

Recurrent Pericarditis: Can Anakinra Offer a Promising Therapy in Adults With Refractory Symptoms? Response



Pericarditis recurrente: ¿la anakinra puede aportar un tratamiento prometedor para adultos con síntomas refractarios? Respuesta

To the Editor,

I have read with interest the correspondence by Chhabra et al. on the issue of refractory recurrent pericarditis.¹ A small but significant subset of patients (overall 5% or less in my experience) may develop several recurrences despite polypharmacy and may become corticosteroid-dependent, since each attempt to taper or withdraw corticosteroids is followed by a recurrence.

Alternative treatments could be immunosuppressive drugs (especially azathioprine) or human intravenous immunoglobulins (hIVIGs). Such drugs are used in 2 broad disease categories: immunodeficiency and autoimmunity. Case reports and small series of patients with idiopathic recurrent pericarditis support the use of hIVIGs at doses of 400 to 500 mg/kg iv for 5 days and a possible repeated therapeutic cycle in cases of disease recurrence.

Anakinra, a recombinant human interleukin-1 β receptor antagonist, is a promising new biologic agent for the treatment of autoinflammatory diseases such as cryopyrinopathies, tumor necrosis factor receptor-associated periodic syndrome, and hyperimmunoglobulinemia D with periodic fever syndrome, especially in the pediatric setting. The main issue is that this drug requires prolonged subcutaneous administration and the exact

length of treatment is unknown. Moreover, withdrawal of these agents is frequently followed by a relapse.

Biological agents are considered a possible new therapeutic frontier in the care of idiopathic recurrent pericarditis but, as correctly pointed out, their usefulness needs to be demonstrated in new randomized studies. As a last resort, pericardiectomy has been proposed especially by US experts from the Mayo Clinic, but such an intervention is controversial and is not recommended by all pericardial experts. Moreover, as pointed out, some patients may still have recurrent chest pain and symptoms after the surgery. Last but not least, pericardiectomy is a long procedure and requires the involvement of a skilled cardiac surgery team.

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Is Cocaine-associated Acute Myocardial Infarction the Same as Myocardial Infarction Associated With Recent Cocaine Consumption?



¿Los trastornos por cocaína asociados al infarto agudo de miocardio son lo mismo que el infarto de miocardio asociado al consumo reciente de cocaína?

To the Editor,

We read with great interest the article published recently by Gili et al,¹ who studied the relationship between cocaine use disorder and the incidence and outcome of acute myocardial infarction by analyzing the Minimum Basic Data Set (MBDS) of 87 hospitals in Spain. The study concluded that cocaine use disorders increased the risk of myocardial infarction 3-fold, thereby extending hospital stay and increasing costs.

As the authors themselves note, the study design could be limited by MBDS coding, which may underestimate the prevalence of cocaine use. If we compare the data with a prospective registry run by our group of consecutive patients younger than 50 years, admitted with acute coronary syndrome, who underwent a structured interview on their history of chronic cocaine use and a cocaine metabolites urine test, the prevalence of cocaine use was 11.7% and recent use as demonstrated by the urine test results was 5.2%.² These figures are much higher than those reported by Gili et al¹ and are in line with other studies that systematically measured metabolites in urine.³ We should also

remember that large biases may be present in the way patients with chest pain are questioned about cocaine use in clinical practice. In 44% of patients, the physician taking the medical history does not ask about cocaine, with obvious differences according to the individual's sociodemographic profile.⁴ Likewise, patients themselves are also a source of bias as a nonnegligible proportion do not admit to cocaine use even after a positive urine test result.^{2,3}

In cases of acute myocardial infarction, recent cocaine use is an important prognostic factor in young patients, as it increases the complications of the acute myocardial infarction itself,⁵ as well as in-hospital mortality.² In view of the importance of cocaine use as a prognostic factor and the difficulty of detecting such use in the initial contact, the European guideline on acute coronary syndrome recommends specific questions about cocaine use as part of the medical history and systematic measurement of cocaine metabolites in urine as part of the work-up.⁶

Assessment of the extent of cocaine use and myocardial infarction through the MBDS may be an interesting initial approach. However, we wonder whether the authors think that the prevalence of myocardial infarction associated with recent cocaine use may be underestimated, given the differences in the detection of cocaine use among studies. Could this underestimation and the greater age of patients with myocardial infarction at inclusion also have led to an underestimation of the prognostic effect of recent cocaine use on acute myocardial infarction? From our standpoint, we think it is important to differentiate between