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KNOWLEDGE AND ATTITUDES OF DENTAL STUDENTS REGARDING THE INFECTIOUS NATURE OF KAWASAKI DISEASE

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ABSTRACT

Introduction: Kawasaki disease is an important condition that, if not properly treated, can lead to coronary artery complications. Therefore, this study was conducted with the aim of assessing the awareness and attitudes of dental students regarding the diagnosis of Kawasaki disease. **Methods:** This was a descriptive, cross-sectional study conducted in 2026 involving 96 dental students from Ilam city. The inclusion criteria for the study were dental students from the 2nd to 5th academic year in Ilam, who provided informed consent to participate. Incomplete questionnaires were the exclusion criteria. The instrument used consisted of Demographic Questionnaire and Kawasaki Disease Awareness and Attitude Questions. The total score for the attitude questions ranged from 20 to 100, where a higher score indicated a more positive attitude towards Kawasaki disease. Data analysis was performed using SPSS version 16, employing descriptive statistical tests. Cronbach's alpha test was also utilized to assess the reliability of the instruments. **Result**: Result showed, 96 dental students from Ilam city participated. Of these, 51 (53.1%) were male and 45 (46.9%) were female. In terms of educational year, 27 (28.1%) were in their second year, 25 (26%) in their third year, 22 (22.9%) in their fourth year, and 22 (22.9%) in their fifth year. Additionally, the mean (SD) knowledge score of dental students was 14.22 (2.16) out of 20. Also Result showed, regarding the awareness questions, the question that received the most correct answers was question number 20, concerning the necessity of cardiac consultation for patients with coronary artery involvement before dental procedures, with 87 (90.6%) respondents answering it correctly. Following question 20, most respondents answered question number 18 correctly. Specifically, 77 (80.2%) of dental students stated that after recovery from Kawasaki disease, periodic cardiovascular examinations are necessary, but this topic is unrelated to dental care. Regarding the questions related to attitude in the context of Kawasaki disease, most participants in the study emphasized the importance of factors such as effective communication with parents and physicians in managing patients suspected of Kawasaki disease, the need for continuous education and knowledge updates about Kawasaki disease for dentists, dentists' awareness regarding the cardiac complications of Kawasaki disease, overlooking the oral manifestations of Kawasaki disease and mistaking these symptoms for other illnesses, and the need for special care (especially cardiac care) after oral treatments. **Conclusion:** Given that the awareness and attitude scores of dental students were not at a desirable level, it is recommended that interventional studies be conducted to enhance the awareness and attitude scores of these students.

KEYWORDS: Kawasaki disease, Infectious diseases, Dental students, Knowledge, Attitude.

INTRODUCTION

Oral and dental health is a fundamental component of public health, significantly impacting individuals' quality of life.[1,2] Neglecting oral hygiene not only affects dental health but also allows various infections to enter the body through the mouth and teeth, thereby compromising overall public health. Despite considerable advancements in global disease control, oral and dental diseases, particularly dental caries, remain among the most prevalent conditions worldwide, including in Iran.[3,4]

Responsive medical education emerged as a global movement within national medical education systems to achieve health equity in societies. The objective of implementing this policy in medical schools is to foster social accountability to the community's health needs, empower governments, and promote inter-sectoral collaboration.[5,6] Incorporating community-oriented dentistry into medical education aims to establish a sustainable solution for improving public oral and dental health by cultivating students proficient in health management and promotion, and by solidifying conservative treatment and preventive approaches.[7-9] Evidence-based dentistry, a branch of evidence-based care, is defined as an approach to decision-making in oral healthcare that requires the judicious appraisal of scientific literature and the extrapolation of the best available evidence, considering the dentist's skills, the patient's history, oral condition, general health status, and the patient's needs and priorities.[10,11]

Currently, a structured educational system based on universities governs the training of dentists in the country. The general dentistry doctoral program is divided into two stages. The first stage includes general and basic science courses, along with some specialized subjects, while the second stage comprises specialized dentistry courses. Upon completion of the first stage, a comprehensive basic science examination is administered, serving as a prerequisite for advancement to the next stage. In essence, the basic science examination aims to assess dental students' mastery of subjects that form the foundation for understanding clinical concepts and can contribute to standardizing the quality of dental education across different faculties.[12-14]

Kawasaki disease is a common childhood vasculitis that is rarely seen in adults. It is characterized by fever and inflammation of the body's tissues, particularly the coronary arteries. Kawasaki disease involves widespread vascular inflammation in various organs of children and is significant due to potential coronary artery involvement.[15-17]

Diagnosis is based on a history of fever lasting 5 days or more, along with at least four of the following signs: bilateral non-exudative conjunctival injection, non-exudative pharyngitis with cracked or red lips, edema or erythema or peeling of the hands and feet, and polymorphous rash. Essentially, Kawasaki disease is an acute febrile illness and considered a rare condition. It primarily affects children and is accompanied by redness of the hands and feet, edema, red lips and mouth, cervical lymphadenopathy, and conjunctivitis. Kawasaki disease is classified into complete and incomplete types. Complete Kawasaki disease involves fever lasting more than 5 days, accompanied by four clinical signs: extremity changes and cervical lymphadenopathy, mucosal involvement, bilateral non-exudative conjunctivitis, and generalized skin rash. Incomplete Kawasaki disease includes fever lasting more than 5 days, which, in addition to the aforementioned criteria, is diagnosed with inflammatory laboratory findings or echocardiography.[18-21]

Kawasaki disease is a critical illness that, if left untreated, can lead to coronary artery abnormalities (aneurysm, coronary artery thrombosis or occlusion, myocardial infarction, aneurysm rupture) and sudden death. Although the exact cause of this disease remains unknown, environmental factors, infections, and antigens may play a role in its

development. In essence, Kawasaki disease is of unknown etiology, but environmental toxins have been proposed as a potential cause. Given its occurrence in specific age groups, periodic epidemics, self-limiting nature, and clinical manifestations such as fever and skin manifestations, an infectious origin for Kawasaki disease is suspected. Alternatively, the causative agent might exist in various locations but manifests in genetically susceptible hosts.[22-26]

Environmental factors have been implicated as triggers for Kawasaki disease, with evidence suggesting it is likely caused by a shared pathway involving microbial, infectious, and environmental elements that trigger infection in genetically susceptible individuals. This disease predominantly affects infants and children under 5 years of age and can lead to coronary artery involvement if left untreated. Complications can include myocarditis, coronary artery dilatation, lack of gradual tapering of the coronary arteries, ectasia, and coronary artery aneurysm. Prompt and timely treatment of the disease can prevent the onset of such complications.[27-29] The clinical course of Kawasaki disease is divided into three phases: acute, subacute, and convalescent. The subacute phase extends up to 6 weeks after the onset of fever. Patients with coronary artery damage during the subacute and early convalescent phases are at the highest risk of sudden death due to acute coronary artery thrombosis. The convalescent phase begins approximately 6 to 8 weeks after the onset of the illness, when all clinical signs and symptoms have disappeared, and inflammatory markers have normalized.[30-32]

This study aims to assess the level of knowledge and attitudes among dental students in Ilam regarding the oral manifestations and their potential role in the early diagnosis of Kawasaki disease, conducted as a cross-sectional study among dental students in Ilam. The findings of this research can assist dental faculty members in Ilam in identifying educational weaknesses and proposing strategies for improving the early diagnosis of this disease.

METHODS

This was a descriptive, cross-sectional study conducted in 2026 involving dental students from Ilam city. The inclusion criteria for the study were dental students from the 2nd to 5th academic year in Ilam, who provided informed consent to participate. Incomplete questionnaires were the exclusion criteria.

The study population comprised all dental students (from the 2nd year upwards). A census method was employed, and out of all available students, 96 individuals expressed willingness to collaborate in the research and fully completed the questionnaires. All information obtained by the researchers was treated confidentially, and students were assured that their data would be reported in aggregate form. Furthermore, it was confirmed that their responses to the questions would not affect their academic evaluations by the faculty, and the results were solely for the purpose of a research project.

The instrument used consisted of three sections:

1. Demographic Questionnaire: Questions regarding age, gender, and academic term.
2. Kawasaki Disease Awareness Questions: 20 questions answered with “Yes” or “No.”
3. Professional Attitude and Approach of Dentists towards Kawasaki Disease Questions: 20 questions answered on a Likert scale, ranging from “Strongly Agree” to “Strongly Disagree.”

For the awareness questions, students received one point for a correct answer and zero points for an incorrect answer. The total awareness score for Kawasaki disease ranged from 0 to 20. For the attitude questions, a 5-point Likert scale

was used, from 1 (Strongly Disagree) to 5 (Strongly Agree), to indicate their level of agreement or disagreement with the statements. The total score for the attitude questions ranged from 20 to 100, where a higher score indicated a more positive attitude towards Kawasaki disease.

Given that the awareness and attitude questionnaires for dental students regarding Kawasaki disease were researcher-developed (with the assistance of artificial intelligence tools), their validity and reliability were reviewed and approved by the researchers. Initially, the Content Validity of the questionnaire was assessed by consulting 10 specialists, including pediatric rheumatologists, pediatric dentists, faculty members in epidemiology, and internal medicine specialists. Following the Content Validity assessment, the Content Validity Index (CVI) and Content Validity Ratio (CVR) were reviewed and calculated. Subsequently, face validity was established through linguistic and conceptual revisions, based on the feedback of 10 dental students from Ilam. For reliability, a small pilot study with a sample size of 25 participants was conducted, yielding a Cronbach's alpha coefficient of 0.82. For questions with true/false answers, the test-retest method (with a 10-day interval) was used to assess temporal stability.

Data analysis was performed using SPSS version 16, employing descriptive statistical tests. Cronbach's alpha test was also utilized to assess the reliability of the instruments.

RESULT

Result showed, 96 dental students from Ilam city participated. Of these, 51 (53.1%) were male and 45 (46.9%) were female. In terms of educational year, 27 (28.1%) were in their second year, 25 (26%) in their third year, 22 (22.9%) in their fourth year, and 22 (22.9%) in their fifth year. Additionally, the mean (SD) knowledge score of dental students was 14.22 (2.16) out of 20. Also, Regarding the attitude score, the obtained score was 68.28 (7.13).

Table 1: Frequency distribution status of awareness questions regarding Kawasaki disease.

-	Questions	Incorrect answer	Correct answer
1	In patients with Kawasaki disease, the usual oral findings include stomatitis, cracked and red lips, and strawberry tongue.	54(56.3)	42(43.8)
2	Lymphadenopathy in Kawasaki disease is usually multiple, bilateral, and often accompanied by pain.	53(55.2	43(44.8)
3	Bilateral non-exudative conjunctivitis is one of the main diagnostic criteria for Kawasaki disease, and the presence of ocular discharge rules it out.	20(20.8)	76(79.2)
4	The rash in Kawasaki disease is typically maculopapular, diffuse, and non-bullous, but it can be variable.	37(38.5)	59(61.5)
5	Changes in the extremities (such as edema and redness of hands and feet, followed by peeling) usually occur in the acute phase.	35(36.5)	61(63.5)
6	Kawasaki disease is primarily a rare disease that occurs in children under 6 months of age.	44(45.8)	52(54.2)
7	The diagnosis of Kawasaki disease is mainly based on laboratory tests such as elevated ESR and CRP.	40(41.7)	56(58.3)
8	In the presence of fever for more than 5 days and 4 out of the 5 main criteria (redness of the eyes, oral manifestations, rash, lymphadenopathy, extremity changes), the diagnosis of Kawasaki disease is definitive.	48(50)	48(50)
9	In cases of incomplete Kawasaki disease, the patient may have a fever but exhibit fewer than 4 main criteria.	42(43.8)	54(56.3)
10	The dentist plays the primary role in the definitive diagnosis of Kawasaki disease.	29(30.2)	67(69.8)
11	The main and worrying complication of Kawasaki disease is coronary artery involvement, which can lead to aneurysm, stenosis, or occlusion.	43(44.8)	53(55.2)
12	Standard treatment for the acute phase of Kawasaki disease includes IVIG	54(56.3)	42(43.8)

	and high-dose aspirin.		
13	In cases resistant to initial treatment (Refractory Kawasaki disease), a second dose of IVIG or corticosteroids may be considered.	44(45.8)	52(54.2)
14	Dentists may be involved in evaluating patients with Kawasaki disease presenting with oral symptoms and need prompt referral.	38(39.6)	58(60.4)
15	If low-dose aspirin is prescribed for Kawasaki disease patients, the dentist should not worry about the risk of bleeding during oral surgical procedures.	40(41.7)	56(58.3)
16	Stevens-Johnson Syndrome (SJS) and similar drug reactions should be considered as the main differential diagnoses alongside Kawasaki disease.	41(42.7)	55(57.3)
17	A precise oral examination and attention to systemic symptoms in febrile children can help in the differential diagnosis of Kawasaki disease.	23(24)	73(76)
18	After recovery from Kawasaki disease, periodic cardiovascular examinations are necessary, but this is unrelated to dental care.	19(19.8)	77(80.2)
19	Oral manifestations of Kawasaki disease are usually the first signs of the disease and appear before fever.	33(34.4)	63(65.6)
20	In patients with a history of Kawasaki disease with coronary artery involvement, consultation with a cardiologist is mandatory before performing invasive dental procedures.	9(9.4)	87(90.6)

Result showed, regarding the awareness questions, the question that received the most correct answers was question number 20, concerning the necessity of cardiac consultation for patients with coronary artery involvement before dental procedures, with 87 (90.6%) respondents answering it correctly. Following question 20, most respondents answered question number 18 correctly. Specifically, 77 (80.2%) of dental students stated that after recovery from Kawasaki disease, periodic cardiovascular examinations are necessary, but this topic is unrelated to dental care (Table 1).

Table 2: Frequency distribution status of attitude questions regarding Kawasaki disease.

-	Questions	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
1	I believe that in the dental curriculum, there should be more emphasis on the differential diagnosis of systemic diseases with oral manifestations such as Kawasaki disease.	4(4.2)	16(16.7)	14(14.6)	27(28.1)	35(36.5)
2	I feel that my current knowledge is sufficient to identify oral signs suggestive of Kawasaki disease.	16(16.7)	26(27.1)	49(51)	5(5.2)	0(0)
3	I believe that dentists should be able to promptly refer patients exhibiting symptoms of Kawasaki disease to specialist physicians.	4(4.2)	8(8.3)	22(22.9)	42(43.8)	20(20.8)
4	I think effective communication with parents and physicians is crucial in managing patients suspected of having Kawasaki disease.	0(0)	2(2.1)	7(7.3)	45(46.9)	42(43.8)
5	I am concerned that if Kawasaki disease is not diagnosed promptly, professional liability may fall on the dentist.	20(20.8)	28(29.2)	18(18.8)	18(18.8)	12(12.5)
6	I believe that sufficient information is available regarding dental considerations in patients with Kawasaki disease (such as cardiac complications and aspirin use).	12(12.5)	16(16.7)	16(16.7)	29(30.2)	23(24)
7	I feel that the dentist's role in the early diagnosis of Kawasaki disease is vital.	21(21.9)	17(17.7)	30(31.3)	23(24)	5(5.2)
8	I think there is a need for continuous education and knowledge update regarding Kawasaki disease for dentists.	0(0)	2(2.1)	9(9.4)	32(33.3)	53(55.2)
9	I believe that a complete oral and dental examination is an essential part of assessing a patient's overall health, especially in children.	3(3.1)	10(10.4)	25(26)	32(33.3)	26(27.1)
10	I feel that if a patient presents with fever and oral	1(1)	6(6.3)	10(10.4)	32(33.3)	47(49)

	symptoms, I must inquire about their complete medical history, including a history of prolonged fever.					
11	I believe that dentists should be aware of the potential risks of cardiac complications in Kawasaki disease patients and consult with a cardiologist if necessary.	0(0)	14(14.6)	24(25)	36(37.5)	22(22.9)
12	I think Kawasaki disease should be considered a significant differential diagnosis, especially in children presenting with non-specific symptoms.	16(16.7)	23(24)	22(22.9)	18(18.8)	17(17.7)
13	I feel that dentists should be familiar with the initial treatment protocols for Kawasaki disease to collaborate with the medical team.	17(17.7)	15(15.6)	27(28.1)	22(22.9)	15(15.6)
14	I believe that accurate documentation of oral findings and patient history in the dental record is of great importance for suspected cases of Kawasaki disease.	11(1.5)	21(21.9)	16(16.7)	23(24)	25(26)
15	I think that oral manifestations of Kawasaki disease are often overlooked or mistaken for other more common conditions.	0(0)	7(7.3)	17(17.7)	31(32.3)	41(42.7)
16	I feel that after recovering from Kawasaki disease, patients may require special dental care (e.g., due to cardiac complications or medication effects).	0(0)	3(3.1)	13(13.5)	43(44.8)	37(38.5)
17	I believe that dentists play an important role in raising public awareness about Kawasaki disease and its symptoms.	4(4.2)	25(26)	20(20.8)	26(27.1)	21(21.9)
18	I think that educating patients and parents about oral hygiene during the treatment of Kawasaki disease is part of a dentist's responsibility.	15(15.6)	24(25)	22(22.9)	17(17.7)	18(18.8)
19	I believe that if Kawasaki disease is suspected, the dentist's primary priority is immediate referral to healthcare facilities, not attempting to treat the oral symptoms.	23(24)	31(32.3)	25(26)	13(13.5)	4(4.2)
20	I feel that with specialized dental knowledge, I can play a more active role in identifying and better managing Kawasaki disease patients.	23(24)	22(22.9)	18(18.8)	25(26)	8(8.3)

Regarding the questions related to attitude in the context of Kawasaki disease, it was observed that in 5 questions from the attitude questionnaire concerning Kawasaki disease, none of the study participants had selected the 'Strongly Disagree' option. In fact, most participants in the study emphasized the importance of factors such as effective communication with parents and physicians in managing patients suspected of Kawasaki disease, the need for continuous education and knowledge updates about Kawasaki disease for dentists, dentists' awareness regarding the cardiac complications of Kawasaki disease, overlooking the oral manifestations of Kawasaki disease and mistaking these symptoms for other illnesses, and the need for special care (especially cardiac care) after oral treatments (Table 2).

DISCUSSION

This study was conducted to assess the knowledge and attitudes of dental students in Ilam regarding Kawasaki disease. According to the findings the mean (SD) knowledge score of dental students was 14.22 (2.16) out of 20. Also, Regarding the attitude score, the obtained score was 68.28 (7.13).

Several studies within dental student populations have investigated Knowledge, Attitude, and Practice (KAP) concerning various factors, including infection control and infectious diseases. For instance, Jafari et al. observed that

students in their twelfth term exhibited the highest scores in awareness, attitude, and practice regarding infection control, while those in the tenth term had the lowest awareness scores, and the eighth term showed the lowest practice scores. Overall, the KAP level concerning infection control among students was deemed insufficient, highlighting the necessity for enhanced training and rigorous supervision in this domain.[33] In another study by Jafari et al. involving 170 fourth to sixth-year dental students in Yazd, the mean KAP scores were 20.77, 32.04, and 46.17, respectively. Despite a moderate level of awareness (KA), students' performance regarding hepatitis and AIDS was assessed as acceptable.[34] Eghbal et al. reported mean student scores of 19 out of 34 for awareness and 21 out of 32 for practice concerning infection control.[35] Furthermore, Kazemi Pour et al. found that in the context of COVID-19 prevention strategies, the mean awareness score was 33.55 (SD=4.19), with no significant difference between men (33.57±4.18) and women (33.54±4.23). The mean perception and attitude score was 6.23 (SD=1.61), with minimal variation between men (6.21±1.55) and women (6.25±1.67).[36]

Collectively, these studies indicate that while dental students generally possess a relatively satisfactory level of awareness regarding infections and infectious diseases, this awareness does not consistently translate into favorable attitudes and, particularly, appropriate practice. Performance levels are often reported as inadequate across numerous studies, with significant variations observed between different academic terms, generally showing better performance among senior students. Consequently, there is a strong imperative to enhance practical training, implement refresher courses, and ensure continuous monitoring of infection control principles. The findings from studies on infections and infectious diseases align with the results of the current study, reinforcing the significance of interventions aimed at improving dental students' awareness, attitude, and practice. Specifically, in the present study, dental students demonstrated a moderate level of awareness regarding the infectious nature of Kawasaki disease, indicating that their awareness was not at an optimal or excellent level.

Other relevant studies include that by Miraki et al., who investigated the KAP status of dentists concerning Dental Cements. They found that the mean KAP scores were moderate to slightly above, with significant correlations observed with educational level, gender, and place of employment. Specialists and women generally achieved higher scorer.[37]

In a study by Shafizadeh et al. focusing on KAP related to fluoride administration methods, the Knowledge and Attitude (KA) levels of students and general dentists regarding fluoride prescription were found to be comparable and acceptable. The majority recommended fluoride therapy for children aged 6-12 and the daily use of fluoride toothpaste and mouthwash.[38] Khami et al. examined dental students' attitudes towards oral hygiene behaviors, finding that preventive attitudes were significantly associated with gender and educational level, with girls showing different perspectives than boys on certain aspects (e.g., the importance of plaque or intolerance to dentures), and variations observed based on university and academic level. Their results underscored the need for enhanced preventive education in dental schools to address these contextual factors.[39]

In summary, various studies indicate that the KAP of dentists and students in areas such as dental cements, fluoride prescription, and oral hygiene is often at a moderate or higher level and is associated with factors including gender, educational level, and employment status. These findings emphasize the necessity of strengthening preventive education in dental schools. Indeed, the results of the aforementioned studies support the findings of the present study, highlighting the importance of interventions aimed at enhancing the KAP of dental students.

CONCLUSION

Given that the awareness and attitude scores of dental students were not at a desirable level, it is recommended that interventional studies be conducted to enhance the awareness and attitude scores of these students.

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