Immunoglobulin G4-related disease (IgG4-RD) is a recently recognized systemic fibroinflammatory disease associated with elevated serum level of IgG4. It was initially described as autoimmune pancreatitis; however, in recent years, there have been reports describing a broadening spectrum of organ involvements. We report a case of IgG4-RD manifesting as constrictive pericarditis.

Case Presentation
A 76-year-old former smoker was admitted to an outside hospital with a 2-year history of progressive exertional dyspnea and lower extremity edema. Initial evaluation revealed the presence of bilateral pleural effusions and ascites. He was diagnosed with congestive heart failure. He was treated with diuretics and an afterload-reducing agent. Subsequent hemodynamic cardiac catheterization revealed findings suggestive of constrictive physiology (Figure 1). Despite aggressive management that included multiple paracenteses and thoracenteses, his overall clinical status did not improve. He was referred to our clinic for further evaluation.

Physical examination was notable for blood pressure of 86/64 mm Hg, hepatojugular reflux, a distended abdomen with shifting dullness, and prominent pitting edema in the lower extremities. Heart sounds were unremarkable; however, the lung examination was notable for dullness to percussion over both bases. Chest radiography showed bilateral pleural effusions with a normal heart size. Echocardiography and subsequent cardiac MRI demonstrated abnormal findings consistent with constrictive pericarditis (online-only Data Supplemental Videos I and II). Laboratory data included normal complete blood count and electrolytes with polyclonal hypergammaglobulinemia. During subsequent pericardectomy, a circumferentially thickened (approximately 2.5 mm) pericardium was noted. Sections of the resected pericardium revealed diffuse fibrous thickening and patchy lymphoplasmacytic infiltration (Figure 2). Immunostaining demonstrated an increased absolute count of IgG4-positive cells (33 per high-power field on average, counted from 3 hot spots) and the ratio of IgG4/IgG-positive cells at 34% (Figure 3). The specimen was negative on microbial cultures and the diagnosis of IgG4-RD was made. Postoperatively, his symptoms improved significantly and he did not require a corticosteroid therapy. There was no evidence of recurrence or other manifestations attributable to IgG4-RD over the next 2 years.

Discussion
IgG4-RD is a newly recognized systemic fibroinflammatory disease that can affect various organs such as the pancreas, biliary system, salivary glands, periorbital tissues, kidneys, lungs, pleura, lymph nodes, meninges, breast, prostate, thyroid gland, and skin. Very little is known regarding possible cardiovascular manifestations of IgG4-RD; a few cases of...
aortitis and a case of pericarditis have been reported in the literature. Our patient presented with findings suggestive of constrictive pericarditis without other organ manifestations such as autoimmune pancreatitis. Patients with IgG4-RD typically have high serum IgG4 levels and polyclonal hypergammaglobulinemia. The clinical presentation of IgG4-RD varies widely and depends on the organs affected. Radiological changes in any affected organs can mimic neoplasms, infections, or other inflammatory disorders and its differentiation can be difficult through radiological findings alone. Characteristic histopathologic features include abundant IgG4-positive lymphoplasmacytic infiltration, fibrosis, and obliterative phlebitis or arteritis. Men are approximately 3 times more frequently affected than women with the median age at diagnosis being approximately 60 years. IgG4-RD is a corticosteroid-responsive disorder, and favorable response is usually observed in 2 to 4 weeks of prednisone therapy, 0.6 mg/kg per day, followed by gradual dose reduction during the following months. Immunosuppressive agents have been used in corticosteroid-refractory disease; however, the data on their efficacy are limited.

Conclusions
IgG4-RD can present with constrictive pericarditis. Cardiovascular manifestations of IgG4-RD have not been adequately explored and this case suggests that other patients with cardiovascular involvement with IgG4-RD have gone unrecognized. Increased awareness of IgG4-RD and measurement of serum IgG4 levels may facilitate diagnosis and minimize morbidity associated with this disease as well as unnecessary diagnostic procedures.

Disclosures
None.

References

Key Words: heart failure  inflammation  pericarditis  pericardium
Constrictive Pericarditis Caused by Immunoglobulin G4-Related Disease
Hiroshi Sekiguchi, Ryohei Horie, Rakesh M. Surí, Eunhee S. Yi and Jay H. Ryu

Circ Heart Fail. 2012;5:e30-e31
doi: 10.1161/CIRCHEARTFAILURE.111.966408
Circulation: Heart Failure is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2012 American Heart Association, Inc. All rights reserved.
Print ISSN: 1941-3289. Online ISSN: 1941-3297

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circheartfailure.ahajournals.org/content/5/2/e30

Data Supplement (unedited) at:
http://circheartfailure.ahajournals.org/content/suppl/2012/03/21/5.2.e30.DC1

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation: Heart Failure can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation: Heart Failure is online at:
http://circheartfailure.ahajournals.org/subscriptions/
Supplemental Material

Video 1: Breath-held 4 chamber cine balanced steady state free precession magnetic resonance image demonstrates abnormal diastolic septal "bounce" characteristic of constriction.

Video 2: Free-breathing ungated steady state free precession magnetic resonance image demonstrates increased right-to-left shift of the interventricular septum with inspiration. The images are slightly oblique from short axis. When the diaphragm moves down, increased systemic venous return and decreased pulmonary venous pressures cause increased filling of the right ventricle at the expense of the left ventricle and resultant shift in the position of the interventricular septum.