

**Table S1: Clinical cases of cardiac sarcoidosis: presentation, diagnosis, and treatment**

Patient Age Sex	Clinical symptoms of cardiac involvement and initial cardiac workup	Diagnosis of cardiac sarcoidosis	Cardiac involvement following initial dx of sarcoidosis	Treatment	Extra-cardiac involvement
Case 1 <b>Probable CS</b> 71 F	Pericarditis LAHB+CRBBB on ECG	<ul style="list-style-type: none"> <li>- CMR with focal LGE in basal-antero-septal wall with less than 1% myocardial involvement and circular LGE of pericardium.</li> <li>- Cardiac PET-FDG without cardiac uptake.</li> <li>- Normal ACE level, elevated CRP level.</li> </ul>	2 years	<ul style="list-style-type: none"> <li>- Colchicine, high dose ASA and</li> <li>- Prednisone taper from 30 mg/day</li> </ul>	<b>RETICULOENDOTHELIAL:</b> hilar LAD with uptake on PET-FDG with NCSs on EBUS-guided biopsy <b>LUNG:</b> Pulmonary nodules, bronchiectasis <b>MSK:</b> Arthritis, diffuse skeletal uptake on PET-FDG
Case 2 <b>Presumed CS</b> 54 F	Syncope and DOE CAVB on ECG + WCT on monitor	<ul style="list-style-type: none"> <li>- CMR with LGE in mid-wall basal septum, less than 1% uptake</li> <li>- Only T1 signal seen without T2 signal, suggesting old granulomatous inflammatory damage</li> <li>- Total body PET-FDG without cardiac uptake</li> <li>- Normal ACE level, normal CRP level.</li> </ul>	Initial presentation	-PM insertion	<b>ISOLATED CARDIAC</b> Dx following COVID-19
Case 3 <b>Probable CS</b> 41 M	-DOE with bradycardia due to CAVB on ECG a month following NSTEMI and cCTA + stent -2 years later, DOE with troponin elevation c/w myocarditis with normal cCTA	<ul style="list-style-type: none"> <li>- CMR with mild basal septal thickening, focal transmural LGE in basal apical segment with mild decrease in global systolic function in RV</li> <li>- Cardiac PM interrogation showing episodes of asymptomatic asystole 2 years later with TTE with EF=25% with global dyskinesia</li> <li>- Normal ACE level, elevated troponin, elevated CRP level.</li> </ul>	Initial presentation	<ul style="list-style-type: none"> <li>- Initial PM insertion</li> <li>- Prednisone taper from 60 mg/day and MTX 20 mg/week with subsequent d/c by patient and loss to follow-up</li> <li>- 2 years later: PM replaced by ICD due to suspected CS</li> <li>- Pulse IV steroids + prednisone taper from 60 mg/day + MTX 15 mg/week which was switched to AZA 150 mg/day due to side effects</li> </ul>	<b>RETICULOENDOTHELIAL:</b> Mediastinal LAD on CT with NCGs on EBUS-guided biopsy <b>NEUROLOGIC:</b> Peripheral nerve B/L drop foot
Case 4 <b>Probable CS</b> 62 F	Generalized weakness due to bradycardia CLBBB +2:1 AVB on ECG + PMVT on monitor	<ul style="list-style-type: none"> <li>- TTE with diastolic dysfunction + asynchrony of septum c/w CLBBB</li> <li>- CMR with increased signal on T1 mapping (fibrosis) in apical septum c/w fibrosis, unable to complete Gadolinium injection to check for LGE due to SOB.</li> </ul>	12 years	<ul style="list-style-type: none"> <li>- Short prednisone taper</li> <li>- ICD insertion when presenting with suspected cardiac involvement</li> </ul>	<b>RETICULOENDOTHELIAL:</b> Generalized LAD on CT with NCGs on EBUS-guided biopsy, splenomegaly <b>LUNG:</b> Pulmonary nodules with uptake on PET-FDG, bronchiectasis <b>LIVER:</b> NCGs on liver biopsy

		<ul style="list-style-type: none"> <li>- Cardiac PET-FDG without myocardial uptake.</li> <li>- Normal ACE level around diagnosis of CS, was chronically elevated up to 95 prior to CS, normal CRP level.</li> </ul>			<b>HEMATOLOGIC:</b> bone marrow biopsy showing NCGs.
Case 5 <b>Presumed CS</b> 47 F	DOE and weakness due to bradycardia CAVB on ECG	<ul style="list-style-type: none"> <li>- CMR with mild LGE in infero-septal (basal) wall involving 1% of myocardium with right atrial enlargement.</li> <li>- Cardiac PET-FDG with poor preparation-non indicative of activity.</li> <li>- Normal ACE level, normal CRP level</li> </ul>	Initial presentation	<ul style="list-style-type: none"> <li>- Prednisone taper from 60 mg/day+ MTX 10 mg/week</li> <li>- ICD insertion</li> <li>- Loss to follow-up.</li> </ul>	<b>ISOLATED CARDIAC</b>
Case 6 <b>Probable CS</b> 61 F	DOE and weakness 2/2 bradycardia Small pericardial effusion CAVB on ECG Normal coronary CT	<ul style="list-style-type: none"> <li>- CMR with LGE in basal septum, no T1 or T2 signal, suggesting old granulomatous inflammatory damage</li> <li>- Total body PET-FDG with no cardiac uptake.</li> <li>- Normal ACE level, elevated CRP level.</li> </ul>	Initial presentation	<ul style="list-style-type: none"> <li>- Prednisone taper from 40 mg/day + MTX</li> <li>- ICD insertion</li> <li>- Loss to follow-up.</li> </ul>	<b>RETICULOENDOTHELIAL:</b> Mediastinal LAD with abnormal uptake on PET-FDG with NCGs on EBUS-guided biopsy <b>LUNG:</b> pleural effusion and GGO in lower lobes <b>LIVER:</b> focal liver uptake on PET-FDG
Case 7 <b>Presumed CS</b> 56 M	DOE, weakness and syncope Alternating CRBBB, CLBBB and PR prolongation on monitor, CAVB on ECG. Mild troponin elevation with normal coronary CT.	<ul style="list-style-type: none"> <li>- CMR with hypokinesis of apex and lateral wall, septal thickening. Positive T1 signal (interstitial fibrosis) and T2 signal (myocardial edema) with epicardial LGE in antero-septal wall and in lateral wall with 8% myocardial involvement.</li> <li>- Cardiac PET-FDG with elevated physiologic uptake in myocardium without ability to discern pathologic uptake</li> <li>- Normal ACE level, mild troponin elevation, normal CRP level.</li> </ul>	Initial presentation	<ul style="list-style-type: none"> <li>- Prednisone taper from 40 mg/day + plan to add MTX by provider</li> <li>- ICD insertion</li> </ul>	<b>ISOLATED CARDIAC</b>
Case 8 <b>Probable CS</b> 40 F	Intermittent CP with DOE, palpitations. Normal TTE.	<ul style="list-style-type: none"> <li>- CMR with LGE in mid-wall of basal septum with 1% myocardial involvement.</li> <li>- Cardiac PET-FDG with perihilar LAD without uptake, cardiac apical uptake, no septal uptake.</li> <li>- Normal ACE level, elevated CRP level.</li> </ul>	Initial presentation	<ul style="list-style-type: none"> <li>- Prednisone taper from 40 mg/day + HCQ for joints</li> <li>- Switched to MTX+SSZ with continuation of low dose prednisone for joints</li> </ul>	<b>RETICULOENDOTHELIAL:</b> Mediastinal LAD on CT with NCGs on EBUS-guided biopsy <b>LUNG:</b> Pulmonary nodules <b>MSK:</b> Arthritis -Crohn's disease dx a few months following sarcoidosis
Case 9 <b>Probable CS</b> 56 M	Intermittent CP with SOB, palpitations, signs and symptoms of heart failure with pulmonary edema. TTE with narrow complex	<ul style="list-style-type: none"> <li>- CMR with severely reduced LVEF with mild-mod reduction in RV function, LGE in mid-wall of basal septum, c/w dilated non-ischemic CMP.</li> <li>- Cardiac PET-FDG without uptake</li> <li>- Previous CMR (2 years prior) with mild lateral wall hypokinesis, LGE in lateral</li> </ul>	2-4 years following initial diagnosis (dx 4 years following initial dx but suspicion arose 2 years prior)	<ul style="list-style-type: none"> <li>- Prednisone taper from 15 mg/day + MTX 20 mg/week on dx, followed by Depo Medrol pulse IV 1 g X 3 days and AZA for a short time replaced by MMF up to 2 g/day (dose</li> </ul>	<b>RETICULOENDOTHELIAL:</b> Perihilar and mediastinal LAD on CT with NCGs on EBUS-guided biopsy <b>LUNG:</b> Interstitial changes and GGO <b>MSK:</b> Muscle biopsy with NCGs

	tachycardia, EF=25%, LVEDD 61 mm (enlarged) with mild-mod MR (prior TTE with normal LVEF=60%). Repeat ECG with NSR with PRWP and with LAHB.	<p>wall with 6% cardiac myocardial involvement- attributed at the time to AMI though cCTA with no significant cardiac lesions.</p> <ul style="list-style-type: none"> <li>- Normal ACE level around CS dx, elevated only once to 148 prior (normal &lt;70), Troponin elevation to 300, pro-BNP elevation&gt;3000, elevated CRP level.</li> </ul>		<p>lowered to 1.5 g/day d/t hypogammaglobulinemia)</p> <ul style="list-style-type: none"> <li>- ICD inserted due to heart failure and NSVT, SVT noted on ICD interrogation</li> </ul>	
Case 10 <b>Probable CS</b> 69 M	Hospitalization for syncope with asystole for 4-5 sec. Follow-up ECG with tri-fascicular block. AF developed later during follow-up.	<ul style="list-style-type: none"> <li>- TTE with widened IVS 1.3 (normal until 1.1).</li> <li>- CMR with suspected LGE in focal infero-septal-mid basal septum with septal thickening.</li> <li>- Cardiac PET-FDG with pathologic cardiac septal and apical uptake.</li> <li>- Repeat PET-FDG 6 months later without cardiac uptake after initiation of immunosuppression, perihilar and mediastinal lymph node uptake still present.</li> <li>- Normal ACE level, normal CRP level.</li> </ul>	1.5 years following dx	<ul style="list-style-type: none"> <li>- Prednisone taper on dx followed by MTX up to 20 mg/week</li> <li>- PM insertion</li> <li>- Chemotherapy for NHL (included RTX and Depo Medrol) following dx of sarcoidosis.</li> <li>- Prednisone later restarted with MMF 2 g/day following cardiac PET-FDG with dx of CS.</li> <li>- Underwent ablation for AF</li> </ul>	<p><b>RETICULOENDOTHELIAL:</b> PET-FDG with uptake in submandibular, cervical and mediastinal lymph nodes, cervical LN biopsy with sarcoid-like NCGs</p> <p><b>EYE:</b> focal uptake in L eye orbit on PET-FDG</p> <p><b>LIVER:</b> focal liver uptake on PET-FDG</p> <p><b>SKIN:</b> L lower eyelid biopsy with NCGs</p>
Case 11 <b>Probable CS</b> 50 M	Worsening DOE and CP with neg cardiac cath, orthopnea	<ul style="list-style-type: none"> <li>- TTE with normal EF</li> <li>- CMR with low-normal cardiac function, increased T1 signal in medial septum and focal LGE in medial septum.</li> <li>- Cardiac PET-FDG with no cardiac uptake.</li> <li>- Normal ACE level, normal Pro-BNP level.</li> </ul>	1.5 years following dx	<p>Prednisone taper from 30 mg/day with MTX 15 mg/week</p> <p>-Switched to AZA 100 mg/day for several months due to lack of efficacy, d/c due to transaminitis</p> <p>-Switched to infliximab biosimilar and later to adalimumab biosimilar due to pruritus on infliximab biosimilar</p>	<p><b>RETICULOENDOTHELIAL:</b> hilar LAD on CT with NCGs on EBUS-guided biopsy</p> <p><b>LUNG:</b> pulmonary nodules with uptake in reticulonodular infiltrates on PET-FDG</p>
Case 12 <b>Definite CS</b> 42 M	-Hospitalized for VT with SCD -Cardiac cath with normal coronaries -TTE with severe LV dysfunction (EF=30-35%)	<ul style="list-style-type: none"> <li>- EMB showing NCGs</li> <li>- CMR: LV and RV LGE and increased T1 and T2 signals, compatible with myocarditis.</li> <li>- Cardiac PET-FDG- diffuse myocardial uptake with resolution of inflammation on therapy</li> <li>- Elevated ACE level 57 U/L (normal&lt;52)</li> <li>- Elevated troponin and pro-BNP levels, normal CRP level.</li> </ul>	Initial presentation	<p>-Prednisone taper from 60 mg/day+ MTX 15 mg/week</p> <p>-ICD insertion</p>	<p><b>RETICULOENDOTHELIAL:</b> LAD with abnormal uptake in supra- and infra-diaphragmatic lymph nodes on PET-FDG</p> <p>Skin: Pruritus, responsive to therapy</p>

<p>Case 13</p> <p><b>Probable CS</b></p> <p>51</p> <p>M</p>	<ul style="list-style-type: none"> <li>- Hospitalized for syncopal episode</li> <li>- ECG: Mobitz II/cAVB</li> <li>- EPS: Severe his-purkinje disease with intrahissian conduction block</li> <li>- TTE: mild LVH, non-obstructive systolic anterior motion of mitral chordae</li> <li>- AF appeared 8 months into Rx</li> </ul>	<ul style="list-style-type: none"> <li>- EMB showing a non-specific mononuclear infiltrate</li> <li>- CMR: LGE in the interventricular septum</li> <li>- Cardiac PET-FDG: heterogenous uptake in the LV, with dominant uptake in the septum, diffuse hypermetabolic LAD; repeat PET-FDG 5 months later showed resolution of inflammation, Rx discontinued 12 months after initiation of Rx with repeat 1-year cardiac PET-FDG again showing activity, including cardiac uptake</li> <li>- Elevated ACE level 100 U/L (normal&lt;52)</li> <li>- Normal troponin level, elevated CRP level.</li> </ul>	<p>Initial presentation</p>	<ul style="list-style-type: none"> <li>- Prednisone taper from 60 mg/day + MTX up to 20 mg/week</li> <li>- ICD insertion</li> <li>- Underwent ablation for AF</li> </ul>	<p><b>RETICULOENDOTHELIAL:</b> Mediastinal LAD on CT with NCGs on EBUS-guided biopsy</p> <p><b>MSK:</b> Arthralgia</p>
<p>Case 14</p> <p><b>Definite CS</b></p> <p>44</p> <p>M</p>	<ul style="list-style-type: none"> <li>-Hospitalized for CP</li> <li>-ECG: tri-fascicular block</li> <li>-Holter: 2 events of MOBITZ 1</li> <li>-TTE: asymmetric septal hypertrophy, mild RVH</li> </ul>	<ul style="list-style-type: none"> <li>- EMB showing NCGs</li> <li>- CMR: LGE in the septum, RV, inferior and posterior walls of LV</li> <li>- Cardiac PET-FDG: Increased uptake in the LV infero-apical wall and in the septum</li> <li>- Repeat cardiac PET-FDG 6 months after initiation of immunosuppression showed no active signal.</li> <li>- Normal troponin level, normal CRP level.</li> </ul>	<p>Initial presentation</p>	<ul style="list-style-type: none"> <li>-Prednisone taper from 60 mg/day + MTX 15 mg/week</li> </ul>	<p><b>RETICULOENDOTHELIAL:</b> Supra- and infradiaphragmatic LAD with uptake on PET-FDG</p> <p><b>RENAL:</b> Hypercalciuria</p> <p><b>MSK:</b> Arthralgia</p>
<p>Case 15</p> <p><b>Probable CS</b></p> <p>67</p> <p>F</p>	<ul style="list-style-type: none"> <li>-Hospitalized for DOE, peripheral edema</li> <li>-TTE: new, severely reduced LV function with moderately reduced RV function and severe PHTN</li> <li>-On monitor: many APBs</li> </ul>	<ul style="list-style-type: none"> <li>- CMR: LGE and increased T2 signal in LV</li> <li>- Cardiac PET-FDG: No uptake.</li> <li>- Normal troponin level, normal CRP level.</li> </ul>	<p>3 years</p>	<ul style="list-style-type: none"> <li>- Prednisone taper from 60 mg/day + MTX 15 mg/week</li> <li>- ICD insertion</li> </ul>	<p><b>RETICULOENDOTHELIAL:</b> LAD on CT</p> <p><b>LUNG:</b> interstitial changes on CT</p> <p><b>LIVER:</b> NCGs on liver biopsy</p> <p><b>RENAL:</b> Hypercalcemia</p> <p><b>SKIN:</b> non-specific skin rash responsive to therapy</p>
<p>Case 16</p> <p><b>Probable CS</b></p> <p>25</p> <p>M</p>	<ul style="list-style-type: none"> <li>-Hospitalized for dyspnea</li> <li>-ECG: normal</li> <li>-TTE: segmental wall motion abnormalities, mainly infero-septal hypokinesis at the basal and mid LV with EF 50-55%</li> </ul>	<ul style="list-style-type: none"> <li>- CMR: LGE and increased T2 signal in LV; normal systolic function</li> <li>- Cardiac PET-FDG: mediastinal and hilar LAD, lung infiltrates; no signs of cardiac disease; bilateral hypermetabolic pleural uptake</li> <li>- Normal troponin, elevated CRP level.</li> </ul>	<p>Initial presentation</p>	<ul style="list-style-type: none"> <li>-Prednisone taper from 40 mg/day+ MTX 15 mg/week</li> </ul>	<p><b>RETICULOENDOTHELIAL:</b> Perihilar and mediastinal LAD on CT with NCGs on EBUS-guided biopsy</p> <p><b>LUNG:</b> pulmonary infiltrates</p> <p><b>RENAL:</b> Hypercalciuria</p> <p><b>MSK:</b> Arthralgia, myalgia</p>

Case 17 <b>Probable CS</b> 52 M	-Hospitalized for dyspnea with transudative pleural effusion -TTE: Diastolic HF, EF 50-55% -ECG: sinus tachycardia -EPS-PVCs	- CMR: LGE and increased T2 signal in LV with normal systolic function; small pericardial effusion - Cardiac PET-FDG :Non-specific septal and near-apical uptake; repeat PET-FDG 14 months following initiation of immunosuppression: resolution of inflammatory findings. - Normal troponin, elevated CRP level.	A few months following uveitis	- Prednisone taper from 60 mg/day + MTX 15 mg/week - Steroid eye gtt	<b>RETICULOENDOTHELIAL:</b> Increased uptake in hilar and mediastinal LAD on PET-FDG with NCGs on EBUS-guided biopsy <b>LUNG:</b> parenchymal involvement, small pleural effusion <b>EYE:</b> Left anterior uveitis <b>MSK:</b> diffuse uptake in lower limb muscles and soft tissues on PET-FDG, a right iliac lytic bone lesion on PET-FDG, NCGs on thigh muscle biopsy <b>SKIN:</b> skin nodules
Case 18 <b>Probable CS</b> 61 F	-Admission for syncope -Mobitz type II	-Normal ACE, normal troponin level, normal CRP level.	Initial presentation, but was initially thought of as idiopathic cardiac conduction abnormality and only 6 years later was extra-cardiac involvement observed and diagnosis of sarcoidosis was made	- Cardiac PM	<b>RETICULOENDOTHELIAL:</b> Mediastinal and hilar LAD on CT with NCGs on EBUS-guided biopsy <b>RENAL:</b> hypercalciuria with hypervitaminosis D
Case 19 <b>Probable CS</b> 57 F	-Dyspnea and palpitations, with sustained VT on ECG -New-onset AF 9 months prior -TTE- EF 40-44%, RV dilatation and dysfunction, LA dilatation, and mild-moderate MR	- CMR: LGE in the mid-myocardial and sub-epicardial septum and lower RV wall - PET-FDG: pathologic and heterogenous myocardial uptake, including septal uptake. - Repeat TTE within 14 months showed EF 45-50% - Repeat PET-FDG after 14 months showed a decrease in myocardial uptake on therapy. - Normal troponin and CPK levels, elevated CRP level.	Initial presentation	- Prednisone 50 mg/day, tapered slowly over months - MTX 15 mg/week - ICD insertion	<b>RETICULOENDOTHELIAL:</b> diffuse supra- and subdiaphragmatic LAD with abnormal uptake on PET-FDG with NCGs on EBUS-guided biopsy <b>LUNG:</b> pulmonary infiltrates and interstitial changes <b>RENAL:</b> Hypercalcemia and hypercalciuria <b>MSK:</b> Arthralgia, jaw uptake on PET-FDG <b>SKIN:</b> non-specific skin rash responsive to therapy

**Abbreviations:** ACE=angiotensin converting enzyme, AF=atrial fibrillation, AMI=acute myocardial infarction, APBs=atrial premature beats, AVB=atrioventricular block (CAVB=complete AVB) , ASA=aspirin, AVNRT=atrioventricular node reentrant tachycardia, AZA=azathioprine, B/L=bilateral, cCTA=cardiac CT angiography, CLBBB, complete left bundle branch block, CMP=cardiomyopathy, CMR=cardiac magnetic resonance imaging, CP=chest pain, CRBBB=complete right bundle branch block, CRP=C-reactive protein, CS=cardiac sarcoidosis, CT=computer tomography, c/w=consistent with, d/c=discontinued, DOE=dyspnea on exertion, dx=diagnosis, EBUS=endobronchial biopsy, ECG=electrocardiogram, EF=ejection fraction, EMB=endomyocardial biopsy, EPS=electrophysiological study, F=female, , GGO=ground glass opacities, GI=gastrointestinal, HCQ=hydroxychloroquine, HF=heart failure, ICD=implantable cardioverter-defibrillator, ILD=interstitial lung disease, L=left, LAD=lymphadenopathy, LAHB=left anterior hemiblock, LGE=late gadolinium enhancement, LN=lymph nodes, LV=left ventricle, LVEDD=left ventricle end diastolic volume, M=male, MMF=mycophenolate mofetil, MR=mitral regurgitation, MSK=musculoskeletal, MTX=methotrexate, NCGs=non-caseating granulomas, NHL=non-Hodgkin's lymphoma, NSR=normal sinus rhythm, NSTEMI=non ST elevation MI, NSVT=non-sustained VT, PET-FDG=positron emission tomography using 18F-Fluorodeoxyglucose, PHTN=pulmonary hypertension, PM=pacemaker, PMVT=polymorphic VT, pro-BNP=pro-bone natriuretic peptide, PRWP=poor R wave progression, PVCs=premature ventricular contractions, RTX=rituximab, RV=right ventricle, Rx=treatment, SCD=sudden cardiac death, SOB=shortness of breath, SSZ=sulfasalazine, SVT=supraventricular tachycardia, TTE=transthoracic echocardiogram, VT=ventricular tachycardia, WCT=wide complex tachycardia

**Table S2: Clinical characteristics of cases of cardiac sarcoidosis**

				Certainty of CS diagnosis based on criteria			CS disease activity			Cardiac clinical presentation							Clinical biomarker elevation			
Patient	Age	Sex	Ethnicity	Definite CS	Probable CS	Presumed CS	Active disease	Inactive disease	Initial presentation	Heart block	AF	VT	AMI	Pericarditis	Myocarditis	HF	ACE	CRP	Troponin	BNP
Case 1	71	F	J		1			1		1				1				1	1	N/A
Case 2	54	F	A			1		1	1	1		1								N/A
Case 3	41	M	J		1		1		1	1			1		1	1		1	1	1
Case 4	62	F	J		1			1		1		1								N/A
Case 5	47	F	A			1	N/A	N/A	1	1										N/A
Case 6	61	F	J		1			1	1	1								1	1	N/A
Case 7	56	M	A			1	1		1	1					1				1	N/A
Case 8	40	F	J		1		1		1									1	N/A	N/A

Case 9	56	M	J		1			1		1		1			1	1		1	1	1
Case 10	69	M	J		1		1			1	1							1	1	
Case 11	50	M	A		1			1								1		N/A	N/A	
Case 12	42	M	J	1			1		1			1			1	1	1		1	1
Case 13	51	M	J		1		1		1	1	1						1	1		N/A
Case 14	44	M	A	1			1		1	1							N/A			N/A
Case 15	67	F	J		1		1									1	N/A			N/A
Case 16	25	M	A		1		1		1							1	N/A	1		N/A

Case 17	52	M	J		1		1									1	N/A	1	N/A	N/A
Case 18	61	F	J		1		N/A	N/A	1	1									N/A	N/A
Case 19	57	F	A		1		1		1		1	1				1	N/A	1		N/A
Total	Avg Age ±SD 52.9±11.8	F=9 M=10	J=12 (63.2%) A=7	2	14	3	11/17	6/17	12	12	3	5	1	1	4	8	2/14	9/18	7/15	<b>4/5</b>

**Abbreviations:** A=Arab, ACE=angiotensin converting enzyme, AF=atrial fibrillation, AMI=acute myocardial infarction, Avg=average, BNP=B-type natriuretic peptide, CRP=C-reactive protein, CS=cardiac sarcoidosis, F=female, HF=heart failure, J=Jewish, M=male, N/A=Not available, SD=standard deviation, VT=ventricular tachycardia.



Table S2a: Clinical characteristics of cases of cardiac sarcoidosis-continued

	Certainty of CS diagnosis based on criteria			CS disease activity		Medications										Device implantation/ Arrhythmia management		
Patient	Definite CS	Probable CS	Presumed CS	Active disease	Inactive disease	GC	Colchicine	HCQ	SSZ	MTX	AZA	MMF	ANTI-TNFα	RTX (ANTI-CD20)	ICD	PM	Ablation	
Case 1		1			1	1	1											
Case 2			1		1	Prescribed Not taken				Prescribed Not taken						1		
Case 3		1		1		1				1	1				1 (switch)	1		
Case 4		1			1	1									1			
Case 5			1	?	?	1				1					1			
Case 6		1			1	Prescribed Not taken				Prescribed Not taken					1			
Case 7			1	1		1				1					1			
Case 8		1		1		1		1	1	1								

Case 9		1			1	1						1			1		
Case 10		1		1		1				1		1		1		1	1
Case 11		1			1	1				1	1		1				
Case 12	1			1		1				1					1		
Case 13		1		1		1				1					1		1
Case 14	1			1		1				1					1		
Case 15		1		1		1				1							
Case 16		1		1		1				1							

Case 17		1		1		1				1							
Case 18		1		?	?												
Case 19		1		1		1				1					1	1	
Total	2	14	3	11/17	6/17	16/18	1	1	1	13/15	2	2	1	1	10	4	2

**Abbreviations:** AZA=azathioprine, CS=cardiac sarcoidosis, GC=glucocorticosteroids, HCQ=hydroxychloroquine, ICD=implantable cardioverter-defibrillator, MMF=mycophenolate mofetil, MTX=methotrexate, PM=pacemaker, RTX=rituximab, SSZ=sulfasalazine