Idiopathic Inflammatory Myopathies (Myositis)

Idiopathic inflammatory myopathies are a group of disorders characterized by inflammation of the skeletal muscles involved in movement, and usually appear in adults between age 40-60 and in children age 5-15, but can occur at any age.

Idiopathic inflammatory myopathy manifests in several forms, including polymyositis (PM), dermatomyositis (DM), and sporadic inclusion body myositis (IBM). The primary symptom of all forms is muscle weakness that may develop gradually over a period of weeks, months, or years. Other symptoms include joint pain and fatigue.

Both PM and DM involve weakness of the proximal muscles, particularly the hips and thighs, upper arms, and neck. DM is distinguished by a red or purple rash on eyelids, elbows, knees, or hands. PM and DM are more common in women while sporadic IBM is more common in men and usually involves muscles of the wrist, fingers, and thigh.

**TYPICAL TESTING STRATEGY**

**Initial Screening Tests**
- Creatine kinase
- Erythrocyte sedimentation rate/C-reactive protein
- Thyroid-stimulating hormone: rule out thyroid disease as etiology for myopathy
- Metabolic profile
- Complete blood count
- Antinuclear antibodies

**Antibody Testing**
See Tests to Consider

**Definitive Diagnosis**
Muscle biopsy (which can be guided by magnetic resonance imaging [MRI]) is gold standard

**DISEASE OVERVIEW**

**Incidence**
4-10/million adults; rare in children

**Age of Onset**
Varies by disorder:
- DM: childhood and 50-70 years
- PM: rare in childhood, typically >20 years
- IBM: >50 years
- Necrotizing autoimmune myositis: primarily adults, often older

**Syndromes**
- DM: associated with cancer
- PM
- IBM
- Necrotizing autoimmune myositis
- Overlap syndrome
- Juvenile DM and PM

**Symptoms**

**General Features**
- Musculoskeletal: progressive muscle weakness (usually symmetrical and proximal)
  - Pharyngeal and neck flexion muscles frequently involved
- Arthralgias/arthritis: wrists, knees, small joints of hands
- Constitutional: fever, weight loss
- Pulmonary: fibrosing alveolitis, aspiration pneumonia
- Gastrointestinal: esophageal dysfunction, dysphagia
- Cardiovascular: myo-/pericarditis, valvular disease, rhythm disturbances
- Renal: rarely myoglobinuria, glomerulonephritis
- Dermatologic: Raynaud phenomenon, rashes, calcinosis over bony prominences
Antisynthetase Syndrome
- Found almost exclusively in middle-aged women with DM or PM
- Characterized by:
  - Low-grade fevers
  - Interstitial pneumonitis: major determinant of morbidity and mortality
  - Hyperkeratosis, cracking of lateral and palmar aspects of the fingers (mechanic’s hands)
  - Raynaud phenomenon
  - Inflammatory polyarthritis, myalgias
- Presence of antinuclear antibodies known as antisynthetases

Dermatomyositis
- Characteristic photosensitive rash accompanied by symmetrical, subacute, proximal muscle weakness
  - Rash usually precedes muscle symptoms
  - Blue-purple rash: symmetrical distribution
  - Violaceous discoloration of upper eyelids with periorbital edema (heliotrope rash)
  - Erythema of metacarpophalangeal proximal and distal joints
    - Raised violaceous rash (Gottron sign) or scaly erythematous plaques over dorsal surface of bony prominences (Gottron papules): considered pathognomonic for DM
  - Macular erythema over the lower neck and upper chest in a V-distribution (V-sign), over upper back (Shawl sign), or over upper thighs (Holster sign)
  - Telangiectasias at base of fingernails, cuticular overgrowth and periangual erythema
  - Vasculitic skin changes
    - Subcutaneous nodules, periungual infaracts, digital ulcerations
- Cancer-associated myositis
  - Most commonly associated with DM, but can be found in PM
  - May be diagnosed prior to, simultaneously with, or after myopathy
  - Increased risk of malignancy (20-25%) of any of the following types (highest risk in first 2-3 years after diagnosis):
    - Ovarian, breast, melanoma, colorectal, non-Hodgkin lymphoma
- Amyopathic DM
  - Characteristic cutaneous findings of DM >6 months without muscle involvement
  - May progress to DM
  - Some risk for lung disease, malignancy
  - Electromyography may demonstrate subtle myopathy

Polymyositis
- Dominated by muscular presentation with no rash
- Usually subacute presentation
- May be associated with other autoimmune diseases
- Diagnosis of exclusion: must rule out the following:
  - Neuromuscular disease
  - Endocrinopathy
  - Muscular dystrophy
  - Known biochemical muscle disorder or familial biochemical disorder
  - Drug-induced myopathy

Inclusion Body Myositis
- Two types: sporadic, hereditary
- Muscle involvement
  - Muscle atrophy early in disease
  - Distal weakness is most common: deep finger flexors and foot extensors common
  - Asymmetric distribution is common
  - Proximal muscles less frequently involved
  - Specific muscles
    - Small muscles in hand frequently involved
    - Quadriceps involvement common: associated with frequent falls
    - Facial muscles frequently involved
  - Extramuscular disease rare: dysphagia is the exception (>50% of patients)
  - May be misdiagnosed as PM, adult-onset muscular dystrophy, or motor neuron disease
  - Associated with other autoimmune diseases

Necrotizing Autoimmune Myositis
- Acute or subacute presentation
- Severe proximal muscle weakness: clinically indistinguishable from PM
- May occur in association with cancer, other CT diseases, or drug use (eg, statins)
- Diagnosis of exclusion

Overlap Syndrome
- Most common in DM but can occur with other inflammatory myopathies
- Myositis in conjunction with connective tissue disease
Most common: systemic sclerosis, mixed connective tissue disease, systemic lupus erythematosus

- Rash: faint or transient
- Frequent association with antisynthetase antibodies
- Myopathy varies from mild to dominant presentation

**Juvenile Disease**

**Juvenile Dermatomyositis (JDM)**

- ~85% of juvenile idiopathic inflammatory myopathy (JIIM)
- Symmetrical and proximal muscle weakness
- Gottron papules
- Heliotrope rash
- Periungual telangiectasia
- Vasculitis: more common than in adults
- Other organ/skeletal involvement: cardiac, joints, gastrointestinal, pulmonary
- May have family history of other autoimmune diseases
- Amyopathic (hypomyopathic form)
  - Inflammatory rashes without muscle weakness
  - ~25% develop full-blown dermatomyositis

**Juvenile Polymyositis**

- 4-8%
- Proximal and distal muscle weakness
- Frequent falling episodes
- Cardiac damage

**Juvenile Connective Tissue Disease Myositis**

- 6-11% of JIIM
- Occurs in conjunction with another connective tissue disease
- Raynaud phenomenon
- Arthritis
- Malar rash
- Interstitial lung disease

**Diagnostic Issues**

May be difficult to distinguish between myopathies

- Antibody testing in conjunction with clinical presentation and muscle biopsy help to confirm the diagnosis
- Differentiation may be important for therapy and prognosis

**Antibody Testing**

Usually associated with connective tissue disease/overlap syndrome

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<thead>
<tr>
<th>Myositis-Specific Antibodies</th>
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<tbody>
<tr>
<td><strong>Antisynthetase antibodies</strong></td>
</tr>
<tr>
<td>Anti-Jo-1 (histidyl-tRNA synthetase): more common in polymyositis</td>
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<tr>
<td>Anti-PL7 (threonyl-tRNA synthetase)</td>
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<tr>
<td>Anti-PL-12 antibodies (anti-alanyl-tRNA synthetase)</td>
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<tr>
<td>Anti-EJ (glycyl-tRNA synthetase)</td>
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<td>Anti-OJ (anti-isoleucyl-tRNA synthetase)</td>
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<td>Anti-KS (asparaginyl-tRNA synthetase)</td>
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<td>Anti-Ha (tyrosyl tRNA synthetase)</td>
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<td>Anti-Zo (phenylalanyl tRNA synthetase)</td>
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<tr>
<th><strong>Myositis-associated antibodies</strong></th>
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<tr>
<td>Anti-PM-Scl: polymyositis-scleroderma</td>
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<tr>
<td>Anti-Smith/RNP</td>
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<tr>
<td>Anti-Ku</td>
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<tr>
<td>Anti-Ro (SSA-52 and SSA-60)</td>
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<tr>
<td>No synthetase antibodies</td>
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<tr>
<td>Anti-p150/140</td>
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<td>Anti-Mi-2</td>
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<td>Anti-CADM-140</td>
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<td>Anti-p140</td>
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<td>Anti-SAE</td>
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<tr>
<td>Anti-HMGCR</td>
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CADM, clinically amyopathic dermatomyositis; HMGCR, 3-hydroxy-3-methylglutaryl-coenzyme A reductase; ILD, interstitial lung disease

**TEST INTERPRETATION**

**Results**
- Positive: as a single test, not diagnostic for inflammatory myopathy
- Negative: does not rule out inflammatory myopathy

**Limitations**
- Results by themselves are not diagnostic; strong clinical correlation is recommended
- Negative results do not rule out a diagnosis of inflammatory myopathy or overlap syndrome

**RELATED INFORMATION**

**Inflammatory Myopathies**

**RELATED TESTS**

**Creatine Kinase, Total, Serum or Plasma** 0020010
Method: Quantitative Enzymatic

**Antinuclear Antibodies (ANA), IgG by ELISA with Reflex to ANA, HEp-2 Substrate, IgG by IFA** 0050080
Method: Qualitative Enzyme-Linked Immunosorbent Assay/Semi-Quantitative Indirect Fluorescent Antibody

**SSA 52 and 60 (Ro) (ENA) Antibodies, IgG** 2012074
Method: Semi-Quantitative Multiplex Bead Assay

**Jo-1 Antibody, IgG** 0099592
Method: Semi-Quantitative Multiplex Bead Assay

**Smith/RNP (ENA) Antibody, IgG** 0050470
Method: Semi-Quantitative Multiplex Bead Assay

**Signal Recognition Particle (SRP) Antibody** 2002098
Method: Immunoprecipitation

**PM/Scl-100 Antibody, IgG by Immunoblot** 2003040
Method: Qualitative Immunoblot

**Fibrillarin (U3 RNP) Antibody, IgG** 2012173
Method: Qualitative Immunoblot