

Colchicine in pericarditis: Why aren't we using it more?

Written by The Life Science Feed Editorial Team · Published 29 October 2026 · Edited by Mara Voss

Acute pericarditis, while often self-limiting, carries a significant risk of recurrence and can lead to debilitating symptoms if not managed appropriately. Despite clear recommendations from major cardiology societies, colchicine, a well-established anti-inflammatory agent, is still not universally adopted in clinical practice for this condition. The reasons for this underuse frequently boil down to a lack of clarity on how to dose it effectively and for how long.

KEY TAKEAWAYS

- **The Pivot:** Colchicine significantly reduces recurrence rates and persistent symptoms in acute pericarditis.
- **The Data:** Colchicine has demonstrated efficacy in reducing recurrence and symptom persistence.
- **The Action:** Clinicians should initiate colchicine early in acute pericarditis, adhering to weight-adjusted dosing and recommended durations to prevent recurrence.

Pericarditis, an inflammatory condition affecting the pericardium, presents with chest pain, pericardial friction rub, and characteristic ECG changes. While non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin form the cornerstone of initial therapy, the addition of colchicine has been shown to improve outcomes, particularly in preventing recurrent episodes.^{1,2,4} This benefit extends to both initial acute episodes and recurrent pericarditis, a condition that can severely impact a patient's quality of life.^{1,3,4}

The mechanism of action for colchicine in pericarditis is rooted in its anti-inflammatory and immunomodulatory properties. It inhibits neutrophil chemotaxis and reduces inflammasome activation, thereby dampening the inflammatory cascade that drives pericardial inflammation. This targeted action helps to resolve the acute episode and, importantly, prevents the chronic inflammatory state that predisposes to recurrence. Understanding this mechanism is key to appreciating why it is not merely an adjunct but a vital component of therapy.

The evidence for colchicine

Clinical experience and guideline recommendations consistently support the use of colchicine in acute pericarditis.⁴ Its inclusion in treatment protocols is based on its ability to reduce the rate of recurrent pericarditis and the incidence of incessant or constrictive pericarditis.^{1,2,3,4} The drug also helps to shorten the duration of symptoms and improve the response to conventional anti-inflammatory therapy.^{1,4} But despite this clear evidence, many clinicians hesitate, often citing concerns about side effects or uncertainty regarding the optimal regimen.

Colchicine has shown particular utility in preventing the cycle of inflammation and recurrence that can trap patients in a chronic disease state.^{2,4} For patients who experience recurrent episodes, the impact on daily life can be substantial,

leading to frequent hospital visits and prolonged periods of disability.³ This is a vital area where colchicine provides a tangible benefit, breaking the inflammatory feedback loop. For a deeper dive into managing these challenging cases, our previous coverage on steroid-dependent pericarditis offers further insights.

Dosing and duration: getting it right

The primary reason for colchicine's underuse or suboptimal use often stems from confusion surrounding its dosing and duration. The drug has a narrow therapeutic window, and inappropriate dosing can lead to either ineffective treatment or significant gastrointestinal side effects. Standard practice dictates a weight-adjusted regimen to minimise adverse events while maximising efficacy. For patients weighing over 70 kg, the recommended dose is typically 0.5 mg twice daily. For those weighing 70 kg or less, a dose of 0.5 mg once daily is usually sufficient. This weight-based approach is important for patient tolerability and treatment adherence.

The duration of colchicine therapy is equally important. For an initial episode of acute pericarditis, treatment should generally continue for at least three months.¹ In cases of recurrent pericarditis, a longer duration, often six months or more, is recommended.¹ Gradual tapering of the dose, rather than abrupt discontinuation, is also advised to prevent rebound inflammation and recurrence. This prolonged treatment course is often overlooked, leading to premature cessation and subsequent relapse. Clinicians should consult a comprehensive resource like the Oxford Handbook of Cardiology for detailed guidance on these protocols.

Managing adverse effects and drug interactions

The most common adverse effects of colchicine are gastrointestinal, including diarrhoea, nausea, and abdominal cramps.⁴ These are typically dose-dependent and can often be managed by reducing the dose or by taking the medication with food. Less common but more serious side effects include myopathy and bone marrow suppression, particularly in patients with renal or hepatic impairment, or those on concomitant medications that inhibit cytochrome P450 3A4 (CYP3A4) or P-glycoprotein. Careful patient selection and monitoring are therefore essential.

The potential for drug interactions is a significant consideration. Colchicine is metabolised by CYP3A4 and is a substrate for P-glycoprotein. Concomitant use with strong inhibitors of these pathways, such as clarithromycin, diltiazem, verapamil, or cyclosporine, can significantly increase colchicine plasma concentrations, leading to toxicity. Clinicians must meticulously review a patient's medication list before initiating colchicine and consider dose adjustments or alternative therapies if significant interactions are anticipated. This vigilance is paramount to patient safety.

Why it remains underused

Despite the clear benefits and established guidelines, colchicine remains underused.⁴ A significant factor is the historical perception of colchicine as a drug with a narrow therapeutic index and a high incidence of side effects, largely based on older, higher-dose regimens used for conditions like gout. Modern dosing strategies for pericarditis are much lower and better tolerated.⁴ Another barrier is the lack of familiarity among some clinicians with the specific dosing and duration recommendations for pericarditis, leading to a reluctance to prescribe.

The complexity of managing recurrent pericarditis, which often involves a multidisciplinary approach, also contributes to the underutilisation of colchicine.³ Patients may cycle through various specialists, each with differing levels of familiarity with the drug's role in this specific context. This fragmentation of care can lead to missed opportunities for effective

prophylaxis. Our previous article, Colchicine in acute pericarditis: why it remains underused, explores these systemic issues in greater detail.

Looking ahead: improving adherence

Improving adherence to colchicine guidelines requires a multi-pronged approach. Education for clinicians on appropriate dosing, duration, and management of side effects is essential. Clear, concise guidelines that are easily accessible at the point of care can also help. Patient education is equally important, ensuring they understand the rationale for prolonged therapy and how to manage potential side effects. Empowering patients to adhere to their treatment regimen is vital for preventing recurrence and improving long-term outcomes.

The development of new anti-inflammatory agents for pericarditis may also influence colchicine's role, but for now, it remains a cornerstone of therapy.² The challenge is not in the drug's efficacy, but in its consistent and correct application.⁴ The field continues to explore novel therapies, such as those targeting interleukin-1 pathways, which offer alternatives for refractory cases.² Our coverage on rilonacept and IL-1 blockade provides context on these emerging treatments. The long-term implications of untreated or inadequately treated pericarditis, including the risk of constrictive pericarditis, highlight the importance of optimal management. Colchicine, when used correctly, offers a straightforward and effective strategy to mitigate these risks.⁴ The ongoing task for clinicians is to integrate this evidence into routine practice, ensuring that patients receive the full benefit of this established therapy. The next step for the field is to ensure that these guidelines are not just published, but truly implemented.

CLINICAL IMPLICATIONS

The persistent underuse of colchicine in acute pericarditis is a missed opportunity for better patient outcomes. Clinicians often default to NSAIDs or corticosteroids alone, overlooking a therapy that demonstrably reduces recurrence and symptom burden. This hesitation frequently stems from outdated perceptions of colchicine's toxicity profile, ignoring modern, weight-adjusted dosing strategies.

The onus is on prescribers to familiarise themselves with current guidelines on colchicine dosing and duration. Three months for an initial episode and six months or more for recurrent cases, with a gradual taper, are not arbitrary numbers; they are derived from evidence designed to break the cycle of inflammation. Premature discontinuation is a common pitfall that directly contributes to relapse.

Industry, specifically pharmaceutical companies, could do more to support education on colchicine's appropriate use in pericarditis. Clearer prescribing information and educational materials, perhaps even decision-support tools, would help bridge the knowledge gap. This is not about promoting a new drug, but ensuring an established, effective, and inexpensive therapy is used correctly.

Patients with pericarditis deserve optimal care that prevents debilitating recurrence. When clinicians fail to incorporate colchicine into their treatment plans, they are inadvertently exposing patients to prolonged suffering and the potential for more severe complications. It is time to move past the myths and embrace the evidence for this essential medication.

EDITORIAL & AI STANDARDS

AI tools are used to structure and summarise evidence from peer-reviewed primary sources. Articles that carry a signed Editor's take have been read in full by William Lopes. The others are not individually read by an editor, so check the cited source before relying on a figure.

REFERENCES

1. Cremer PC, Klein AL, Imazio M. Diagnosis, Risk Stratification, and Treatment of Pericarditis: A Review. JAMA. 2024;332(13):1090-1100. doi:10.1001/jama.2024.12935
2. Andel PM, Aukrust P, Gleditsch J, et al. Recurrent pericarditis. Tidsskr Nor Laegeforen. 2023;143(8). doi:10.4045/tidsskr.22.0580
3. Imazio M, Battaglia A, Gaido L, Gaita F. Recurrent pericarditis. Rev Med Interne. 2017;38(5):307-311. doi:10.1016/j.revmed.2016.12.006
4. Norrid SE, Oliphant CS. Colchicine for the Treatment of Acute and Recurrent Pericarditis. Ann Pharmacother. 2014;48(8):1050-1054. doi:10.1177/1060028014535907

LICENCE & RIGHTS

© 2026 The Life Science Feed. All rights reserved. This content is produced for medical education purposes. It may not be reproduced, distributed, or transmitted without prior written permission from The Life Science Feed.

MEDICAL DISCLAIMER

This content is intended for healthcare professionals only and does not constitute medical advice. Clinical decisions must be made by qualified practitioners based on individual patient circumstances.

FOLLOW THE LIFE SCIENCE FEED

Instagram @lifesciencefeed **LinkedIn** linkedin.com/company/thelifesciencefeed

thelifesciencefeed.com