

Myopericarditis and Giant Cell Arteritis in the Elderly

To the Editor:

We read with great interest 2 recent reports by Pugnet, *et al*¹ and Granel, *et al*². We appreciated the extensive investigations of their interesting cases. We have also published a case of giant cell arteritis (GCA) myopericarditis in a patient who presented with chest pain mimicking acute coronary syndrome whose cranial symptoms of GCA developed only 3 months after the initial presentation. We would point out a few issues arising from the article by Granel, *et al*.

First, although cardiac magnetic resonance imaging (MRI) is the best available diagnostic investigative tool for myocarditis, it does not always differentiate the various etiologies of myocarditis. Myocardial biopsy, immune-histopathological analysis, and polymerase chain reaction studies are therefore useful in various etiological evaluations and should be performed when indicated. We cannot dismiss a role for endomyocardial biopsy, particularly in unique myocardial pathologies where prognostication and management may be dependent on it; cardiac MRI is not always an alternative to myocardial biopsy as probably suggested by Granel and colleagues. Its role, although very limited and performed only in centers of excellence, is very much recommended, especially when myocarditis leads to cardiac failure (Class of Recommendation I, Level of Evidence B)³.

Second, their patient who had dyslipidemia presented with cardiac chest pain and breathlessness. Echocardiography showed T wave inversion in lateral leads, which could have been due to myocarditis or coronary ischemia. The computed tomography scan showed thickening of aortic walls and positron emission tomography scan showed aortic inflammation. All this would have warranted a coronary angiography to look for unstable plaques due to coronary inflammation, particularly because large and small arterial stenosis, coronary aneurysm, and fatal myocardial infarcts have been reported in GCA. In the elderly patient with coronary risk factors presenting with cardiac chest pain, a diagnostic coronary angiogram may be necessary, because an atherosclerotic and inflammatory disease such as GCA may coexist.

GCA can present with significant cardiac morbidity. There have been a few case reports of fatal acute myocardial infarction (MI)⁴ and severe heart failure requiring cardiac transplant⁵ in GCA. The incidence of fatal acute MI due to GCA in the coronary arteries is rare⁶, as is nonfatal acute MI. Acute MI and severe heart failure have also occurred during treatment of GCA⁶.

The true incidence of GCA complicating atherosclerotic coronary disease will always be difficult to define in the elderly population. As most cases are diagnosed retrospectively, the physician should be alert to the diverse presentations and complications of a systemic vasculitis such as GCA and coexistence of coronary artery disease due to hypertension and diabetes mellitus; early and appropriate treatment may then be offered, reducing morbidity and mortality.

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