11/March/22

GenesisCare

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11 March 2022

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Dr Louise McCormack
Arthritis Care
24 Railway Terrace
DUTTON PARK QLD 4102

Dear Louise

Re: **Julian TUBMAN DOB 28/02/1997**
2505/1918 Creek Road, CANNON HILL 4170
Telephone: 0426 280 297

Background:

1. Persistent pericardial effusion (since November 2022) likely sequelae of pericarditis post-Moderna COVID-19 vaccine
   - Probable myocarditis March 2022
2. Raynaud's disease
3. Osteoporosis

Medications:

- Prednisone 10 mg daily
  - Started at 25 mg daily 12/01/2022, dropping dose by 2.5 mg each week, until recurrence of symptoms occurred Feb 2022 when dose decreased from 10 mg to 7.5 mg daily
- Colchicine 500 mcg bd
- Ibuprofen 400 mg tds (reinitiated this week)
- Actonel 35 mg weekly

Thank you for seeing Julian further assessment and for assistance in managing what initially was a persistent pericardial effusion, which likely arose post-pericarditis following the Moderna COVID-19 vaccine. He now has manifestations consistent with myocarditis and I would be grateful for your help in consideration of steroid-sparing agents, given his concomitant history or osteoporosis.

Julian received his first dose of the Moderna COVID-19 vaccine on 29/10/2021. He developed central chest discomfort and dyspnoea leading to a hospital presentation where he was commenced colchicine empirically along with ibuprofen starting at 600 mg tds, following ECG changes consistent with pericarditis. Troponin levels at that point were negative.

I first saw him on 12/11/2021 when echocardiogram revealed the presence of a small circumferential pericardial effusion with no haemodynamic compromise. The rest of the echocardiogram was unremarkable with no evidence of a myocarditis. We decided to persist with colchicine and ibuprofen but he had increasing symptoms over the following fortnight.

Given his history of Raynaud's disease, we proceeded to have an autoimmune screen, the full results of which should be available via the Sullivan Nicolaides portal. This included a normal CRP, ESR, ANA, ENA and ANCA. Rheumatoid factor was undetectable.

He came back for follow up in early January with a slight increase in the size of his pericardial effusion even though his symptoms had been stable. At that point, I decided to start him on corticosteroids, as I was worried about the

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non-resolving effusion and the risk of constrictive pericarditis in the long term. Given his history of osteoporosis, he also consulted Dr Peter Ebeling in Victoria who he has previously seen and he commenced Actonel weekly.

His symptoms improved on the prednisone but recurred when the dose was dropped from 10 mg daily to 7.5 mg daily. A repeat echocardiogram on 8/3/2022 showed a persisting pericardial effusion, unchanged in size, with cardiac function remaining normal. The pericardial effusion remains too small to be drained or tapped at this stage.

A repeat set of blood tests on 9/3/2022 showed a troponin elevation at 97 ng/L, though the inflammatory markers remained within normal limits.

I am repeating a cardiac MRI, as one performed in December 2021 was equivocal. I have reinitiated NSAIDS and advised Julian to reescalate the prednisone dose to 10 mg daily, while continuing colchicine.

I would appreciate your input as I am concerned this could be a manifestation of a broader serositis or autoimmune condition, with small pleural effusions also incidentally seen on the cardiac MRI in December, with all this unmasked rather than caused by the vaccine. It will also be beneficial to reduce his dependence on corticosteroids down the line.

As he has recently lost his job as a result of the events above and is only due to start a new one in the coming month, I would be grateful if you could bulk-bill his consultation in the short term. I look forward to your assessment of Julian.

With kind regards

Electronically Signed

Dr Ben Ng
Cardiologist and Cardiac Electrophysiologist
GenesisCare Cardiology