Response to Letter Regarding Article, “Good Prognosis for Pericarditis With and Without Myocardial Involvement: Results From a Multicenter, Prospective Cohort Study”

We thank Drs Mewton and Bresson for their interest in our article.¹ The issues raised by the authors are essentially 3: the diagnosis being based on subjective criteria, the exclusion of patients with systemic inflammatory diseases, and the rationale for the definition of pericarditis and myocarditis.

First, in clinical practice, a spectrum of myocardial syndromes can be encountered, ranging from pure pericarditis to increasing degrees of inflammatory myocardial involvement (myopericarditis and perimyocarditis) to pure myocarditis.²³ Diagnostic criteria for acute pericarditis are well recognized and established.¹⁷ Although not supported by guidelines and consensus documents, myopericarditis and perimyocarditis definitions also have been proposed on the basis of clinical criteria.³ Myopericarditis is a primarily pericardial inflammatory syndrome occurring when clinical diagnostic criteria for pericarditis are satisfied and concurrent mild myocardial involvement is documented by elevation of biomarkers of myocardial damage (ie, increased troponins).¹³

In our article,¹ a clinical diagnosis of myopericarditis was made in patients with a definite diagnosis of acute pericarditis and elevation of cardiac markers of injury (troponin I or T, creatine kinase-MB fraction) without new onset of focal or diffuse depressed left ventricular function by echocardiography or cardiac magnetic resonance. Perimyocarditis was diagnosed in patients with clinical criteria for acute pericarditis, elevation of cardiac markers of injury, and evidence of new onset of focal or diffuse depressed left ventricular function by echocardiography or cardiac magnetic resonance. The rationale for these diagnostic criteria is that pure pericardial or predominant pericardial inflammatory involvement is not characterized by significant impairment of myocardial function and that, on the contrary, focal or diffuse abnormalities of ventricular wall motion or function imply substantial myocardial inflammatory involvement.¹ On this basis, we disagree and believe that reported clinical criteria have been published several times previously and are based on the best available clinical evidence. Obviously, there is a need for further research and especially a better understanding of the pathophysiology, but a proper classification with or without myocardial involvement and with or without ventricular dysfunction is clinically useful and may help guide different management strategies (similar for pericarditis and myopericarditis, ie, pericarditis with mild myocardial involvement and preserved ventricular function, and similar for perimyocarditis and myocarditis).

Second, the article included all consecutive patients with pericardial inflammatory syndromes (acute pericarditis, myopericarditis, and perimyocarditis) and thus there is no reason to exclude patients with systemic inflammatory syndromes who may be a part of the group.²³

Third, the pathophysiology of inflammatory myopericardial syndromes is still under investigation, and the adopted classification and diagnostic criteria are clinically based and useful in clinical practice. We would like also to clarify that troponin was measured serially in all patients.

In conclusion, we presented commonly adopted clinical criteria that are useful for the clinical management of patients with mixed forms of inflammatory myopericardial involvement. Further research is obviously needed to better understand the pathophysiology and to improve treatment, and study of the long-term outcomes is needed.

Disclosures

None.
Maria Grazia Modena, MD  
Policlinico  
Azienda Ospedaliero-Universitaria  
Modena, Italy  
Riccardo Belli, MD  
Cardiology Department  
Maria Vittoria Hospital  
Torino, Italy

References
Response to Letter Regarding Article, "Good Prognosis for Pericarditis With and Without Myocardial Involvement: Results From a Multicenter, Prospective Cohort Study"
Massimo Imazio, Antonio Brucato, Andrea Barbieri, Francesca Ferroni, Silvia Maestroni, Guido Ligabue, Alessandra Chinaglia, Davide Cumetti, Giovanni Della Casa, Federica Bonomi, Francesca Mantovani, Paola Di Corato, Roberta Lugli, Riccardo Faletti, Stefano Leuzzi, Rodolfo Bonamini, Maria Grazia Modena and Riccardo Belli

_Circulation_. 2014;129:e443-e444
doi: 10.1161/CIRCULATIONAHA.114.008025

_Circulation_ is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2014 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/129/14/e443

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in _Circulation_ can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to _Circulation_ is online at:
http://circ.ahajournals.org/subscriptions/