according to age. The prevalence of dermatologic symptoms was highest among children 0 to 5 years of age, and the prevalence of myocarditis (diagnoses and clinical) was highest among the adolescents. The prevalence of gastrointestinal symptoms was high in all age groups.

These patients met a case definition developed by the CDC that was designed to be sensitive. Although more than one third of the patients had Kawasaki's disease-like clinical features, 60% of the patients would not have met complete or incomplete criteria for Kawasaki's disease [9-10].

Although both Kawasaki's disease and MIS-C can have cardiovascular involvement, the nature of this involvement appears to differ between the two syndromes. We observed cardiovascular involvement leading to vasopressor or vasoactive support as a common and severe subphenotype, most frequently in older children and adolescents. Approximately 5% of children with Kawasaki's disease in the United States present with cardiovascular shock leading to vasopressor or inotropic support, [10] as compared with 50% of the patients in our series. Myocardial dysfunction is a prominent extrapulmonary manifestation of Covid-19 that has been associated with increased mortality in adults [11-12].

Consistent with the diagnosis of MIS-C, multiple inflammatory markers were elevated. Examining the trends of some of these values may provide biologic insight to the disease or may serve as potential predictors of MIS-C outcomes. In

particular, the following analytes were elevated: proBNP, elevated IL-6 and D-dimer [14-15].

Understanding the pathogenesis of MIS-C will be necessary to inform clinical management and prevention efforts [13]. In our case series, a majority of patients were treated with immunomodulatory drugs, most commonly intravenous immune globulin (84%) and systemic glucocorticoids (90%). Vasopressors were also used. The use of these three agents suggests a pro-inflammatory state, with slight similarities to Kawasaki Disease and toxic shock syndrome [16].

5. CONCLUSION

Although most children have mild or no illness from SARS-CoV-2 infection, MIS-C may follow Covid-19 or asymptomatic SARS-CoV-2 infection. Recognition of the syndrome and early identification of children with MIS-C, including early monitoring of blood pressure and electrocardiographic and echocardiographic evaluation, could help in the timely institution of appropriate supportive care and other potential therapeutic options. As children present with mild symptoms of Covid-19 and are less frequently tested than adults, the incidence of MIS-C among children infected with SARS-CoV-2 is unclear. It is essential to establish proper surveillance and maintain a high degree of suspicion, especially in areas where the transmission of SARS-CoV-2 is high.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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