We describe a rare case of infiltrative cardiomyopathy characterized by multiple low-signal myocardial lesions consistent with nodular calcifications. A retrospectively detailed clinical history and the use of multimodality imaging enabled us to identify the final diagnosis. (Level of Difficulty: Advanced.) (J Am Coll Cardiol Case Rep 2021;3:1509-1511) © 2021 The Authors. Published by Elsevier on behalf of the American College of Cardiology Foundation. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).
On tissue characterization, the lesions appeared to have low signal in all sequences: half-Fourier acquisition single-shot turbo spin echo imaging (HASTE), cine, T1 turbo spin echo (TSE), fat-saturation sequences, T2-weighted imaging, first-pass perfusion, and early and late gadolinium enhancement, demonstrating low or no vascularization, suggesting a calcific nature of these lesions. This was confirmed by low values on native T1 and T2 mapping (Figure 1). The findings were consistent with infiltrative restrictive cardiomyopathy with diffuse nodular calcifications. Chest radiography also showed myocardial and pericardial calcifications. The calcific nature of the lesions was further confirmed on subsequent chest computed tomography (CT) (Figure 1). Abdominal CT also showed bilateral renal calcifications.

Hyperparathyroidism and hypercalcemia were excluded. A more detailed retrospective clinical history investigation identified a diagnosis of lung tuberculosis 40 years earlier. The patient was referred to the respiratory team, but it was decided not to investigate because the current presentation was unlikely related to active tuberculosis. The then patient suddenly deteriorated neurologically, and she died before further assessment and treatment could be administered.

**DISCUSSION**

Infiltrative diffuse myocardial calcifications are rare findings; they can be associated with ventricular wall motion abnormalities, present as restrictive cardiomyopathy, and can be associated with sudden cardiac death (1).
The possible causes of myocardial calcifications are dystrophic or metastatic (2); some investigators have also described idiopathic causes (3). Dystrophic calcifications are the most common and result from direct tissue damage and cellular necrosis of different origins (e.g., traumatic, ischemic, infectious). Metastatic calcifications are consequences of systemic disorders and abnormal calcium metabolism. The most common example is found in patients with renal failure, which was excluded in our patient.

Myocardial calcifications can be secondary to hyperparathyroidism and subsequent hypercalcemia, and accurate identification is crucial to guide treatment and reverse the course of the disease. A detailed clinical history and multimodality imaging are key in the assessment of myocardial calcifications. Cardiac CT is the most adequate technique to image myocardial calcifications; however, this case shows that CMR tissue characterization also identified the calcific nature of these lesions.

CONCLUSIONS

Infiltrative cardiomyopathy with diffuse nodular calcification is a rare entity. Cardiac calcification secondary to tuberculosis is also a rare finding. Multimodality imaging was crucial to determine the final diagnosis.

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