CORRESPONDENCE

No Standard Biopsy

There have repeatedly been reports of “almost healthy patients” who underwent endomyocardial biopsy—out of whatever considerations—and then died from cardiac tamponade with complications. The risk of a fatal event is 0.1% (1) to 0.03% (2), that of fatal cardiac tamponade is 0.42%. Certain disorders do not usually constitute an indication for myocardial biopsy—for example, atrial fibrillation without any indication of inflammatory cardiac disease, or moderate arrhythmias (extra systole in patient with unrestricted cardiac function), or re-entry tachycardia caused by an additional pathway, which is never of inflammatory origin. In case of suspected myocarditis with unrestricted cardiac functioning, myocardial biopsy is indicated as a measure of last resort only. The article remains too euphoric in its key messages because ultimately, only very few inflammations can be treated causally (for example, giant cell myocarditis); many forms of myocarditis heal spontaneously. Patients with uncharacteristic symptoms and moderate disorders should not undergo biopsy by default, since this exposes them to unnecessary risks and causes unnecessary expense. I would have wished for a more critical assessment of the method in a review article that is accessible to a wide range of doctors.

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Conflicts of interest statement
The author declares that no conflict of interest exists.

Therapeutic Recommendations Were Non-Specific

The problem of differential diagnosis and treatment of myocarditis is one of the biggest challenges in internal medicine, and it is for this reason that the value of myocardial biopsy is often underestimated. While fully supporting the authors on this point, I wish to add some comments from a clinical-immunological perspective.

If the patient has a systemic-immunological disorder rather than myocarditis only, the respective therapeutic regimen should immediately change according to the recommendations for the underlying disorder as the systemic aspect then becomes the therapeutic priority. Furthermore, it is to be expected that, after the suggested (minimum) duration of therapy of 6 months in patients with autoimmune myocarditis, a (possibly avoidable) episode of the underlying disorder may occur. Fortunately, in this situation, a much wider therapeutic repertoire is available for these oligosymptomatic, but fundamentally systemic, immunological disorders.

In addition, the therapeutic recommendations listed in the table could have been outlined more specific for routine clinical practice; consistently with the TIMIC study, mention should not be made of “cortisone” or “methylprednisolone,” but a defined dose of prednisolone equivalent (for which gastroprotection with proton pump inhibitors is not automatically necessary, and calcium is now regarded obsolete). A maintenance dose of >5 mg prednisolone equivalent usually also indicates insufficient effect of the immunosuppressive drug. It is furthermore worth mentioning that some of the risk factors not listed in the table should also be considered—for example, mesalazine as a trigger of myocarditis, but also routine vaccinations for chickenpox and diphtheria/tetanus.

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