Letter by Chhabra and Spodick Regarding Article, “Treatment of Acute and Recurrent Idiopathic Pericarditis”

To the Editor:

We read with great interest the publication by Lilly in a recent issue of Circulation.1 Lilly has provided a brief yet comprehensive review of the management of acute and recurrent pericarditis.

Lilly has recommended that corticosteroids should never be used as a primary line of therapy in acute or recurrent idiopathic pericarditis, unless the disease symptoms are refractory to nonsteroidal anti-inflammatory drugs or colchicine. It is indeed true for the most practical purposes because the steroids have been shown to increase the rate of future relapses. However, one must remember that the pathogenic spectrum of acute pericarditis is quite wide, but in most patients (≈85–90%), it is presumed to be idiopathic (or viral in nature) because the yield of diagnostic tests to confirm pathogenesis has been relatively low.2 Thus, presumed idiopathic pericarditis may not be necessarily idiopathic, and, on some occasions, therapy may need guidance based on underlying or coexistent systemic disease. Based on the evidence from recent trials, colchicine can certainly and should be used as a primary line of therapy in combination with nonsteroidal anti-inflammatory drugs for idiopathic acute or recurrent pericarditis. Apart from refractory pericarditis, it may be considered appropriate to use steroids as initial therapy on a few other occasions. One may consider the use of steroids as first-line therapy especially when the pericarditis (acute or recurrent forms) may be suspected to be related to an underlying autoimmune phenomenon, connective tissue disease, or uremia.3–6 Steroids may also be considered as first-line treatment modality if patients are already on steroid therapy for another systemic cause.4 On such occasions, it is often recommended to increase the dose of ongoing steroids, followed by a slow gradual taper.4,5 Last, idiopathic pericarditis in pregnant women is preferably treated with corticosteroids, especially in the last trimester when nonsteroidal anti-inflammatory drugs are contraindicated because of the risk of premature closure of ductus arteriosus. Also, colchicine is not recommended in pregnancy because of the potential risk of teratogenicity.

In our opinion, physicians should thus be aware of these indications to make an appropriate informed decision and selection of treatment therapy.

Disclosures

Dr Spodick receives royalties from his textbook, The Pericardium: A Comprehensive Textbook (Fundamental and Clinical Cardiology), Marcel Dekker, New York, 1997. Dr Chhabra reports no conflicts.

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