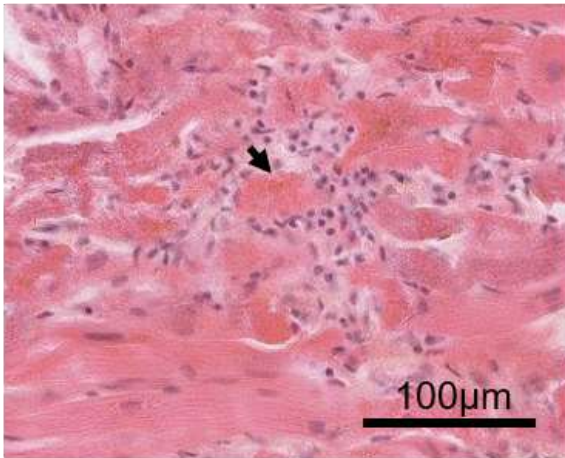
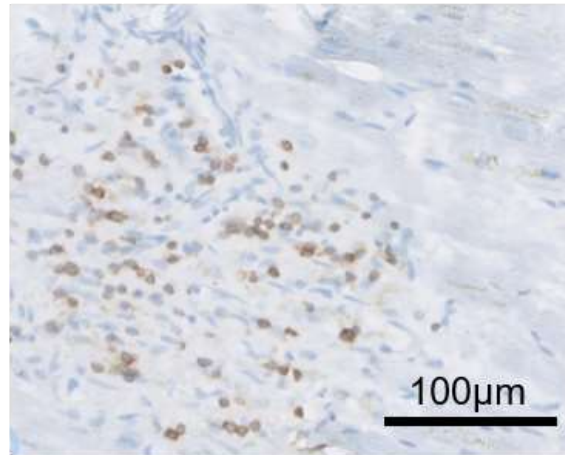


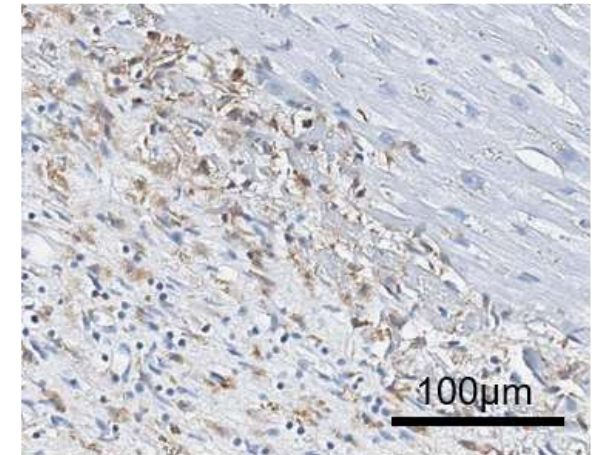
**A** *Cardiomyocyte necrosis*



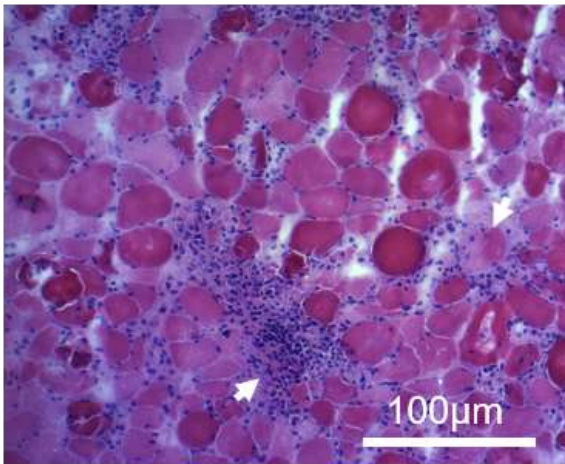
**B** *T-cells (CD3<sup>+</sup>) in the myocardium*



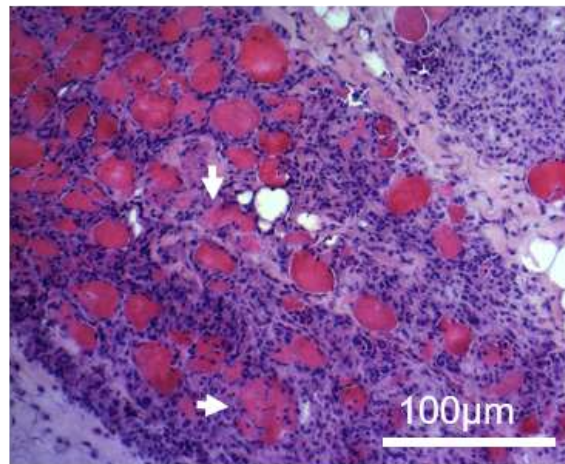
**C** *Macrophages (CD68<sup>+</sup>) in the myocardium*



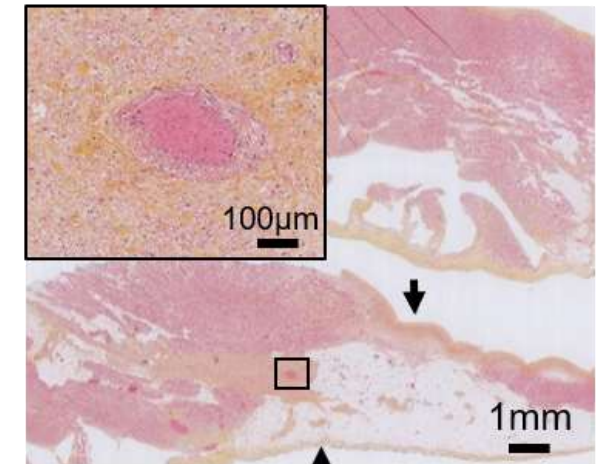
**D** *Deltoid lymphocytic infiltration*



**E** *Diaphragm lymphocytic infiltration*



**F** *Sinus node destruction*



**Supplementary Figure 1. Examples of cardiac and skeletal muscle pathology findings on autopsies of 2 patients.** Panels A-E are from a patient dead acutely from a fulminant ICI-myocarditis. Inflammatory infiltrates surrounding cardiomyocyte necrosis (A, black arrow, hematoxylin and eosin). These inflammatory infiltrates are composed by CD3<sup>+</sup> T-cells (B) and CD68<sup>+</sup> macrophages (C). Skeletal muscles were also affected by endomysial lympho-histiocytic inflammatory infiltrates and myocyte necrosis (white arrows) affecting the diaphragm (D, hematoxylin and eosin) and the psoas muscles (E, hematoxylin and eosin). Panel F is from a patient dead from COVID-19 approximately one-year after an ICI-myocarditis episode complicated by appearance of an irreversible high-grade sinus node dysfunction requiring pacemaker implementation. Heart pathology (F, hematoxylin and eosin) revealed a complete sinus node destruction replaced by a yellowish fibrous tissue surrounding the sinoatrial nodal artery (visible within the small black square) instead of cardiomyocytes normally present. The sinus node spot is located between the superior vena cava (arrow) and the pericardium (arrowhead).