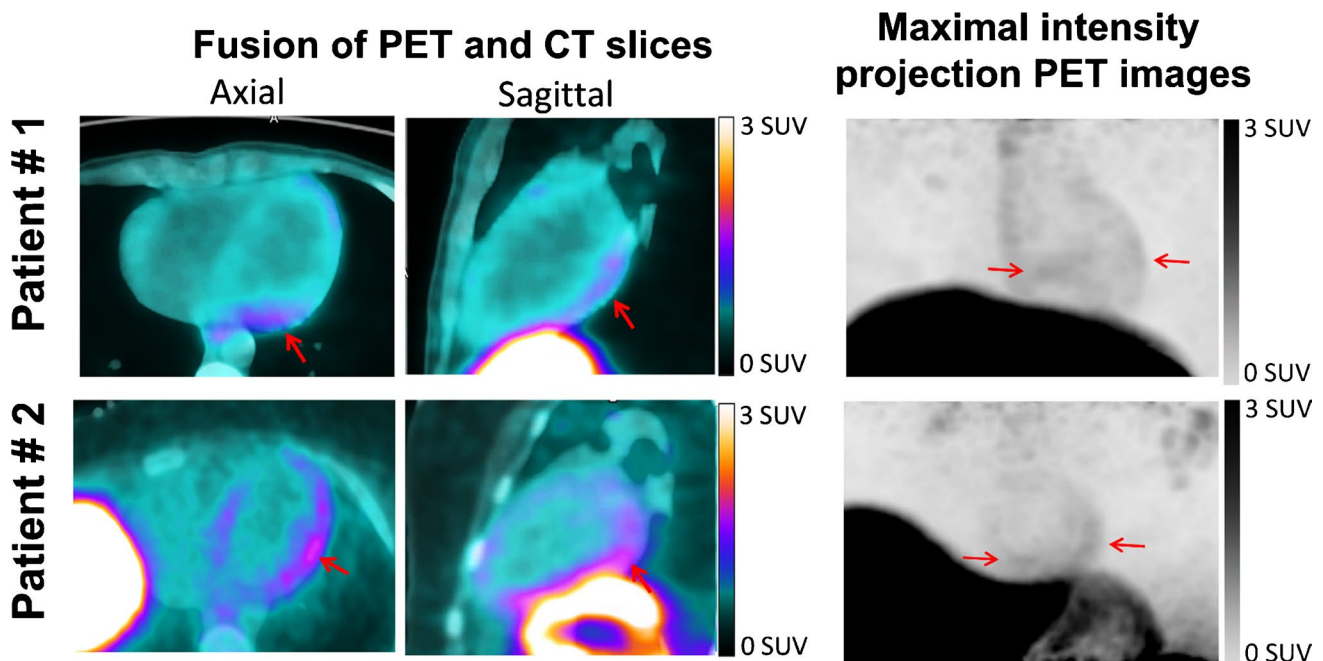




^{68}Ga -DOTATOC digital-PET imaging of inflammatory cell infiltrates in myocarditis following COVID-19 vaccination

Caroline Boursier¹ · Elodie Chevalier¹ · Laura Filippetti² · Laetitia Imbert^{1,3} · Veronique Roch¹ · Olivier Huttin^{2,4} · Marine Claudin¹ · Pierre-Yves Marie^{1,4}

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✉ Caroline Boursier
c.boursier@chru-nancy.fr

- 1 Department of Nuclear Medicine and Nancyclotep Imaging Platform, CHRU-Nancy Brabois, Université de Lorraine, Allée du Morvan, 54000 Vandoeuvre-lès-Nancy, France
- 2 Department of Cardiology, CHRU-Nancy, 54000 Nancy, France
- 3 IADI, INSERM, UMR 1254, Université de Lorraine, 54000 Nancy, France
- 4 INSERM, UMR 1116, Université de Lorraine, 54000 Nancy, France

Acute myocarditis was recently reported after mRNA COVID-19 vaccination. Here we present images from two male (18 and 21 years old) patients that were recorded with a digital-PET/CT system (Vereos, Philips) 1 h after the injection of 2 MBq/kg of ^{68}Ga -DOTATOC, as part of an ongoing clinical study (NCT03347760 on ClinicalTrials.gov). Both patients experienced myocarditis 2 to 3 days after the second dose of an mRNA COVID-19 vaccine (Moderna and Pfizer, respectively) and fulfilled the cardiovascular magnetic resonance 2018 Lake Louise criteria for myocarditis, associated with increased plasma troponin (peak troponin: 771 ng/L and 10 830 ng/L) but normal plasma fibrinogen. Plasma C-reactive protein was increased in the 21-year-old patient (41 mg/L).

The DOTATOC-PET images, recorded at 1 to 3 days from peak troponin, showed an increase in myocardial uptake relative to blood activity, predominantly in the lateral and inferior walls (red arrows) and which are even better depicted on the gated-PET cine-loops in the [online supplement](#). Myocardial/blood SUVmax ratio was > 2.2 in both cases and, thus, higher than what we commonly observe in non-myocarditis patients. This likely reflects a myocardial infiltrate of inflammatory cells overexpressing somatostatin receptors (lymphocytes, macrophages, activated monocytes) [1–4], presumably within specific antigenic sites.

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Data availability All data are available on request.

Declarations

Informed consent A written informed consent for the procedure and for the publication of images was obtained from all participants.

Conflict of interest The authors declare no competing interests.

References

1. Lichtenauer-Kaligis EG, Dalm VA, Oomen SP, Mooij DM, van Hagen PM, Lamberts SW, et al. Differential expression of somatostatin receptor subtypes in human peripheral blood mononuclear cell subsets. *Eur J Endocrinol.* 2004;150(4):565–77.
2. Lapa C, Reiter T, Li X, Werner RA, Samnick S, Jahns R, et al. Imaging of myocardial inflammation with somatostatin receptor based PET/CT - a comparison to cardiac MRI. *Int J Cardiol.* 2015;194:44–9.
3. Pizarro C, Kluncker F, Dabir D, Thomas D, Gaertner FC, Essler M, et al. Cardiovascular magnetic resonance imaging and clinical performance of somatostatin receptor positron emission tomography in cardiac sarcoidosis. *ESC Heart Fail.* 2018;5:249–61.
4. Amini A, Dehdar F, Jafari E, Gholamrezanezhad A, Assadi M. Somatostatin receptor scintigraphy in a patient with myocarditis. *Mol Imaging Radionucl Ther.* 2021;30:50–3.

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