Cardiac Sarcoidosis Treatment Revisited

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To the Editor We read the article about the effects of treatment with low doses of corticosteroids (CS) and methotrexate (MTX) in cardiac sarcoidosis with great interest (1). However, in our opinion, there are several weaknesses of the study in respect to the proper diagnosis, comparability of the groups and interpretation of the results.

The presented data include a very small group of patients, but only in 9 (53%) cases were the granulomas confirmed by a biopsy, and thus suggesting sarcoidosis. Therefore, the other 8 patients included in the study (without biopsy-proven sarcoidosis) should not be considered as meeting the criteria indicated in point 2 of the used guidelines (2). Moreover, based on the performed tests, it is difficult to assess the true nature of the heart lesions as PET imaging (highly sensitive for active lesions) was positive in only 6 of 17 patients. Furthermore, especially as the average age of patients was close to 70 years, co-existence of other disease, particularly ischemic heart disease, cannot be excluded (the authors mentioned that patients had comorbidities like diabetes mellitus, hypertension and hyperlipidemia which required treatment). This additionally may affect the measured outcome indices. Namely, there is serious doubt as to the accuracy of the diagnosis and the activity of disease.

The authors did not clearly indicate how the specific treatment was chosen for each patient (was it randomly or for other reasons?). Furthermore, the comparability of the groups is also questionable, e.g., Table 1 indicates that patients in the “CS only” group had an FEV1 half that seen in the “CS+MTX” group (without statistical significance?) with comparable FVC suggesting airway obstruction, which is a well-recognized independent risk factor for progressive heart failure (3). The number of comorbid conditions seems to be too laconic and nonsufficient as clinical characteristics.

Regarding the results and interpretation: the authors analyzed only the differences in the outcome indices (including the left ventricular ejection fraction) between the groups at specific time points. They found significance after 3 years, which in fact was a result of a transient increase from the baseline in the “CS+MTX” group (with 7% fall over 2 years) compared with an approx. 7% fall over 5 years in the “CS only” group. It is rather difficult to call this “long term stabilization.”

There was also a slight increase in the cardio-thoracic ratio (CTR) associated with an increase of the NT-proBNP. In light of the poorly documented diagnosis and possibility of other confounders, these findings should not be attributed directly to the treatment method. Therefore, the conclusion about the superiority of treatment with a combination of low doses of CS and MTX over the “classical” treatment with CS is therefore considered to be premature and poorly documented.

The authors state that they have no Conflict of Interest (COI).

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References