ACVC
Association for
Acute CardioVascular Care

Edition 2025

CLINICAL DECISION MAKING TOOLKIT

Instant guidance for diagnosis, risk stratification and management

ESC
European Society
of Cardiology

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Acute CardioVascular Care

The Clinical Decision Making Toolkit

is produced by the Association for Acute CardioVascular Care (ACVC) of the European Society of Cardiology (ESC).

This toolkit is supported by Boston Scientific and Inari Medical in the form of an unrestricted financial support. The scientific programme has not been influenced in any way by its sponsor.

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Clinical Decision-Making TOOLKIT

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ISBN: 978-2-9537898-7-4

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ACUTE MYOCARDIAL AND PERICARDIAL SYNDROMES

CHAPTER 8.1
ACUTE MYOCARDITIS

A. Keren, ALP. Caforio

General Assessment of Inflammatory Myopericardial syndrome (IMPS).

Definitions

· The term IMPS was introduced in the recently published ESC guidelines for the management of myocarditis and pericarditis (1). It serves as an umbrella term during the initial diagnostic process until a final diagnosis of myocarditis, pericarditis, or a combination of both is established (Figures on pages 7&8).

· Acute myocarditis and/or pericarditis are defined as inflammatory processes of <4 weeks' duration, triggered by infectious agents (e.g. viruses), or by non-infectious immune-mediated, autoimmune responses, or toxic exposure.

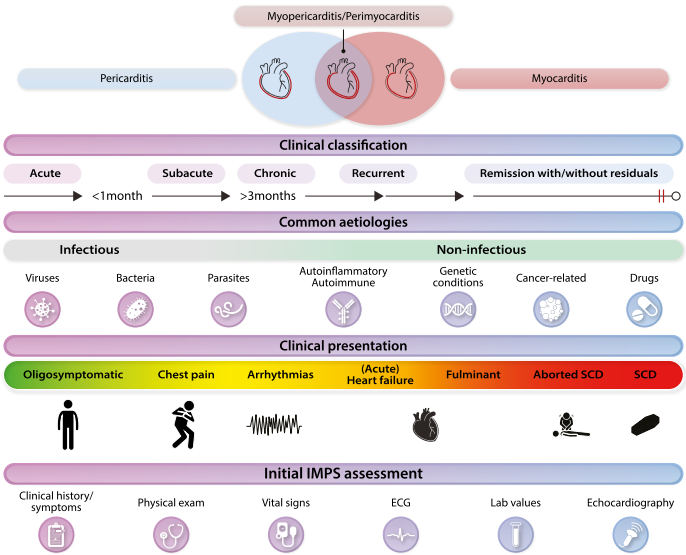
- **General assessment** in myocarditis or in pericarditis has to focus on careful history for triggers (like viral infections, exposure to dugs and toxins), recurrent episodes, history of autoimmune disease, family history, abnormalities in examination and in laboratory findings.
- The differential diagnosis requires exclusion of obstructive coronary artery disease / acute coronary syndrome (Page 7 & 8).

Importance of family history and recommendations for genetic evaluation

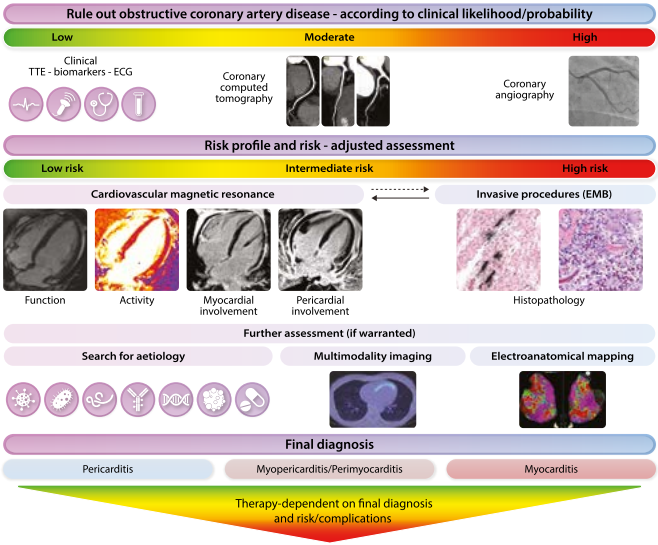
- It is recommended to get a family history and to include pedigrees in cases with recurrent myocarditis or pericarditis.
- Genetic testing should be considered in those with recurrent IMPS, definite familial myocarditis or pericarditis, and in myocarditis cases with family history of inherited cardiomyopathy, severe arrhythmic presentation, relapse or persistent troponin elevation, significant & extensive LGE (e.g. ring-like LGE pattern).

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041

Inflammatory myopericardial syndrome



Inflammatory myopericardial syndrome (Cont.)



Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Figure 1

Basic assessment of suspected IMPS

Basic assessment:

- History: potential causes and triggers (viral infection of upper respiratory or gastrointestinal tract, toxins, drug use, medications), recurrent symptoms, family history of IMPS/cardiomyopathy/SCD, and systemic inflammatory/autoimmune diseases
- Physical examination: assess clinical stability, symptoms (chest pain, HF symptoms, palpitations, syncope), malaise, general weakness and fatigue, pericardial friction rub, clinical symptoms/signs of CTP
- ECG: PR-segment depression, ST/T-wave changes, AVB, and ventricular arrhythmias
- Chest X-ray
- Basic laboratory data:
- Markers of myocardial lesion (e.g. hs-TnT/TnI)
- Markers of systemic inflammation (e.g. CRP, ESR, WBC count)
- Markers of heart failure (e.g. NT-proBNP)
- Complete blood count (including eosinophilic count)
- Renal function and electrolytes (e.g. sodium, potassium, creatinine)
- Thyroid function (e.g. TSH)
- Hepatic function and additional testing (e.g. lactate dehydrogenase, aspartate aminotransferase, alanine aminotransferase)
- Echocardiography including strain imaging

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Table 9

Advanced assessment of suspected IMPS

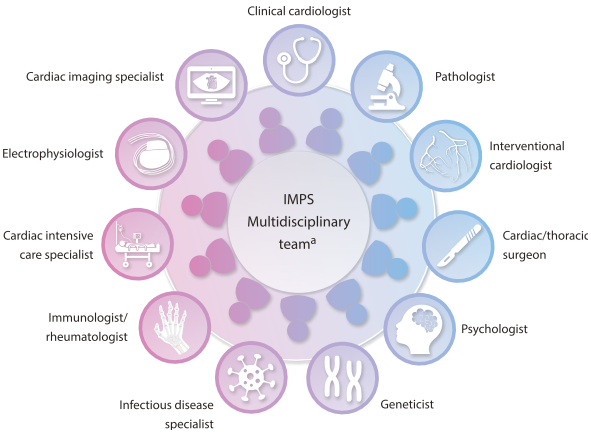
Advanced assessment after admission:

- Coronary anatomy evaluation (if needed for differential diagnosis by invasive coronary angiography or coronary CT depending on the clinical likelihood of ACS
- CMR to assess signs of myocardial and pericardial inflammation and/or fibrosis
- Arrhythmia screening depending on risk stratification (e.g. Holter-ECG)
- Additional laboratory parameters guided by clinical suspicion (e.g. if therapeutic consequences are expected)
- Dedicated genetic testing if indicated (See recommendations)
- CT to assess concomitant pleuropulmonary diseases
- **Specific for Myocarditis:** EMB in high-risk and in intermediate-risk cases to detect specific histology and aetiology and to provide EMB-guided immunosuppressive therapy in non-infectious autoimmune biopsy-proven myocarditis
- **Specific for Pericarditis:** Diagnostic pericardiocentesis when indicated

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, table 9

Multidisciplinary teams for inflammatory myopericardial syndrome.

High-risk cases of inflammatory myopericardial syndrome have to be transferred to specialized centers where a multidisciplinary team can provide tailored management for the specific case.



Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, figure 20

Follow up of IMPS after hospital discharge

		Within 1 month	Within 3–6 months	12 months	>1 year and long-term FU[a]
Clinical evaluation and ECG	Myocarditis	X	X	X	X
	Pericarditis	X	X	X	X
Biomarkers (TnI, C-reactive protein)	Myocarditis	X	X	(X)	(X)
	Pericarditis	X	X	(X)	(X)
Rhythm (stress and/or Holter-ECG)	Myocarditis	–	X	(X)	(X)
	Pericarditis	–	–	–	–
Imaging myocarditis	TTE	X[b]		X[c]	X[c]
	CMR	X[b]		X[c]	X[c]
Imaging pericarditis	TTE	X[b]		X[c]	X
	CMR	(X)[b]		(X)[d]	(X)[d]

Restriction of physical exercise, for at least 1 month is recommended, using an individualized approach

All follow-ups should be adapted to the clinical situation and severity. In round brackets, optional testing according to clinical presentation [(X), case-by-case decision].

[a]A long-term FU, e.g. after 2 years, is suggested only for complicated cases of IMPS, usually myocarditis.

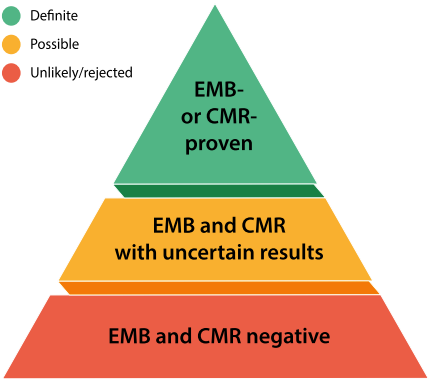
[b]In complicated cases or if abnormal at 1 month, imaging should be repeated between 3 and 6 months.

[c]If abnormal at 6 months, imaging should be repeated within the next 6 months and/or in the next 12 months.

[d]Follow-up proposed for uncomplicated cases of acute pericarditis. Long-term follow-up, tailored to the single patient, is recommended for high-risk cases

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Table 15

Diagnosis of ACUTE MYOCARDITIS & General Principles of Management



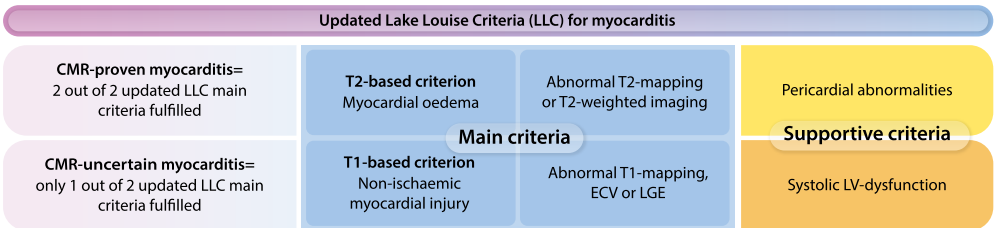
The diagnosis of "Definite" acute myocarditis is recommended to be reached by cardiac magnetic resonance (CMR) in stable, low risk patients and by endomyocardial biopsy in intermediate or high risk patients (see pages 18-20).

However, CMR and EMB provide different information:

- CMR provides noninvasive tissue characterization of inflammation for clinical diagnosis.
- EMB is the only diagnostic tool to identify the histological type (i.e lymphocytic, or non lymphocytic, such as giant cell or eosinophilic), and etiology (infectious or non infectious autoimmune/immune mediated), and to allow EMB-guided etiology-directed therapies, such as tailored immunosuppression in non-infectious autoimmune myocarditis.

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Figure 2

Diagnosis of ACUTE MYOCARDITIS & General Principles of Management (Cont.)



Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Figure 4

Diagnostic criteria and classification

Diagnostic criteria and categories for diagnosis of acute myocarditis	
Definite	• Clinical presentation and CMR- or EMB-proven
Possible	• Clinical presentation with at least 1 additional criterion • MR- or EMB-uncertain or not available
Unlikely/Rejected	• Only clinical presentation without additional criteria
Additional criteria beyond clinical presentations	
ECG	• ST-T changes
Biomarkers	• Troponin elevation
Imaging* *See section 5.4-5.8 of the guidelines for detailed description of imaging findings	• Abnormal strain, wall motion, reduced EF (ECHO) • Myocardial oedema and/or LGE (CMR)

Clinical presentations

- **Chest pain** (most frequent)
- **Arrhythmias/Conduction disturbances/Syncope**
- **Heart Failure/** Heart Failure with haemodynamic instability (Fulminant)
- **Sudden cardiac death** (Aborted)

Initial assessment includes history and laboratory tests (Pages 9&10).

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, table 4

Clinical and diagnostic features leading to the clinical diagnosis of myocarditis

- Recent or concomitant flu-like syndrome or gastroenteritis
- Infarct-like chest pain
- Palpitations
- HF symptoms
- ECG changes
- Ventricular arrhythmias (isolated, complex)
- Syncope
- Haemodynamic instability
- Elevated markers of myocardial lesion (hs-Tn, CK-MB elevation)
- Elevated inflammatory markers (ESR/CRP/White blood cell count)
- Elevated markers of HF (NT-proBNP)
- Abnormal wall motion, increased wall thickness and/or impaired systolic function on echocardiographic imaging
- Abnormal CMR imaging with myocardial oedema and/or LGE by the updated Lake Louise criteria

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Table 6

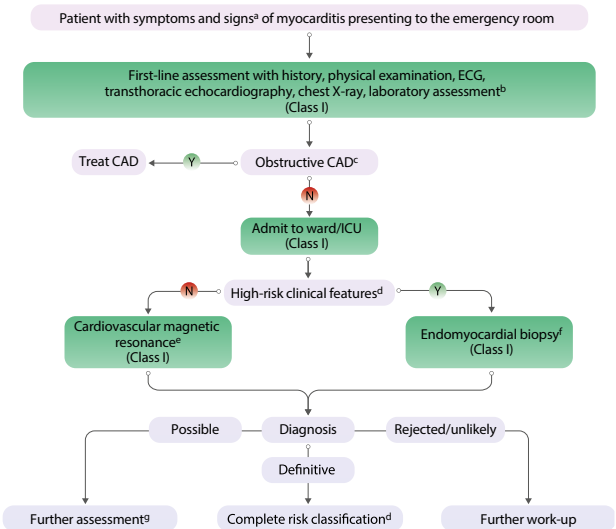
Clinical risk stratification to guide work up and initial management

Risk	High risk	Intermediate risk	Low risk
Myocarditis	• Acute HF/cardiogenic shock • Dyspnoea NYHA III–IV refractory to medical therapy • Cardiac arrest/syncope[a] • Ventricular fibrillation/sustained ventricular tachycardia[a] • High-level AV block[a]	• New/progressive dyspnoea • Non-sustained ventricular arrhythmias • Persistent release or relapsing troponin	Stable symptoms or oligosymptomatic
	Imaging criteria:	**Imaging criteria:**	**Imaging criteria:**
	• Newly reduced LVEF (<40%)[a] • Extensive LGE on CMR[a]	• Newly mildly reduced LVEF (41%–49%) and/or WMA • Preserved LVEF (≥50%) and LGE ≥2 segments on CMR	• Preserved LVEF (≥50%) without LGE or limited LGE (<2 segments) on CMR

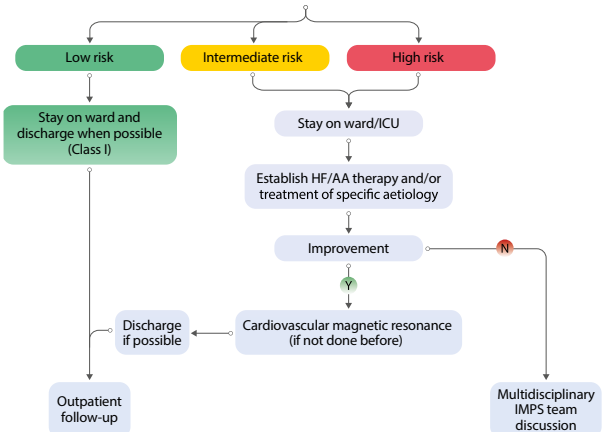
High risk patents should be transferred to specialised centers with availability of EMB, advanced mechanical support and multidisciplinary teams for administration of EMB-guided tailored specific therapy to each patient, in particular immunosuppression in biopsy-proven non infectious forms to suppress the autoimmune response.

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Table 7

Diagnostic algorithm and therapy initiation in ACUTE MYOCARDITIS



Diagnostic algorithm and therapy initiation in ACUTE MYOCARDITIS (Cont.)



Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Figure 5

Therapy for specific forms of myocarditis

Lymphocytic myocarditis (virus-negative)	
1st line therapy	Non-severe: prednisone 1 mg/kg/day p.o. then tapered Severe: i.v. methylprednisolone 7–14 mg/kg/day for 3 days, then 1 mg/kg/day p.o.
2nd line therapy	Oral corticosteroids + azathioprine[a] or mycophenolate mofetil[b], cyclosporine[c], methotrexate[d]
3rd line therapy	IVIG[e] or plasmapheresis[f]
Eosinophilic myocarditis	
1st line therapy	Same as lymphocytic myocarditis + Treat EM-associated condition if identified
2nd line therapy	Same as lymphocytic myocarditis + Treat EM-associated condition if identified
3rd line therapy	–
Giant-cell myocarditis	
1st line therapy	Non-severe: prednisone 1 mg/kg/day p.o. then tapered Severe: i.v. methylprednisolone 7–14 mg/kg/day for 3 days, then 1 mg/kg/day p.o. + immunosuppressive (azathioprine[a] or mycophenolate mofetil[b], cyclosporine[c])
2nd line therapy	Antithymocyte Globulin (ATG)[g] cyclophosphamide[h], rituximab[i]
3rd line therapy	–

Ref: 2025 ESC Guidelines for the management of myocarditis and pericarditis European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Table 12

Therapy for specific forms of myocarditis (Cont.)

Cardiac sarcoidosis	
1st line therapy	Non-severe: prednisone 1 mg/kg/day p.o., tapering from 40–60 mg daily Severe: i.v. methylprednisolone 7–14 mg/kg/day for 3 days, then 1 mg/kg/day p.o.
2nd line therapy	Methotrexate[d] (1st choice), or azathioprine[a] mycophenolate mofetil[b], cyclophosphamide[h]
3rd line therapy	Infliximab[j] or adalimumab[k], rituximab[i]
Lyme carditis	
1st line therapy	(a) Oral antibiotics (mild cases): – Doxycycline 100 mg b.i.d. (14–21 days) – Amoxicillin 500 mg t.i.d. (14–21 days) – Cefuroxime axetil 500 mg b.i.d. (14–21 days) (b) i.v. antibiotics (severe cases): – Ceftriaxone 2 g/day (14–21 days)
2nd line therapy	i.v. antibiotics: Cefotaxime (2 g q8h × 14–21 days) or Penicillin G (18–24 MU/day i.v. q4h × 14–21 day)
3rd line therapy	–
Chagas disease	
1st line therapy	Benznidazole 5–7 mg/kg/day in 2 doses for 60 days Nifurtimox 8–10 mg/kg/day in 3 doses for 60–90 days
2nd line therapy	–
3rd line therapy	

Ref: European Heart Journal, Volume 46, Issue 40, 21 October 2025, Pages 3952–4041, Table 12

Summary of Principles of Therapy of ACUTE MYOCARDITIS

- Supportive therapy and guidelines recommended management of heart failure, arrhythmias and etiology specific therapies are indicated
- NSAIDs (together with proton pump inhibition) should be considered in patients with associated pericarditis to reduce symptoms
- Beta blockers should be considered post-myocarditis at least for 6 months, particularly in those with troponin elevation, to control symptoms and prevent arrhythmias
- Anti-arrhythmic therapy should be considered post-myocarditis in those with recurrent , symptomatic VT to reduce the arrhythmic burden
- A wearable cardioverter – defibrillator (WCD) should be considered for 3-6 months in selected patients with sustained ventricular arrhythmia during the acute phase of myocarditis, as a bridge to recovery
- Corticosteroids should be considered in patients with fulminant, non-infectious forms of myocarditis to stabilise the patients
- Immunosuppressives/Corticosteroids are indicated in specific non infectious immune/autoimmune etiologies proven by EMB like lymphocytic, eosinophilic myocarditis, cardiac sarcoidosis, giant cell and immune checkpoint inhibitors related myocarditis .
- Specific antiviral treatments following identification of a pathogenic virus on EMB should be agreed upon with an infectious disease expert as part of the multidisciplinary team
- Etiology based therapies are indicated when specific etiologies are diagnosed by EMB

Follow up recommendations after hospital discharge

- Restriction of physical exercise, for at least 1 month is recommended, using an individualised approach
- It is recommended that all patients with definite myocarditis, to be followed with clinical assessment, biomarkers (troponin, CRP), ECG, exercise test, Holter-ECG monitoring, echocardiography, and CMR at least within 6 months after the index hospitalisation (Page 12)
- Long-term follow-up, e.g. for more than 2 years, is recommended for patients with complicated myocarditis during the acute phase or residua to identify a potential progression or new complications

CHAPTER 8.2

ACUTE PERICARDITIS AND CARDIAC TAMPONADE

A. Tycinska & F. Chacon-Lozan

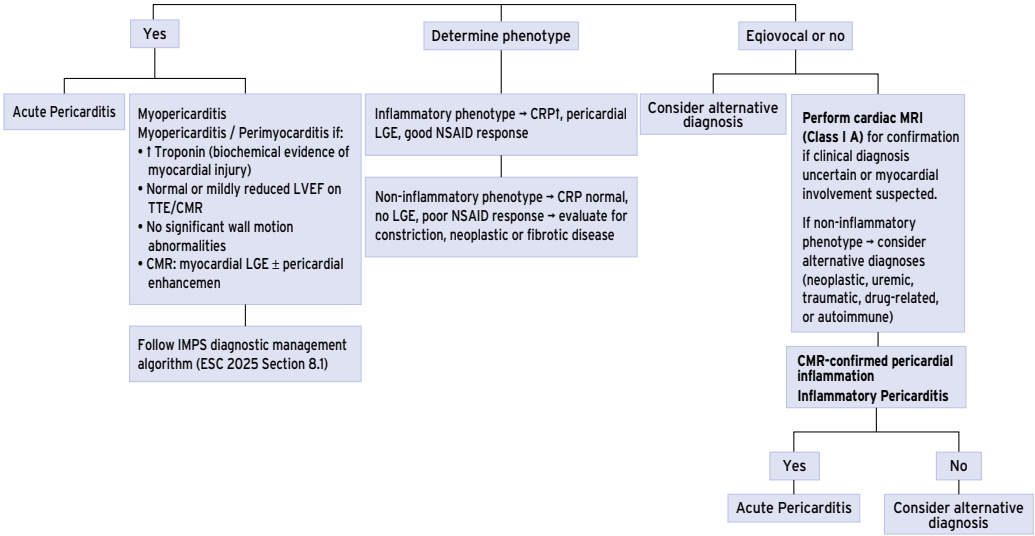
ACUTE PERICARDITIS:
Diagnostic Criteria and Phenotypic Classification

Diagnostic Criteria

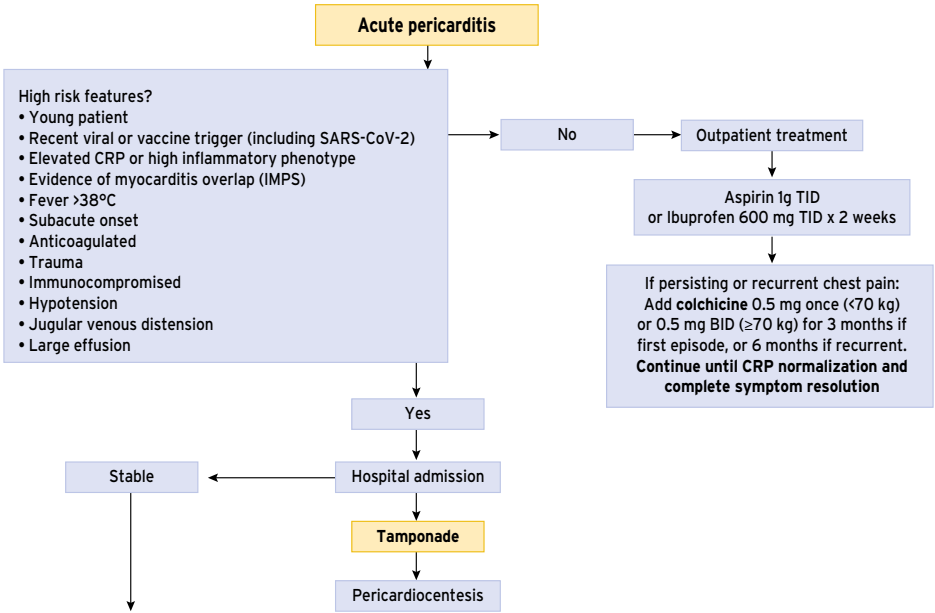
Definitive diagnosis requires ≥1 of the following:

- Recent flu-like syndrome or gastroenteritis.
- Pleuritic/infarct-like chest pain.
- Right HF symptoms and sings of constriction
- Fever
- Pericardial rubs
- C-Reactive protein elevation
- Pericardial/Pleural effusion
- Polyserositis
- CMR imaging with pericardial oedema and/or LGE

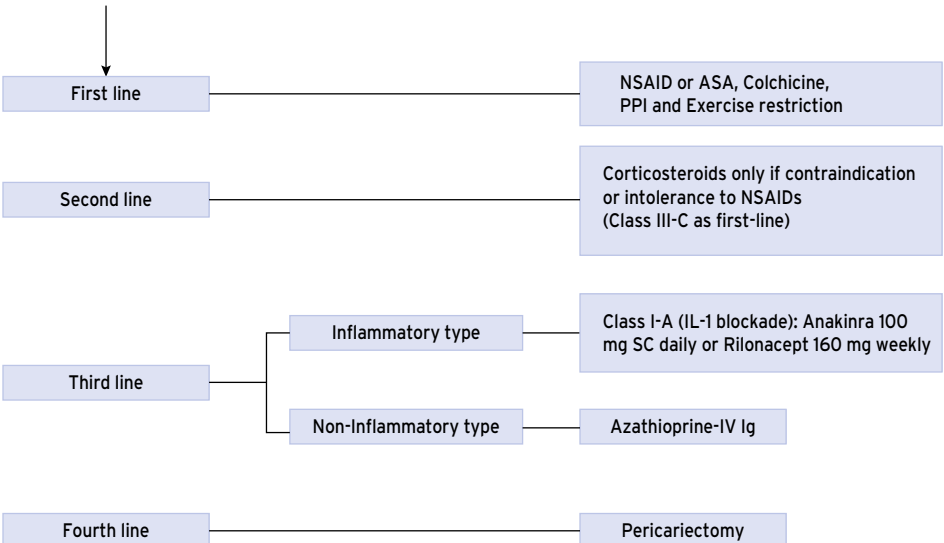
ACUTE PERICARDITIS:
Diagnostic Criteria and Phenotypic Classification (Cont.)



ACUTE PERICARDITIS: Management



ACUTE PERICARDITIS: Management (Cont.)



CARDIAC TAMPONADE: Diagnosis and management

Physical examination
- Distended neck veins
- Shock
- Pulsus paradoxus
- Muffled heart sounds

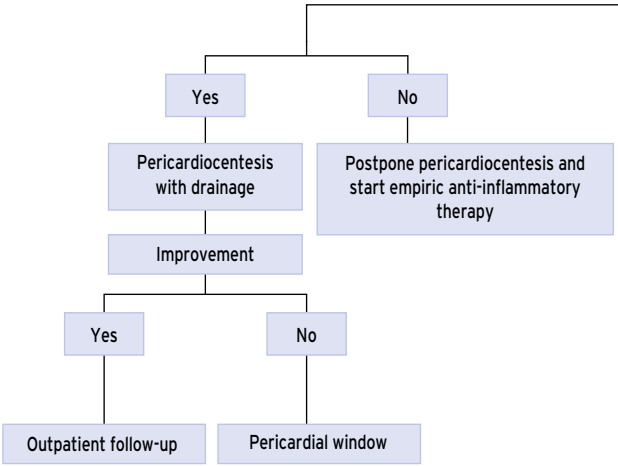
Yes? Proceed with echocardiography with respirometer

Presence of moderate to large pericardial effusion
Diastolic collapses of right atrium and right ventricle
Increased tricuspid and pulmonary flow velocities >50% with decreased mitral and aortic flow velocities >25% during inspiration?

Patient with definitive diagnosis of Cardiac Tamponade

High-risk features?
(with cumulative score >6)

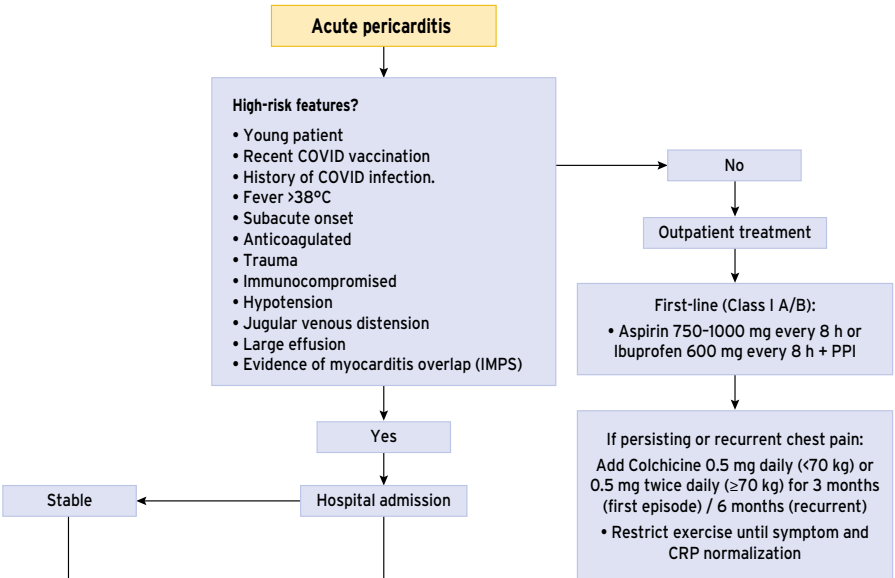
CARDIAC TAMPONADE: Diagnosis and management (Cont.)



CARDIAC TAMPONADE: Diagnosis and management (Cont.)

Criteria for triage for patients with pericardial effusion at risk of progression to cardiac tamponade					
Aetiology		**Clinical presentation**		**Imaging**	
Malignant disease	2	Dyspnoea/tachypnoea	1	Cardiomegaly on chest X-Ray	1
Tuberculosis	2	Orthopnoea	3	Electrical alternans on ECG	0,5
Recent radiotherapy	1	Hypotension (SBP<90Hgmm)	0,5	Microvoltage on ECG	1
Recent viral infection	1	Progressive sinus tachycardia	1	Circumferencial large PEff	3
Recurrent PEff	1	Oliguria	1	Moderate PEff	1
Chronic terminal renal failure	1	Pulsus paradoxus (>10Hgmm)	2	Small PEff	-1
Immunisupression	1	Pericardial chest pain	0,5	Right atrial collapse	1
Dysthiroidism	-1	Pericardial friction rub	0,5	IVC dilated not collapsible	1,5
Systemic autoimmune disease	-1	Rapid worsening of symptoms	2	Left atrial collapse	1,5
		Slow disease evolution	-1	Mitral/Tricuspidal resp. flow variations	2
				Swinging heart	1

COVID-related acute pericarditis: Management



COVID-related acute pericarditis: Management (Cont.)

First-line treatment (Class I A/B)
NSAID + Colchicine + PPI + Exercise restriction

- Aspirin 750–1000 mg q8h or Ibuprofen 600 mg q8h (Class I B)
- Add Colchicine 0.5 mg qd (<70 kg) or 0.5 mg BID (≥70 kg) for 3 months (Class I A)
- Restrict exercise until symptoms and CRP normalize

Monitor response (Class I A)

- Re-check CRP 2–4 weeks after initiation
- Repeat TTE if effusion present
- Consider CMR to confirm resolution or exclude myocardial involvement
- Extend Colchicine to 6 months if recurrent episodes

Tamponade?

Pericardiocentesis

Monitoring & Follow-up:

- Re-check CRP after 2–4 weeks (continue therapy until normalized)
- Consider CMR if diagnosis uncertain or persistent symptoms (Class I A)

P.34

Abbreviations

APTT = Activated partial thromboplastin time
AB = Airway and breathing
ABG = Arterial blood gas
AADs = Antiarrhythmic drugs
AAS = Acute aortic syndrome
ACEI = Angiotensin converting enzyme inhibitor
ACLS = Advanced cardiovascular life support
ACS = Acute coronary syndrome
ACT = Activated clotting time
AD = Aortic Dissection
AED = Automated external defibrillator
AF = Atrial fibrillation
ANA = Antinuclear antibodies
Ao = Aortic
aPTT = Activated partial thromboplastin time
ARB = Angiotensin receptor blockers
AS = Aortic stenosis
AV = Atrioventricular
AVB = Atrioventricular conduction block
AVN = Atrioventricular node
AVNRT = Atrioventricular nodal re-entrant tachycardia
AVNT = Atrioventricular nodal tachycardia
BID = Twice a day
BBB = Bundle branch block
BLS = Basic life support
BNP = Brain natriuretic peptide
BP = Blood pressure
CABG = Coronary artery bypass grafting
CAD = Coronary artery disease
Cath Lab = Catheterisation laboratory
CCB = Calcium channel blockers
CCU = Coronary care unit
CHF = Congestive heart failure
CMR = Cardiovascular magnetic resonance
COPD = Chronic obstructive pulmonary disease
CPAP = Continuous positive airway pressure
CPR = Cardiopulmonary resuscitation
Cr = Creatinine blood level (mg/dL)
CrCl = Creatinine clearance
CRP = C-reactive protein
CS = Cardiogenic shock
CSM = Carotid sinus massage
CSNRT = Corrected sinus node recovery time

Abbreviations (Cont.)

CSS = Carotid sinus syndrome
CT = Computed tomography
CT-angio = Computed tomography angiography
cTn = Cardiac troponin
CUS = Compression venous ultrasound
CV = Cardiovascular
CVA = Cerebrovascular accident
CXR = Chest X-ray
DAPT = Dual antiplatelet therapy
DD = Dyastolic dysfunction
DM = Diabetes mellitus
dTT = Diluted thrombin time
DVT = Deep vein thrombosis
ECG = Electrocardiogram
Echo = Echocardiogram
ECMO = Extracorporeal membrane oxygenation
ECT = Ecarin clotting time
ED = Emergency department
EF = Ejection fraction
EG = Electrograms
eGFR = Estimated glomerular filtration rate (ml/min/1.73 m^2)
EMB = Endomyocardial biopsy
EMS = Emergency medical services
EPS = Electrophysiological study
ERC = European Resuscitation Council
ESR = Erythrocyte sedimentation rate
ETT = Exercice treadmill testing
FFP = Fresh frozen plasma
FMC = First medical contact
FU = Follow-up
GER = Gastroesophageal reflux
GFR = Glomerular flow rate
GI = Gastrointestinal
GP = Glycoprotein
Hb = Haemoglobin
HF = Heart failure
HIT = Heparin-induced thrombocytopenia
HOCM = Hypertrophic obstructive cardiomyopathy
HTN = Hypertension
HR = Heart rate
hsTn = High-sensitive troponin
IABP = Intra-aortic balloon pump
ICC = Intensive cardiac care
ICCU = Intensive cardiac care unit

Abbreviations (Cont.)

ICD = Implantable cardioverter defibrillator
ICI = Immune checkpoint inhibitors
IHD = Ischemic heart disease
IMH = Intramural hematoma
IMPS = Inflammatory myopericardial syndrome
IRF = Immediate-release formulation
ISFC = International Society and Federation of Cardiology
i.o. = Intraosseous
IV = Invasive ventilation
i.v. = Intravenous
KD = Kidney disease
LBBB = Left bundle branch block
LD = Loading dose
LGE = Late gadolinium enhancement
LMWH = Low-molecular weight heparin
LOC = Loss of consciousness
LV = Left ventricular
LVAD/Bi-AD = left ventricular, bi-ventricular assist device
LVD = Left ventricular dysfunction
LVEF = Left ventricular ejection fraction
LVH = Left ventricular hypertrophy
LVSD = Left ventricular systolic dysfunction
MCS = Mechanical circulatory support
MD = Maintenance dose
MDCT = Computed tomography with >4 elements
MI = Myocardial infarction
MRA = Mineralocorticoid receptor antagonist
MRI = Magnetic resonance imaging
Mvo = Microvascular obstruction
NIV = Non-invasive ventilation
NOAC = New oral anticoagulants
NSAID = Non-steroidal anti-inflammatory drugs
NSVT = Non-sustained ventricular tachycardia or recurrent
NSTE-ACS = Non ST-segment elevation acute coronary syndrome
NSTEMI = Non ST-segment elevation myocardial infarction
NTG = Nitroglycerin
NT-proBNP = N-terminal pro brain natriuretic peptide
NVAF = Non-valvular atrial fibrillation
NYHA = New York Heart Association

Abbreviations (Cont.)

OH = Orthostatic hypotension
PAP = Pulmonary arterial pressure
PAU = Penetrating aortic ulcer
PCI = Percutaneous coronary intervention
PCM = Physical counter-measures
PCP = Pulmonary capillary pressure
PE = Pulmonary embolism
PEA = Pulmonary endarterectomy
PEEP = Positive end expiratory pressure
PPC = Prothrombin complex concentrate
PR = Pulmonary regurgitation
PRECISE-DAPT = PREdicting bleeding Complications In patients undergoing Stent implantation and subsEquent Dual Anti Platelet Therapy
PRF = Prolonged-release formulation
ProCT = Procalcitonin
PRN = Pro re nata
PS-PEEP = Pressure support-positive end-expiratory pressure
PSVT = Paroxysmal supraventricular tachycardia
QD = Once a day
QPM = Every evening
rFVIIa = Recombinant factor VIIa
rtPA = Recombinant tissue plasminogen activator
RV = Right ventricular
RVOT-VT = Right ventricular outflow tract ventricular tachycardia
SBP = Systemic blood pressure
s.c = Subcutaneous
SIRS = Systemic inflammatory response syndrome
SLE = Systemic lupus erythematosus
SMU = Syncope management units
STE-ACS = ST-segment elevation acute coronary syndrome
STEMI = ST-segment elevation myocardial infarction
SVT = Supraventricular tachycardia
Spo_2 = Oxygen saturation
TEE = Transesophageal echocardiography
TEVAR = Thoracic endovascular aortic repair
TIA = Transient ischemic attack
TID = Three times a day
TLOC = Transient loss of consciousness
TnL = Troponin I
TOE = Transoesopageal echocardiography

Abbreviations (Cont.)

TSH = Thyroid-stimulating hormone
TTE = Transthoracic echocardiography
UA = Unstable angina
UFH = Unfractionated heparin
ULN = Upper limit of normal
VBGA = venous blood gas analysis
VF = Ventricular fibrillation
VR = Vascular resistance
VT = Ventricular tachycardia
VTE = Venous thromboembolism
VVS = Vasovagal syncope
WBC = white blood cell count
WHO = World Health Organization
WPW = Wolff-Parkinson-White

References and copyright acknowledgments

Jeanette Schulz-Menger, Valentino Collini, Jan Gröschel, Yehuda Adler, Antonio Brucato, Vanessa Christian, Vanessa M Ferreira, Estelle Gandjbakhch, Bettina Heidecker, Mathieu Kerneis, Allan L Klein, Karin Klingel, George Lazaros, Roberto Lorusso, Elena G Nesukay, Kazem Rahimi, Arsen D Ristić, Marcin Rucinski, Leyla Elif Sade, Hannah Schaubroeck, Anne Grete Semb, Gianfranco Sinagra, Jens Jakob Thune, Massimo Imazio, the ESC Scientific Document Group , 2025 ESC Guidelines for the management of myocarditis and pericarditis: Developed by the task force for the management of myocarditis and pericarditis of the European Society of Cardiology (ESC)
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Acknowledgements

We are indebted to all the authors for their commitment and for the strong effort to synthesise their wide scientific knowledge and clinical experience into simple algorithms and schemes using the aim to help clinicians in everyday clinical practice in the easiest possible manner as the main driver of their work.

The support of this initiative by the Association for Acute CardioVascular Care (ACVC) board members was essential to launch this initiative as was the hard work of the ESC staff to make this project move forward.

March 2025

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