

literature, but then to perform a small validation study before adopting a new technique with confidence.

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Therapy of Recurrent Pericarditis

We read with interest the paper by Raatikka et al. (1) that gives us a useful piece of information regarding pericarditis in children. The data are relevant, particularly regarding the good long-term outcome, with no instance of constriction, in agreement with our experience in adults. We would like to comment on some statements regarding therapy. The authors in fact conclude that corticosteroids, methotrexate, azathioprine, cyclosporine, and colchicine did not prevent recurrences. Should we conclude that no drug is effective, so that no drug should be employed? We have published case reports describing different experiences. A 14.5-year-old boy (2) previously treated with high-dose steroids, intravenous immunoglobulin, and indomethacin experienced an excellent response when colchicine 1 mg was added, while slowly tapering steroids and continuing indomethacin. In another 12-year-old boy (3) who did not respond well to nonsteroidal anti-inflammatory drugs (NSAIDs) and prednisone, the introduction of colchicine proved beneficial; thereafter, the patient presented with six relapses, each occurring 1 to 4 weeks after the discontinuation of colchicine on his own initiative. The excellent study by Raatikka et al. (1), in our opinion, was not designed to assess the problem of therapy, with the interactions between different drugs, dosages, and combinations: we have to wait for more definitive studies specifically addressing therapy. Moreover, we have to evaluate if efficacy of a drug means that it must work after discontinuing all the previous therapies (e.g., to stop steroids and NSAIDs and add de novo colchicine) or, probably more wisely, if a drug's efficacy means that it works when added to a previous active therapy (e.g., to add colchicine to steroids and NSAIDs).

In the meantime, even if it will be proved true that recurrent pericarditis has a chronic course irrespective of the therapy given, and that the activity of the disease gradually “burns out” spontaneously, it remains necessary to use some drugs, the less toxic ones, during the acute phases. In our opinion, this is best accomplished

with a multidrug therapy including: 1) a very slow tapering of steroids (months), similar to what is often done in many rheumatologic conditions; 2) NSAIDs used at the recommended dosages; and 3) introduction of colchicine, if tolerated. In our experience, this therapy greatly ameliorates the quality of life of these patients, and possibly may reduce the number of recurrences. We acknowledge that it will be difficult to formally prove the efficacy of this therapy in the framework of a randomized, controlled trial.

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REPLY

We appreciate the interest of Dr. Brucato and his colleagues in our study on recurrent pericarditis in children and adolescents (1). We agree that the treatment of this condition is often problematic and frustrating. The goals of the therapy are to control the pain, to prevent tamponade, and to stop recurrences. In our series, threatening tamponade was not encountered after first attacks and pericardial effusion diminished in later relapses irrespective of the given therapy. Thus, the control of pain remains the main task in therapy during a recurrence of the disease. This is possible in most cases with nonsteroidal anti-inflammatory drugs (NSAIDs) in sufficient doses, added with other pain killers if needed. Even recurrences with high C-reactive protein values usually settle down with such treatment within 7 to 10 days. It is tempting to use corticosteroids as they are very effective in suppressing the pain and in relieving the pericardial effusion. However, in our patients steroid treatment tended to increase the number of relapses. Further, the well-known side effects of corticosteroids are especially undesirable in growing children and adolescents. Therefore, we would spare the corticosteroid treatment for the most severe cases only.

Colchicine treatment for preventing relapses has raised considerable expectations because of the good results published by Adler et al. (2). Sadly, this treatment failed to prevent recurrences in all four of our patients in whom colchicine was added to corticosteroid treatment. One possible reason for the contradicting results may lie in the different genetic characteristics of the study