

Clinical Characteristics and Short-Term Outcomes of Multisystem Inflammatory Syndrome in Children: A Single-Center Case Series from China

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Abstract

Objective: To describe the clinical manifestations, laboratory abnormalities, treatment patterns, and short-term outcomes of children with multisystem inflammatory syndrome in children (MIS-C) treated at a tertiary pediatric emergency center in China during the early 2023 SARS-CoV-2 wave. **Methods:** We retrospectively reviewed nine consecutive children diagnosed with MIS-C and admitted to the Department of Pediatric Emergency, Guangzhou Women and Children's Medical Center, between January and March 2023. Demographic characteristics, clinical manifestations, laboratory findings, treatment, and in-hospital outcomes were summarized descriptively. **Results:** Nine children were included; seven (77.8%) were male and the mean age was 5 ± 3 years. Fever occurred in all patients. Frequent mucocutaneous findings included red lips/strawberry tongue (88.9%), conjunctival injection (77.8%), lymphadenopathy (66.7%), and rash (66.7%). Coronary artery thickening/dilatation or ectasia occurred in four patients (44.4%), sinus tachycardia in four (44.4%), and systemic inflammatory response syndrome in three (33.3%). Laboratory findings showed prominent inflammation and cardiac involvement, including median C-reactive protein 85.9 mg/L, procalcitonin 3.3 ng/mL, D-dimer 2.1 $\mu\text{g/mL}$, interleukin-6 90.4 pg/mL, and NT-proBNP 4953 pg/mL, together with relative lymphopenia and hypoalbuminemia. All patients received intravenous immunoglobulin and aspirin; one received corticosteroids. One patient required mechanical ventilation and vasoactive support. Median length of stay was 8 days, and all patients survived to discharge with clinical improvement. **Conclusions:** In this small single-center case series, MIS-C was characterized by fever, prominent mucocutaneous inflammation, laboratory evidence of hy-

perinflammation, and frequent cardiovascular involvement. The findings are broadly consistent with contemporary Chinese and international cohorts, but the small sample and absence of a comparator group preclude estimates of incidence, treatment effectiveness, or risk. Larger multicenter studies with standardized case definitions and longitudinal cardiac follow-up are needed.

Keywords

Multisystem Inflammatory Syndrome in Children, MIS-C, SARS-CoV-2, Kawasaki Disease, Cardiac Involvement, China

1. Introduction

Multisystem inflammatory syndrome in children (MIS-C) is a rare but potentially severe post-infectious hyperinflammatory condition associated with SARS-CoV-2. It typically develops several weeks after infection and is characterized by fever, systemic inflammation, and variable involvement of the cardiovascular, gastrointestinal, mucocutaneous, hematologic, and other organ systems [1]-[3]. Although its phenotype overlaps with Kawasaki disease (KD), MIS-C more often affects older children and is more frequently accompanied by gastrointestinal symptoms, shock, myocardial dysfunction, and marked elevations of inflammatory and cardiac biomarkers [2]-[5].

Knowledge of MIS-C has evolved substantially since the first reports in 2020. The Council of State and Territorial Epidemiologists and the US Centers for Disease Control and Prevention (CSTE/CDC) introduced an updated surveillance case definition effective in 2023, emphasizing hospitalization, fever, C-reactive protein ≥ 30 mg/L, and new-onset involvement of at least two specified organ-system categories, together with laboratory or epidemiologic evidence of SARS-CoV-2 infection [6]. Importantly, this definition was designed for surveillance and does not replace clinical judgment [6].

More recent evidence also shows that the epidemiology of MIS-C has changed across SARS-CoV-2 variant and vaccination eras. The risk of MIS-C has been lower during Omicron-predominant periods than during earlier waves, and population-based data suggest declining incidence with increasing pediatric immunity and vaccination [7] [8]. Nevertheless, MIS-C continued to occur during the large SARS-CoV-2 wave in China in late 2022 and early 2023. Chinese multicenter and single-center MIS-C series from this period have similarly described hyperinflammation, cardiovascular involvement, and KD-like features [9] [10]. MIS-C was also documented among severe/critical pediatric COVID-19 cases during the late-2022 Omicron outbreak in Guangdong [11].

Because early Chinese data remain less abundant than data from Europe and North America, detailed description of cases from the early 2023 wave may help define the clinical spectrum in this setting. We therefore retrospectively summarized the clinical manifestations, laboratory findings, treatment patterns, and

short-term outcomes of nine children with MIS-C treated at a tertiary pediatric emergency center in Guangzhou.

2. Materials and Methods

2.1. Study Design and Population

This retrospective observational case series included consecutive children admitted to the Department of Pediatric Emergency, Guangzhou Women and Children's Medical Center, between January and March 2023 who were diagnosed with MIS-C. Nine children met the clinical diagnosis recorded by the treating team and were included, SARS-CoV-2 nucleic acid test was positive. Patients were followed through hospital discharge. Because the cohort was assembled during the transition to the updated 2023 CSTE/CDC surveillance definition, the present study reports the diagnosis documented in the medical record rather than retrospectively reclassifying cases using a surveillance definition that was not prospectively applied. This distinction is important because surveillance definitions are not intended to substitute for bedside diagnostic judgment [6].

2.2. Data Collection

Data were extracted from the electronic medical record and laboratory information systems. Variables included age, sex, place of origin, symptoms and signs, cardiovascular and systemic complications, complete blood count, inflammatory and coagulation markers, cardiac biomarkers, liver-related biochemical indices, immunomodulatory and supportive treatment, length of hospital stay, survival, and clinical status at discharge. Because this was a retrospective case series, tests were obtained according to clinical need rather than a prespecified research schedule.

2.3. Outcomes

The study was descriptive. The principal outcomes were the spectrum and frequency of clinical manifestations, laboratory abnormalities, treatments used, need for organ support, length of hospital stay, and in-hospital survival. No causal comparison of treatment strategies was planned.

2.4. Ethical Approval

The study protocol was approved by the Clinical Research Ethics Committee of Guangzhou Women and Children's Medical Center (approval No. 432A01). The requirement for informed consent from patients or legal guardians was waived because of the retrospective observational design. Clinical data were handled confidentially in accordance with institutional requirements.

2.5. Statistical Analysis

Analyses were descriptive and were performed using SPSS version 26.0. Normally distributed continuous variables are presented as mean $\pm$ standard deviation, non-normally distributed continuous variables as median (lower quartile, upper quar-

tile), and categorical variables as number (percentage). Given the sample size of nine, no inferential hypothesis testing or multivariable modeling was performed.

3. Results

3.1. Demographic Characteristics and Clinical Manifestations

Nine children with MIS-C were included. Seven (77.8%) were male, the mean age was 5 ± 3 years, and six (66.7%) were from Guangzhou. Fever occurred in all patients, with a median duration of 5 (4, 7) days. Frequent mucocutaneous manifestations were red lips/strawberry tongue (88.9%), conjunctival injection (77.8%), lymphadenopathy (66.7%), rash (66.7%), and hand/foot edema or desquamation (33.3%). Cardiovascular findings were prominent: four children (44.4%) had coronary artery thickening/dilatation or ectasia, four (44.4%) had sinus tachycardia, and one (11.1%) had a coronary artery aneurysm. Echocardiogram examination was performed on the fifth to tenth day of fever, the left ventricular systolic function was normal in all nine children. Three children (33.3%) met criteria for systemic inflammatory response syndrome (see **Table 1**).

Table 1. Demographic and clinical characteristics of the nine children with MIS-C.

Characteristic	Value
Demographic characteristics	
Sex, n (%)	
Male	7 (77.8)
Female	2 (22.2)
Age, years, mean $\pm$ SD	5 ± 3
Place of origin, n (%)	
Guangzhou	6 (66.7)
Dongguan	1 (11.1)
Yunfu	1 (11.1)
Shaoguan	1 (11.1)
Clinical manifestations	
Fever, n (%)	9 (100)
Red lips/strawberry tongue, n (%)	8 (88.9)
Conjunctival injection, n (%)	7 (77.8)
Lymphadenopathy, n (%)	6 (66.7)
Rash, n (%)	6 (66.7)
Hand/foot edema or desquamation, n (%)	3 (33.3)
Duration of fever, days, M (Q1, Q3)	5 (4, 7)
Complications	
Coronary artery thickening/dilatation, n (%)	4 (44.4)
Sinus tachycardia, n (%)	4 (44.4)
Systemic inflammatory response syndrome, n (%)	3 (33.3)
Coronary artery aneurysm, n (%)	1 (11.1)

Data are presented as n (%), mean $\pm$ SD, or median (Q1, Q3), as appropriate. MIS-C, multisystem inflammatory syndrome in children; SIRS, systemic inflammatory response syndrome; SD, standard deviation; M (Q1, Q3), median (first quartile, third quartile).

Laboratory findings

The laboratory profile was characterized by systemic inflammation, coagulation activation, relative lymphopenia, hypoalbuminemia, and frequent elevation of cardiac biomarkers tested upon admission. Median CRP was 85.9 mg/L, procalcitonin 3.3 ng/mL, D-dimer 2.1 µg/mL, fibrinogen 5.2 g/L, IL-6 90.4 pg/mL, NT-proBNP 4953 pg/mL, and troponin 62.7 pg/mL. Median lymphocyte percentage was 10.0% and albumin 33.1 g/L. TNF- α , in contrast, remained within the stated laboratory reference range at the cohort median (see **Table 2**).

Table 2. Laboratory findings of the nine children with MIS-C (N = 9).

Laboratory parameter	Value, M (Q1, Q3)	Reference range
Hematologic parameters		
White blood cell count ($\times 10^9/L$)	10.9 (8.2, 16.3)	4.3 - 11.3
Neutrophils (%)	78.0 (72.5, 81.5)	37.2 - 69.0
Lymphocytes (%)	10.0 (9.0, 13.0)	34.9 - 40.7
Hemoglobin (g/L)	102 (96, 112)	118 - 156
Platelet count ($\times 10^9/L$)	236 (159, 383)	167 - 453
Inflammatory markers		
C-reactive protein (mg/L)	85.9 (66.3, 146.4)	<8.2
Erythrocyte sedimentation rate (mm/h)	45.0 (20.5, 52.5)	0 - 20
Procalcitonin (ng/mL)	3.3 (1.4, 8.8)	<0.1
Interleukin-6 (pg/mL)	90.4 (58.8, 132.4)	0 - 8.9
Tumor necrosis factor- α (pg/mL)	1.0 (0.9, 1.4)	0 - 5.4
Coagulation parameters		
D-dimer (µg/mL)	2.1 (0.7, 2.9)	<0.5
Fibrinogen (g/L)	5.2 (4.7, 7.5)	2.0 - 4.0
Cardiac biomarkers		
NT-proBNP (pg/mL)	4,953 (353, 7,314)	0 - 125
Troponin (pg/mL)	62.7 (3.5, 416.4)	<26.2
Biochemical parameters		
Serum albumin (g/L)	33.1 (29.3, 39.3)	40 - 55
Aspartate aminotransferase (U/L)	25 (19, 32)	7 - 40
Lactate dehydrogenase (U/L)	252 (232, 288)	159 - 322

Data are presented as n (%), mean $\pm$ SD, or median (Q1, Q3), as appropriate. MIS-C, multisystem inflammatory syndrome in children; SIRS, systemic inflammatory response syndrome; SD, standard deviation; M (Q1, Q3), median (first quartile, third quartile).

3.2. Treatment and Clinical Outcomes

All nine children received intravenous immunoglobulin (IVIG) and aspirin, while six (66.7%) received antibiotics and one (11.1%) received corticosteroids. Supportive treatments included albumin administration in four children (44.4%), mechanical ventilation in one (11.1%), and vasoactive agents in one (11.1%). The

median length of hospital stay was 8 (6, 12) days. All nine children showed clinical improvement and survived to hospital discharge (see **Table 3**).

Table 3. Treatment and clinical outcomes of the nine children with MIS-C.

Variable	Value
Treatment, n (%)	
Intravenous immunoglobulin	9 (100)
Aspirin	9 (100)
Antibiotics	6 (66.7)
Albumin administration	4 (44.4)
Corticosteroids	1 (11.1)
Mechanical ventilation	1 (11.1)
Vasoactive agents	1 (11.1)
Clinical outcomes	
Length of hospital stay, days, M (Q1, Q3)	8 (6, 12)
Clinical improvement at discharge, n (%)	9 (100)
Survival to hospital discharge, n (%)	9 (100)

MIS-C, multisystem inflammatory syndrome in children; IVIG, intravenous immunoglobulin; M (Q1, Q3), median (first quartile, third quartile). One patient required both mechanical ventilation and vasoactive support.

4. Discussion

This case series describes nine children with MIS-C treated in Guangzhou during January-March 2023, immediately after the major SARS-CoV-2 wave in China. The principal phenotype was fever with prominent mucocutaneous inflammation, relative lymphopenia, markedly elevated inflammatory markers, and frequent cardiovascular involvement. Despite the small sample, this pattern is broadly consistent with contemporary evidence. A 2024 systematic review of 120 studies encompassing 20,881 MIS-C cases found fever to be nearly universal and reported gastrointestinal, dermatologic, inflammatory, coagulation, and cardiac abnormalities as central features of the syndrome [3]. A Chinese multicenter series of 64 children treated between December 2022 and June 2023 and a Beijing series of 11 children after Omicron infection similarly documented substantial systemic inflammation and cardiovascular involvement [9] [10].

The cardiovascular signal in our cohort deserves emphasis. Four of nine children had coronary artery thickening/dilatation or ectasia, one had a coronary artery aneurysm, and cardiac biomarkers were substantially elevated at the cohort level. MIS-C can involve myocarditis-like ventricular dysfunction, shock, arrhythmia, and coronary abnormalities, and its cardiovascular phenotype partly overlaps with KD [2] [4] [5]. However, the two conditions are not interchangeable. Contemporary comparative studies and reviews indicate that MIS-C more often presents with shock, gastrointestinal involvement, myocardial dysfunction, lymphopenia, thrombocytopenia, and marked CRP, D-dimer, troponin, or natriuretic

peptide elevation, whereas classic KD has a different age distribution and characteristic coronary vasculitis phenotype [2] [4] [5] [12]. In the updated CSTE/CDC surveillance definition, a final diagnosis of KD by the treating team is considered an alternative diagnosis for surveillance classification, underscoring the need for careful phenotyping rather than labeling every KD-like illness after SARS-CoV-2 as MIS-C [6].

Our laboratory findings also align with the recognized hyperinflammatory phenotype. CRP, procalcitonin, fibrinogen, D-dimer, and IL-6 were elevated, while lymphocyte percentage and albumin were reduced. NT-proBNP and troponin were frequently elevated, supporting the importance of systematic cardiac assessment in suspected MIS-C. Notably, the median TNF- α concentration in this cohort was within the local reference interval; therefore, the data do not support describing TNF- α as uniformly elevated. Recent mechanistic work continues to distinguish MIS-C from severe acute pediatric COVID-19 at the immunologic and myeloid-response levels, reinforcing the concept that MIS-C is a post-infectious immune dysregulation syndrome rather than simply severe acute viral disease [13].

Treatment of MIS-C has evolved since the earliest pandemic period. In our cohort, all children received IVIG and aspirin, whereas only one received corticosteroids. This pattern should be interpreted in the historical and local context of early 2023 and should not be read as a current treatment recommendation. Contemporary reviews generally support IVIG and glucocorticoids as commonly used first-line immunomodulatory therapies, particularly in patients with cardiovascular involvement, although comparative observational studies have not been completely concordant [14]–[18]. A large international propensity-weighted cohort found no significant difference in major outcomes among IVIG alone, IVIG plus glucocorticoids, and glucocorticoids alone [15], while other cohorts have reported cardiovascular advantages with combination therapy [16]. More recent data also suggest that selected mild cases may respond to glucocorticoid-based strategies and that treatment should be individualized by severity and organ involvement [14] [17]. Biologic agents are generally reserved for refractory or severe disease, but their optimal role remains uncertain [14].

The epidemiologic context has also changed. MIS-C became less frequent during Omicron-predominant periods, and population-level studies have documented declining incidence as immunity accumulated and pediatric vaccination expanded [7] [8]. This is relevant to interpretation of our cohort: the nine cases were concentrated in a short interval following a major community SARS-CoV-2 wave, and the study was not designed to estimate incidence. The series therefore provides a clinical snapshot rather than evidence that MIS-C was common in the underlying pediatric population.

Several limitations should be acknowledged. First, this was a single-center retrospective case series of only nine patients, resulting in substantial imprecision and limiting generalizability. Second, there was no comparator group with KD,

acute COVID-19, bacterial sepsis, or other inflammatory disorders, so the study cannot identify discriminative biomarkers or estimate diagnostic performance. Third, laboratory and imaging tests were obtained according to clinical need and were not measured at standardized time points, preventing analysis of biomarker trajectories. Fourth, treatment was not protocolized, and the study cannot compare the effectiveness of IVIG, glucocorticoids, aspirin, or other therapies. Fifth, only in-hospital outcomes were available; longer-term coronary and myocardial recovery cannot be assessed. Finally, because the cohort was assembled during a period when MIS-C definitions were evolving, future studies should prospectively apply a single prespecified case definition and explicitly report the timing and modality of SARS-CoV-2 evidence.

5. Conclusion

In conclusion, children with MIS-C in this early-2023 Guangzhou case series most often presented with fever, KD-like mucocutaneous inflammation, marked systemic inflammation, and cardiovascular involvement. All patients survived to discharge, but the small sample precludes conclusions about prognosis or treatment effectiveness. Multicenter prospective studies using standardized diagnostic phenotyping, serial cardiac assessment, and longer follow-up are needed to define the contemporary MIS-C phenotype in China and to distinguish it reliably from KD, acute COVID-19, and other hyperinflammatory conditions.

Ethics Approval and Consent to Participate

The study protocol was approved by the Clinical Research Ethics Committee of Guangzhou Women and Children's Medical Center (approval No. 432A01). The requirement for informed consent was waived because of the retrospective observational design.

Availability of Data and Materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Highlights

- This case series characterizes MIS-C in Chinese children during the early-2023 period following a major community SARS-CoV-2 wave.
- MIS-C showed a prominent Kawasaki disease-like mucocutaneous phenotype accompanied by frequent cardiovascular involvement.
- Hyperinflammation, coagulation activation, relative lymphopenia, hypoalbuminemia, and elevated cardiac biomarkers constituted the major laboratory phenotype.
- All children received IVIG and aspirin, while only one received corticosteroids; all survived to hospital discharge.

- These findings provide a clinically detailed snapshot of MIS-C in China during a rapidly changing post-Omicron epidemiologic era.

Author Contributions

Yining Sun: data curation, formal analysis, and writing—original draft. Li Huang: Study design, manuscript review. Zihao Tan: conceptualization, supervision, and writing—review and editing.

Conflicts of Interest

The authors declare that they have no competing interests.

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