Top 5 tips: Idiopathic Inflammatory myopathies

Arthritis Subcommittee

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IIM CLASSIFICATION



"*Finger flexor weakness and response to treatment: not improved, or **Muscle biopsy: rimmed vacuoles, is required for diagnosis. ***Juvenile myositis other than JDM was developed based on expert opinion. IMNM and hypomyopathic DM were too few to allow sub-classification.

PM, polymyositis; IMNM, immune-mediated necrotizing myopathy; IBM, inclusion body myositis; ADM, amyopathic dermatomyositis; DM, dermatomyositis; JDM, juvenile dermatomyositis.'

Lundberg IE, et al. EULAR/ACR Classification Criteria for Adult and Juvenile Idiopathic Inflammatory Myopathies and their Major Subgroups . Ann Rheum Dis. 2017 December ; 76(12): 1955–1964





MR imaging, based on T1 + STIR or T2 DIXON (Fat + Water), depicts muscle edema and fatty replacement/atrophy at diagnosis, may guide biopsies and is useful also to assess the response to treatment. Given the association of IIM with cancer and interstitial lung diseases, further imaging (e.g., HRCT, PET/CT) might be considered according to autoantibody profile.





In **inclusion body myositis** the inflammation frequently affects the anterior muscles of the thigh and forearm.







Dermatomyositis is usually characterized by subcutaneous edema, fascial edema, and muscle edema with peripheral distribution.









Dystrophic soft tissue calcifications (calcinosis) typically occur in **juvenile dermatomyositis** and most frequently affect elbows, knees, trunk, hands, feet, and head.







Immune-mediated necrotizing myopathy causes more widespread muscle edema, atrophy, and fatty replacement than dermatomyositis and it might be associated with the use of statins; moreover adductor brevis edema and obturator externus atrophy are especially common.



References

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