Population-based Incidence of Myopericarditis After COVID-19 Vaccination in Danish Adolescents

Nygaard, Ulrikka; Holm, Mette; Bohnstedt, Cathrine; Chai, Qing; Schmidt, Lisbeth Samso; Hartling, Ulla Birgitte; Petersen, Jens Jakob Herrche; Thaarup, Jesper; Bjerre, Jesper; Vejlstrup, Niels Grove; Juul, Klaus; Stensballe, Lone Graff

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APPENDIX

ADDITIONAL MIS-C-TASK FORCE CONTRIBUTORS

Hemalatha Srinivasalu, MD, and Tova Ronis, MD, Division of Rheumatology, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Anita Krishnan, MD, Division of Cardiology, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Kavita Parikh, MD, and Karen Smith, MD, Division of Hospitalist Medicine, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Meghan Delaney, DO, and Joseph Campos, PhD, Division of Laboratory Medicine and Pathology, Children’s National Hospital, Washington, DC, and Department of Pathology, The George Washington University School of Medicine and Health Sciences, Washington, DC; Jaclyn N. Kline, MD, Division of Emergency Medicine, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Sangeeta Sule, MD, Division of Rheumatology, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Suvankar Majumdar, MD, Division of Hematology, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Jay Pershad, MD, Division of Emergency Medicine, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Michal Bell, MD, Division of Critical Care Medicine, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Michael Bell, MD, Division of Critical Care Medicine, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC; Charles I. Berul, MD, Division of Cardiology, Children’s National Hospital, Washington, DC, and Department of Pediatrics, The George Washington University School of Medicine and Health Sciences, Washington, DC.

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from our prospective nationwide study of multisystem inflammatory syndrome in children (MIS-C) in Denmark during the COVID-19 era (March 1, 2020, to 28 February 28, 2021). The background incidence of myocarditis in Danish adolescents 12–17 years of age was calculated using the Danish National Patient Register in 2014–2018, the pre-COVID-19 era.

Informed adolescent and parental consents were provided before participation. The study was approved by the Ethics Committee of Capital Region of Denmark (H-20028631) and the Danish Data Protection Agency (P-2019-29).

**RESULTS**

Thirteen (87%) male and 2 (13%) female previous healthy adolescents were hospitalized with myopericarditis after receiving Pfizer-BioNTech mRNA COVID-19 vaccination (Table 1). Twelve (80%) patients had myocarditis or myopericarditis (cases 1–12), including 1 meeting the criteria for MIS-C after vaccination (MIS-V) (case 12). Three (20%) had pericarditis (cases 13–15). Eighty-five (53%) patients presented with chest pain after the first vaccine and 7 (47%) after the second vaccine. Eleven (73%) had fever. Investigations for differential diagnoses did not reveal viral or bacterial causes. The patients did not have previous SARS-CoV-2 infection, determined by history, repetitive PCR investigations, or negative nucleocapsid antibodies, except case 1 (confirmed by PCR 8 months before) and 8 (confirmed by nucleocapsid antibodies). All patients had resolution of symptoms with nonsteroidal anti-inflammatory drugs or no treatment, except case 12 who required treatment at intensive care unit.

The median duration of hospitalization was 3 days (1–10). A total of 133,477 males and 127,857 females 12–17 years of age had received the first vaccine between May 15 to August 15, 2021. The incidence of myopericarditis among males and females 12–17 years of age was 97 and 16 per million, equaling 1 of 10,000 males and 1 in 63,000 females, respectively.

During the first 12 months of the COVID-19 era, 6 males and 3 females 12–17 years of age with MIS-C and elevated troponin levels were identified among 16,900 males and 16,044 females 12–17 years of age infected with SARS-CoV-2. This equals 355 and 187 per million male and female adolescents infected with SARS-CoV-2 (1 in 2800 males and 1 in 5300 females), significantly higher than the incidence of myopericarditis after COVID-19 vaccination in both males and females (Fisher’s exact test; \( P < 0.01 \)). During the pre-COVID-19 era (2014–2018), the monthly incidence of myocarditis was 3 males and 0.5 females per million Danish males and females 12–17 years of age, respectively, equaling 12 males and 2 females per million during a corresponding 4-month period.

**DISCUSSION**

This study is based on a prospective detailed phenotyping of myopericarditis cases after Pfizer-BioNTech mRNA COVID vaccination in the very well registered population of Denmark. Among individuals 12–17 years of age, the study revealed an incidence of 97 males and 16 females per million. The incidence among males was higher than the reported rates until now from the US VAERS by Gargano et al finding 63 cases per million male adolescents 12–17 years of age. Although that report was based on 8.9 million vaccinated adolescents, underreporting is one of the limitations of this passive surveillance system.1,2

The incidences in our study are encumbered with uncertainty due to the small population of Denmark. Further, our incidences may be overestimated due to possible inclusion of cases unrelated to the vaccine, but occurring in vaccinated adolescents, since myopericarditis without a known etiology is quite common among male adolescents.5 Such overestimation is expected to be similar in the reported rates from the US VAERS. We estimated the background incidence of myocarditis to be 12 male and 2 female adolescents per million during a four-month period. Thus, the incidence of mRNA COVID-19 vaccine induced myopericarditis among adolescents is likely to be 10% lower than the reported incidences.

On the contrary, our incidences may also be underestimated. First, cases may have gone undiagnosed due to lack of clinical suspicion of this new association between vaccination and myopericarditis. Accordingly, 4 patients were initially discharged without evaluation for myocarditis despite chest pain and fever following COVID vaccination. Second, the inclusion period ended 4 weeks after the first vaccine. As myopericarditis appears to be more frequent after the second dose, cases could have been missed if the second dose was not administered timely. Finally, the incidences could be underestimated if patients were admitted to Departments of Adult Cardiology. Our research set-up included all Pediatric Departments in Denmark, but not Departments of Adult Cardiology, as the national guidelines recommend referral of adolescents with myopericarditis to the 3 Tertiary Pediatric Cardiology Centers in Denmark. Despite, 2 patients were admitted to Departments of Adult Cardiology and it cannot be excluded that other patients were admitted likewise, and not included in the study. However, this is less likely as the cross check with the Nationwide VAERS, as part of this study, did not reveal additional cases from Departments of Adult Cardiology.

Studies from the United States have found three-quarters, or more, to occur after the second vaccine.3,4 In contrast, our cases occurred equally after the first and the second vaccine. In 2 patients, myocarditis occurred 5 weeks after the first vaccine, just before the planned administration of the second vaccine, which was delayed according to the recommended dose interval of 3 weeks. Thus, we speculate that myocarditis may occur several weeks after the first vaccine, independent of the second dose, similar to the time interval between exposure of SARS-CoV-2 and the development of MIS-C. However, this hypothesis remains unexplored as most individuals receive the second vaccines after 3 weeks.

The mild phenotype of myopericarditis cases in our study were comparable with cases described in other studies,1,6 except 1 patient with myocarditis and MIS-C, who needed treatment at intensive care unit. This contrasts MIS-C with cardiac involvement following SARS-CoV-2 infection, where more than half of patients need treatment at intensive care unit.5,7 We found the incidence of MIS-C with cardiac involvement among SARS-CoV-2 infected adolescents significantly higher than myopericarditis after COVID-19 vaccination in both males and females (355 vs. 97 per million males and 187 vs. 16 per million females), although both estimates are encumbered with uncertainty due to the few cases included. Yet, these incidences may be difficult to compare, as most individuals are expected to receive the COVID-19 vaccination with a mass vaccination strategy, while the total number of adolescents who will become infected with SARS-CoV-2 may be low in countries with high vaccination coverage among the adult population.

In conclusion, this population-based prospective study suggests the incidence of myopericarditis in male adolescents to be higher than previous reported and that more severe phenotypes of myopericarditis may occur.

**REFERENCES**


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<th>Biochemistry*</th>
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*Highest value. Days from vaccination to initiation of chest pain.
SARS-CoV-2 PCR at admission.
†Reference limit of CRP is 10 mg/L.
‡Reference limit of TnI and TnT is 5 ng/L and 14 ng/L.
§Reference limit of CK-MB is 7 µg/L.
**Reference limit of BNP is 125 pmol/L.
††Six of 9 (67%) cases met the diagnostic cardiac MRI Lake Louise criteria for myocarditis.
BNP indicates brain natriuretic peptide; CK-MB, creatine kinase-MB; CRP, C-reactive protein; ECG, electrocardiogram; ECHO, echocardiogram; IVIG, intravenous immunoglobulin; LVEF, left ventricular ejection fraction; MIS-V, multisystem inflammatory syndrome after vaccination; MRI, magnetic resonance imaging; NE, not examined, NSAID, nonsteroidal anti-inflammatory drugs; PCR, polymerase chain reaction; Tn, Troponin.

