Inflammatory Myopathies

Dermatomyositis (DM) & Polymyositis (PM)

- Clinical similarity: Gradual onset, painless, proximal muscle, pharyngeal, and respiratory muscle weakness. Muscle pain is atypical.
- Clinical difference: DM has a rash.
- Pathophysiology difference: DM is a capillary vasculitis. PM is a direct muscle fiber insult.
- Well established correlation with malignancy.

Rashes of Dermatomyositis

- Sun sensitive.
- Hand → purple papules over joints ("Gottron papules")
- Near eye → edematous lilac discoloration ("heliotrope rash")
- V-neck
- Shawl sign

Testing

- ANA positivity: 80% of DM or PM. <20% of inclusion-body.
- Serum CK
- Aldolase level
- EMG testing
- (equivocal work up) Muscle biopsy and/or MRI of proximal thighs.

Anti-Synthetase syndrome

- Seen in patients with DM or PM, but not inclusion body myositis.
- Syndrome:
  - Interstitial lung disease +
  - Inflammatory polyarthritis +
  - Fever +
  - Raynaud +
  - "mechanic's hand".
- Increased risk of sudden death

Treatment

- 1st line: High dose oral steroids.
- 2nd line: MTX or azathioprine.
- 3rd line: Rituximab
- Plaquenil for rashes

Inclusion-Body Myositis

- Insidious onset (like others)
- Proximal & **Distal** joints involvement.
- Frequently **asymmetric**.

Toxic myopathies

- Steroid induced
- Statin induced
- Alcohol induced.

Differential to consider

- ALS (muscle fasciculations)
- Myasthenia Gravis (oculomotor weakness with ptosis)
- Polymyalgia rheumatica (pain/tenderness)
- Peripheral neuropathy (muscle atrophy / hyporeflexia)
- Hypothyroidism (delayed reflexes, weight gain, goiter)

Garg's Simple Medicine

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