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 is bimodal: 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
- Arthralgia/arthritis: wrists, knees, small joints of hands
- Constitutional: fever, weight loss
- Pulmonary: fibrosing alveolitis, aspiration pneumonia
- Gastrointestinal: esophageal dysfunction, dysphagia
- Cardiovascular: myocarditis, 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 peri-orbital 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 periungual erythema
  - Vasculitic skin changes
    - Subcutaneous nodules, periungual infarcts, 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

Polymyositis Panel 2013990

**Method:** Qualitative Immunoprecipitation/Semi-Quantitative Multiplex Bead Assay

May be useful for evaluation of patients with progressive proximal muscle weakness and antisynthetase syndrome

**Components:**

- Jo-1 antibody, IgG
- PL-7 (threonyl-tRNA synthetase) antibody
- PL-12 (alanyl-tRNA synthetase) antibody
- EJ (glycyl-tRNA synthetase) antibody
- SRP (signal recognition particle) antibody
- OJ (isoleucyl-tRNA synthetase) antibody

Dermatomyositis Autoantibody Panel 3001782

**Method:** Qualitative Immunoprecipitation/Qualitative Immunoblot

May be useful for evaluation of patients with characteristic cutaneous manifestations of dermatomyositis with or without muscle weakness

**Components:**

- Mi-2 (nuclear helicase protein) antibody
- P155/140 antibody
- SAE1 (SUMO activating enzyme) antibody
- MDA5 (CADM-140) antibody
- NXP-2 (nuclear matrix protein-2) antibody
- TIF1-gamma (TIF1-γ) antibody

Interstitial Lung Disease Autoantibody Panel 3001784

**Method:** Qualitative Immunoprecipitation/Semi-Quantitative Multiplex Bead Assay/Qualitative Immunoblot/Semi-Quantitative Enzyme-Linked Immunosorbent Assay/Quantitative Immunoturbidimetry

May be useful for evaluation of interstitial lung disease in the context of connective tissue disease

**Components:**

- SSA-52 (Ro52) and SSA-60 (Ro60) (ENA) antibodies, IgG
- Scleroderma (Scl-70) (ENA) antibody
- Jo-1 antibody, IgG
- PL-7 (threonyl-tRNA synthetase) antibody
- PL-12 (alanyl-tRNA synthetase) antibody
- EJ (glycyl-tRNA synthetase) antibody
- Ku antibody
- SRP (signal recognition particle) antibody
- OJ (isoleucyl-tRNA synthetase) antibody
- PM/Scl-100 antibody, IgG by immunoblot
- MDA5 (CADM-140) antibody
- NXP-2 (nuclear matrix protein-2) antibody
- Rheumatoid factor
- Cyclic citrullinated peptide (CCP) antibody, IgG
- Antinuclear antibody (ANA) with HEp-2 substrate, IgG by IFA
- RNA polymerase III antibody, IgG

3-Hydroxy-3-Methylglutaryl Coenzyme A Reductase (HMGCR) Antibody, IgG
Differential diagnosis of myositis in patients with or without statin exposure

In addition to clinical evaluation for muscle strength and serum creatine kinase, may be useful to monitor response to treatment. See 3-Hydroxy-3-Methylglutaryl Coenzyme A Reductase (HMGCR) Antibody, IgG Test Fact Sheet for more information.

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 (JIM)
- Symmetrical and proximal muscle weakness
- Gottron papules
- Heliotrope rash
- Periungal telangiectasia
- Vasculectis: 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

2013101

Method: Semi-Quantitative Enzyme-Linked Immunosorbent Assay

Differential diagnosis of myositis in patients with or without statin exposure

In addition to clinical evaluation for muscle strength and serum creatine kinase, may be useful to monitor response to treatment.

See 3-Hydroxy-3-Methylglutaryl Coenzyme A Reductase (HMGCR) Antibody, IgG Test Fact Sheet for more information.

See Related Tests
~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

<table>
<thead>
<tr>
<th><strong>Myositis-Specific Antibodies</strong></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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<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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<tr>
<td>Anti-Ha (tyrosyl-tRNA synthetase)</td>
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<td>Anti-Zo (phenylalanyl-tRNA synthetase)</td>
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<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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<td>Anti-Ku</td>
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<td>Anti-Ro (SSA-52 and SSA-60)</td>
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CADM, clinically amyopathic dermatomyositis; HMGCR, 3-hydroxy-3-methylglutaryl-coenzyme A reductase; ILD, interstitial lung disease
No synthetase antibodies | Antisignal recognition particle (anti-SRP)
- Necrotizing myopathy
- Severe cardiac involvement

Anti-p155/140
- JDM, DM, and ulceration
- Adults: DM, increased malignancy risk

Anti-Mi-2
- Found in DM
- Not associated with increased malignancy risk
- Responsive to steroids

Anti-CADM-140
- CADM
- Rapidly progressive ILD

Anti-p140
- JDM, DM, and calcinosis
- Adults: DM, increased malignancy risk, ILD

Anti-SAE
- DM

Anti-HMGCR
- Necrotizing myopathy
- Response to short-term statin withdrawal

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 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 S2 and 60 (Ro) (ENA) Antibodies, IgG 2012074
Method: Semi-Quantitative Multiplex Bead Assay

**Jo-1 Antibody, IgG 0099592**

**Smith/RNP (ENA) Antibody, IgG 0050470**

**Signal Recognition Particle (SRP) Antibody 2002098**

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

**Fibrillarin (U3 RNP) Antibody, IgG 2012173**