Common Pediatric Rheumatologic Diseases

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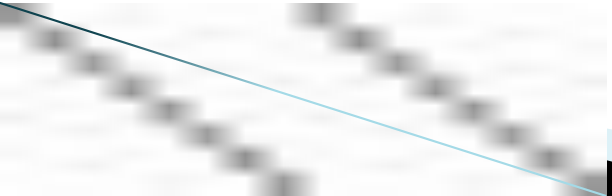
- Juvenile Idiopathic Arthritis
- SLE
- HSP
- JDM



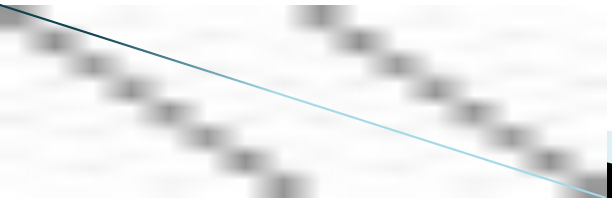
Juvenile idiopathic arthritis (JIA)

Accepted name

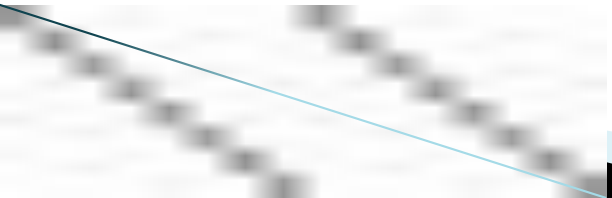
Old names

Juvenile Rheumatoid Arthritis

Juvenile Chronic Arthritis



Arthritis: swelling within a joint, or limitation in the range of joint movement with joint pain or tenderness, which persists for at least 6 weeks, is observed by a physician, and is not due to primarily mechanical disorders or other identifiable causes.



- JIA is a group of disorders characterized by chronic arthritis.
- It is the most common chronic rheumatic illness in children.
- It is a clinical diagnosis made in a child less than 16 years of age with arthritis.
- The incidence of JIA ranges from 1 to 22 per 100,000.

Pathophysiology:

The pathogenesis of JIA is not understood well.

Substantial evidence suggests that JIA is an autoimmune process.

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- Classification of JIA:
  - Oligoarticular JIA.
  - Polyarticular rheumatoid factor positive JIA.
  - Polyarticular rheumatoid factor negative JIA.
  - Systemic JIA.
  - Psoriatic JIA.
  - Enthesitis related arthritis(ERA).
  - Undifferentiated.

- Oligoarticular JIA
  - <5 joints during the first 6 months of disease.
  - At high risk for developing uveitis especially ANA-positive girls.
  - Persistent & extended oligoarticular JIA.

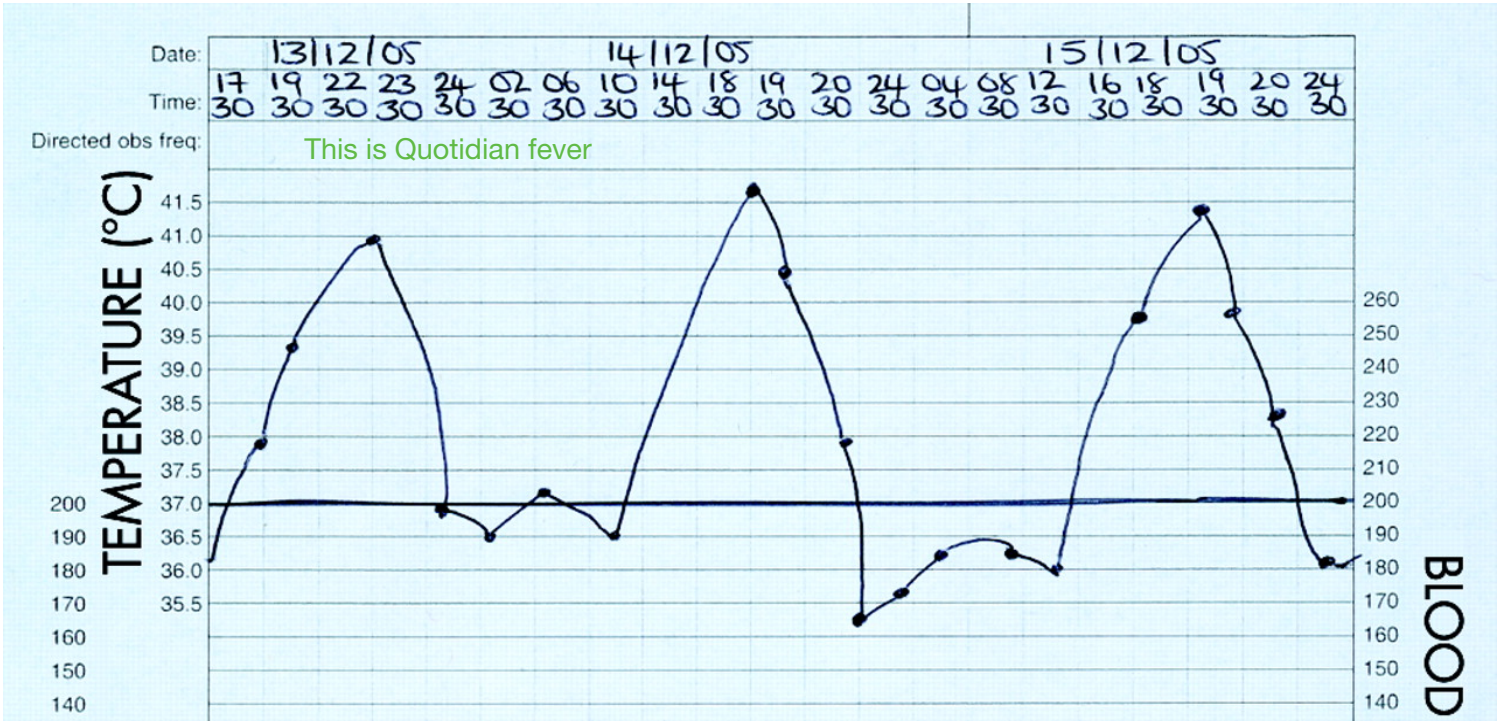
Shape of pupils isn't rounded this results from the chronic inflammation in the eye and this dx by JIA most likely oligoarticular *JIA*

Normal shape of pupil

- Polyarticular JIA
  - RF-negative disease (20% to 30% of JIA patients)
  - RF-positive disease (5% to 10% of JIA patients).
  - Both types affect girls more frequently than boys.
  - RF-negative patients often develop polyarthritis in early childhood.

- Systemic onset juvenile idiopathic arthritis:
  - No specific age and gender.
  - At onset, extra-articular manifestations including rash, fever, lymphadenopathy, hepatosplenomegaly, and serositis predominate.
  - The classic rash is evanescent . Comes and goes
  - Stress or a warm bath may exacerbate the rash.

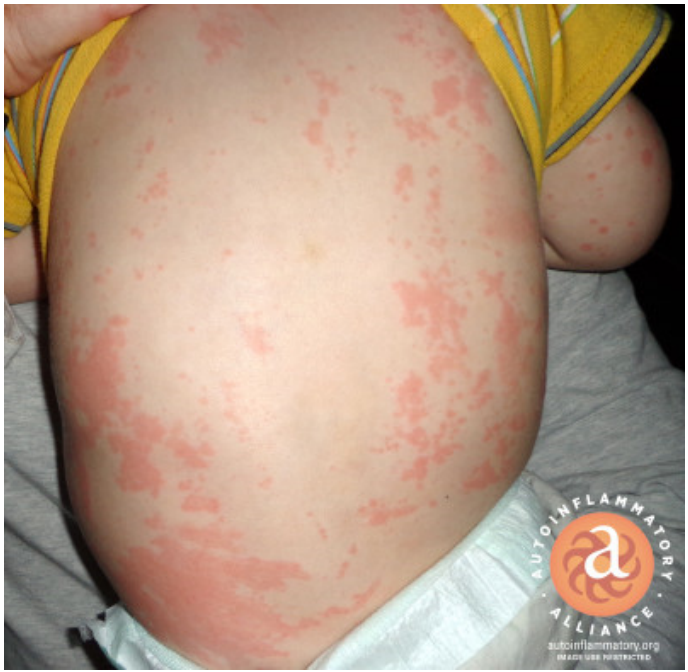
Quotidian fever skin rash arthritis this is in favor of systemic JIA



- # Evancent rash

  Or salmon patch rash and can disappear within few hours

If you are on call and nurse call you for pt possible systemic JIA you may not see it but it can come again few hours later



Classification of macrophage activation syndrome in systemic juvenile idiopathic arthritis

A febrile patient with known or suspected systemic juvenile idiopathic arthritis is classified as having macrophage activation syndrome if the following criteria are met:

Ferritin >684 ng/ml
and any 2 of the following:
Platelet count ≤181 x 10^9/liter
Aspartate aminotransferase >48 units/liter
Triglycerides >156 mg/dl
Fibrinogen ≤360 mg/dl

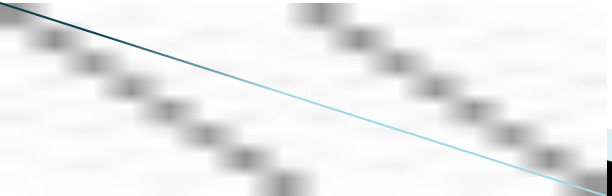
Persistent high fever not quotidian they look sick and have pancytopenia

Figure 2. Criteria for the classification of macrophage activation syndrome in patients with systemic juvenile idiopathic arthritis. Laboratory abnormalities should not be otherwise explained by the patient's condition, such as concomitant immune-mediated thrombocytopenia, infectious hepatitis, visceral leishmaniasis, or familial hyperlipidemia.

You have to exclude mimicker, most of the pt they should go for bone marrow aspiration and biopsy to rule out malignancy

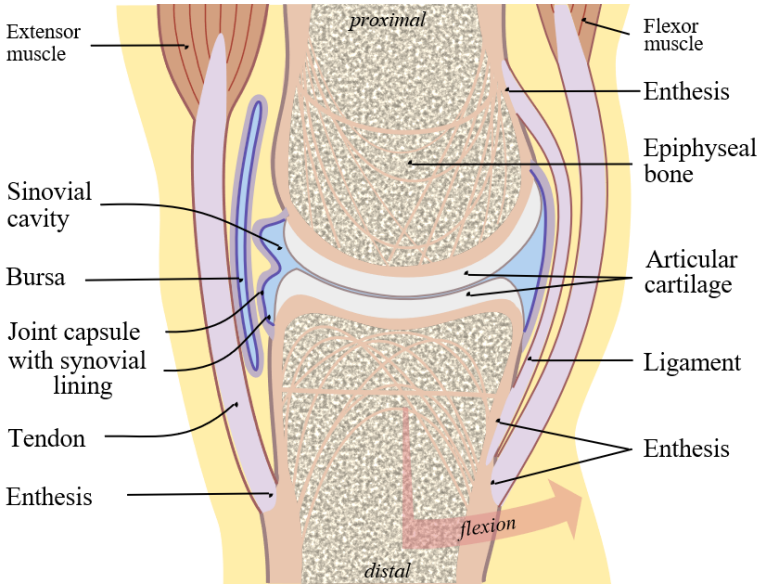
- Enthesitis-related arthritis:
  - Most common in boys older than 8 years of age.
  - It has a strong genetic predisposition.
  - The hallmarks of the disease are pain, stiffness, and eventual loss of mobility of the back.

They may have acute eye inflammation not chronic like oligoarticular JIA



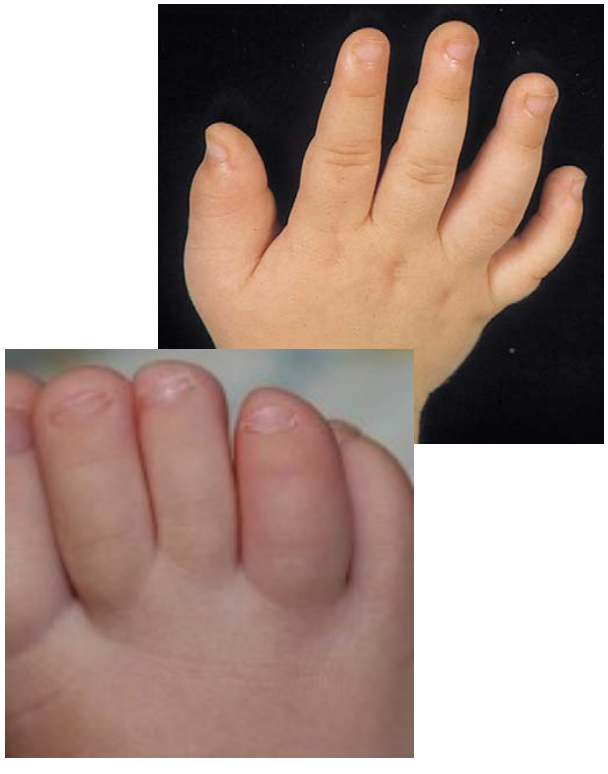
Enthesis

insertion of the ligament tendon or fascia to the bone called enthesis

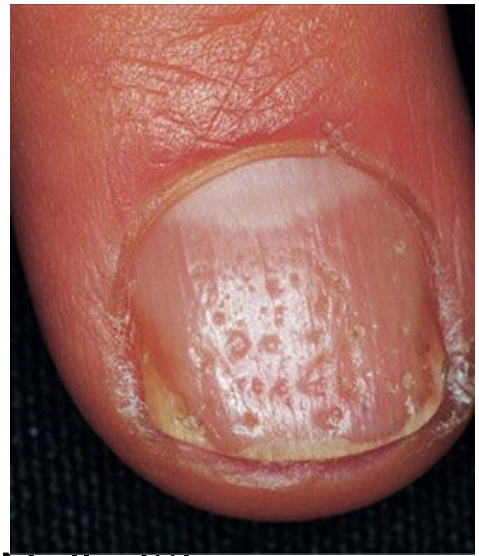


Psoriatic arthritis:

A peak age of onset in mid childhood.
Extra-articular manifestations include rash, nail changes (including pitting, onycholysis) and uveitis.

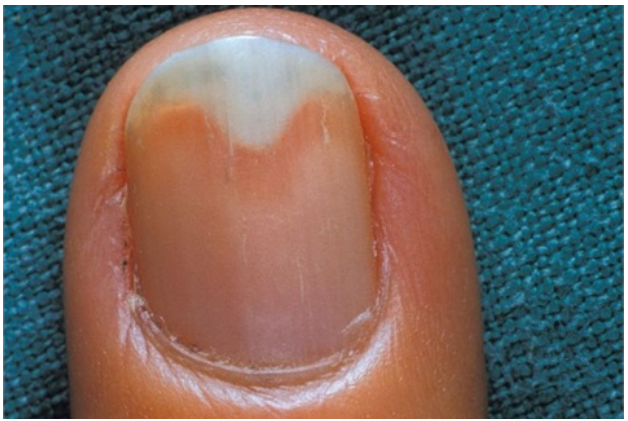


Dactylitis inflammation of the whole digit



Nail pitting

Inflammation under the nail bed



onycholysis

Differential diagnosis of arthritis: called undifferentiated If it's not fit any class

Before labeling JIA we have to search for the causes

Reactive:
- Post-enteric.
- Rheumatic fever.
- Post-streptococcal.

Inflammatory:
- Juvenile idiopathic arthritis.
- Inflammatory bowel disease.
- Sarcoidosis.

Systemic:
- Kawasaki disease.
- Behcet's disease.
- Henoch-Schonlein purpura.
- Serum sickness.
- Systemic lupus erythematosus.
- Dermatomyositis.

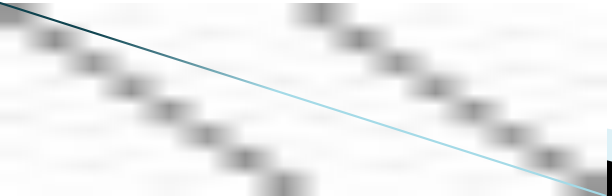
Malignancy:
- Leukemia.
- Neuroblastoma.
- Malignant bone tumors.

Infection:
- Septic.
- Osteomyelitis.
- Viral.
- Bacterial sacroilitis.

Benign bone tumors.

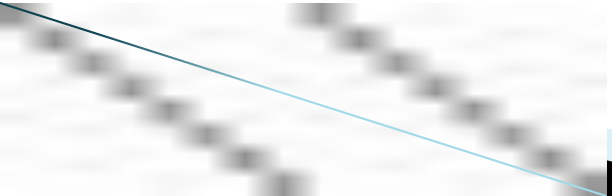
Trauma.

- Laboratory :
  - No specific lab. can confirm the diagnosis
  - Lab. can be used to :
    - Provide evidence of inflammation.
    - Support the clinical diagnosis.
    - Monitor treatment toxicity.



- Limited joint disease:
  - Mild anemia.
- Moderate –extensive arthritis:
  - Normocystic hypochromic anemia or severe anemia.
  - Iron deficiency anemia.
  - High WBC count.
  - High platelets.

Pt with systemic JIA presents with of Pancytopenia think of macrophages activation syndrome

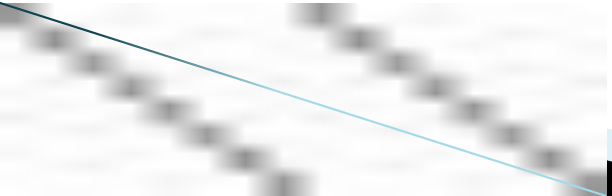


- ESR (erythrocyte sedimentation rate):
  - Useful but not totally reliable measure of active disease.
  - Helpful in monitoring the therapeutic efficacy of the medications .

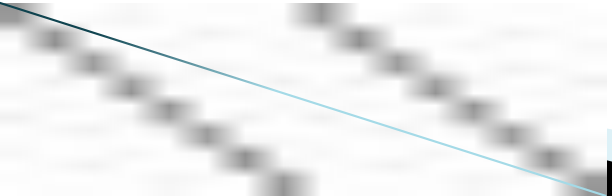
Oligoarticular particularly may normal

- CRP (c –reactive protein):
  - More reliable monitor of inflammation response.
- Rheumatoid factor:
  - IgM anti IgG
  - RF positive in:
    - Later childhood poly arthritis
    - Subcutaneous nodules
    - Articular erosions.

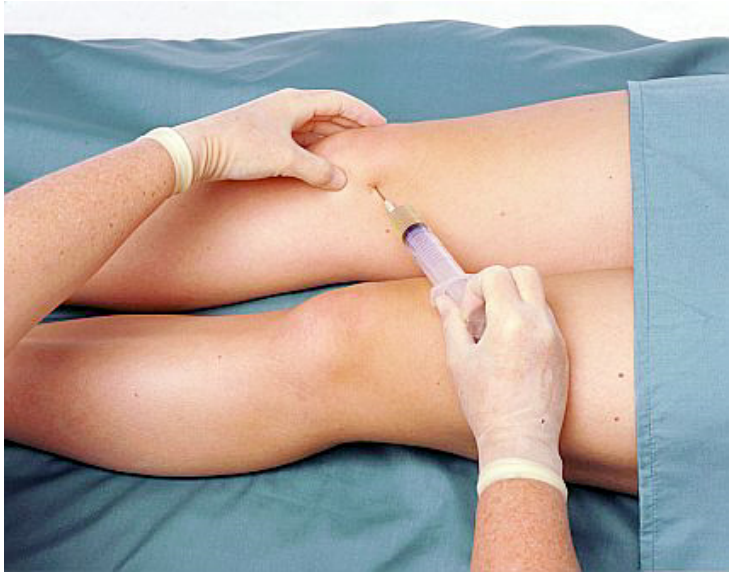
Help in differentiate + -



- ANA (antinuclear antibody):
  - More frequent in young girls with oligo JIA.
  - Less frequent in older boys with systemic arthritis.

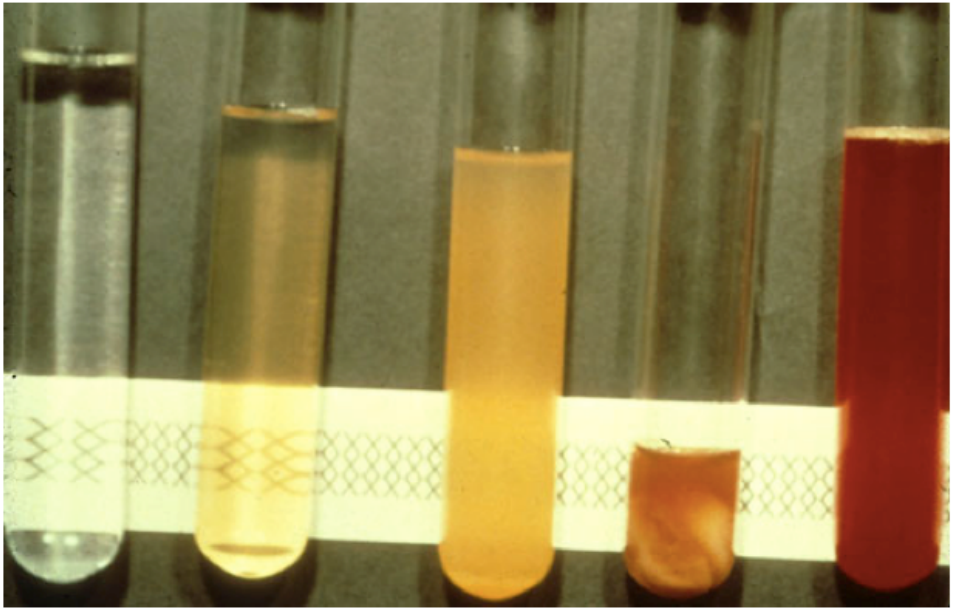


easiest joint to aspirate is knee



Send for culture and cell count when we decide to give intra-articular steroid injection but it's not routine as a diagnostic tool

Synovial Fluid Color and Clarity

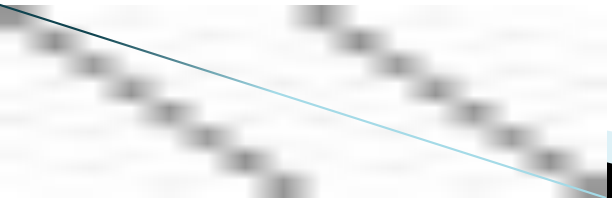


Normal | Non-inflammatory | Inflammatory | Septic | Hemorrhage

- Radiology:

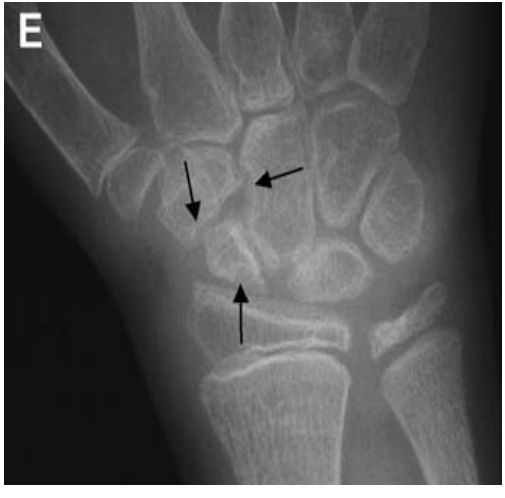
Plain x-ray

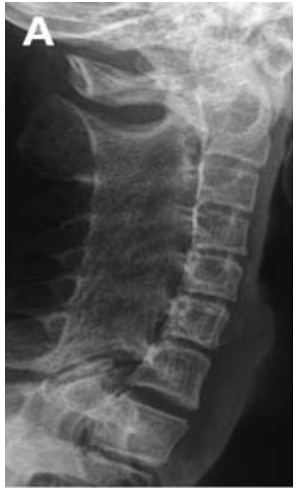
- Early radiological changes:
  - Periosteal soft tissue swelling.
  - Widening of the joint space.
  - Juxta articular osteoporosis.



E: When the chronic inflammation is not treated ,there will be Area of erosion (bone eaten up by chronic) osteopenia and opsteoprosis and fracture

A: Cervical vertebra you expect cervical spine be separated , but it will be ankylosed due to aggressive or chronic inflammation





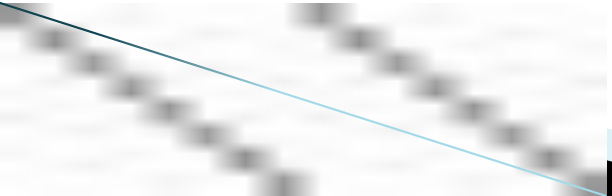
Later changes:

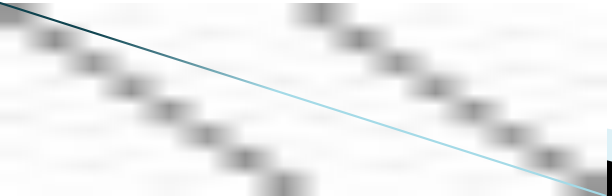
- Joint space narrowing
- Erosions.
- Subluxation.
- Ankylosis.
- Fracture.

Management:

- Multidisciplinary approach.
- The aim of management of JIA include:
  - Controlling pain.
  - Controlling inflammation.
  - Preserving function.
  - Promoting normal growth.
  - Promoting overall development.
  - Manage systemic complication.

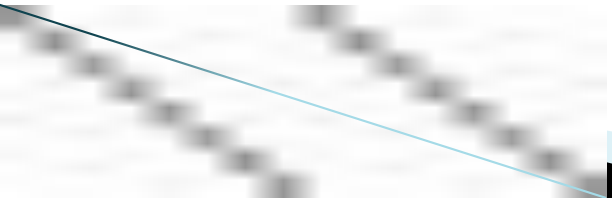
- Medications:
  - NSAIDS:
    - Naproxen.
  - Methotrexate. to treat specially polyarticulate JIA
  - Steroids:
    - Systemic.
    - Intra-articular.
  - Biologics (relatively new). We added it when it's Not respond to treatment TNF antagonist like humera





Systemic Lupus Erythematosus

- SLE is a multisystem autoimmune disease with a great variability in disease presentation and course.
- The diagnosis of SLE is based on the clinical and laboratory features consistent with this illness.

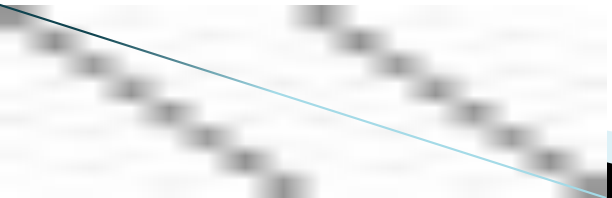


- The etiology of systemic lupus erythematosus (SLE) remains unknown and it is multifactorial.

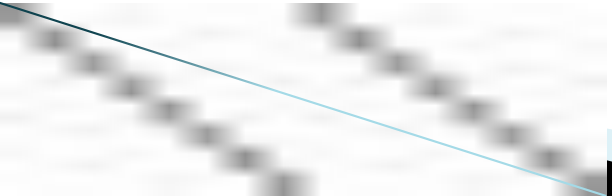
- Genetic factors :

  There is a high concordance rate (14 to 57 percent) of SLE in monozygotic twins.

  Children of mothers with lupus may have a positive test for anti -nuclear antibodies



- Hormonal factors :
  - The use of estrogen-containing contraceptive agents is associated with a 50 percent increase in risk of developing SLE
- Immune abnormalities:
  - SLE is primarily a disease with abnormalities in immune regulation
- Environmental factors :
  - Viruses
  - Ultraviolet (UV) light
  - Allergies to medications Hydrazine or anti TB



Criteria for classification of systemic lupus erythematosus:

Old criteria

SLICC† Classification Criteria for Systemic Lupus Erythematosus

RheumTutor.com

Requirements: ≥ 4 criteria (at least 1 clinical and 1 laboratory criteria)
OR biopsy-proven lupus nephritis with positive ANA or Anti-DNA

Clinical Criteria

1. Acute Cutaneous Lupus*
2. Chronic Cutaneous Lupus*
3. Oral or nasal ulcers *
4. Non-scarring alopecia
5. Arthritis *
6. Serositis *
7. Renal *
8. Neurologic *
9. Hemolytic anemia
10. Leukopenia *
11. Thrombocytopenia (<100,000/mm^3)

Immunologic Criteria

1. ANA
2. Anti-DNA
3. Anti-Sm
4. Antiphospholipid Ab *
5. Low complement (C3, C4, CH50)
6. Direct Coombs' test (do not count in the presence of hemolytic anemia)

†SLICC: Systemic Lupus International Collaborating Clinics
* See notes for criteria details

Petri M, et al. Arthritis and Rheumatism. Aug 2012

A must to have ANA

How to dx lupus nowadays

Don't remember all the numbers but I want you to have an idea

Entry criterion

Antinuclear antibodies (ANA) at a titer of ≥1:80 on HEp-2 cells or an equivalent positive test (ever)

↓

If absent, do not classify as SLE
If present, apply additive criteria

↓

Additive criteria

Do not count a criterion if there is a more likely explanation than SLE.
Occurrence of a criterion on at least one occasion is sufficient.
SLE classification requires at least one clinical criterion and ≥10 points.
Criteria need not occur simultaneously.
Within each domain, only the highest weighted criterion is counted toward the total score§.

Clinical domains and criteria	Weight	Immunology domains and criteria	Weight
Constitutional		***Antiphospholipid antibodies***	
Fever	2	Anti-cardiolipin antibodies OR	
Hematologic		Anti-β2GP1 antibodies OR	
Leukopenia	3	Lupus anticoagulant	2
Thrombocytopenia	4	***Complement proteins***	
Autoimmune hemolysis	4	Low C3 OR low C4	3
Neuropsychiatric		Low C3 AND low C4	4
Delirium	2	***SLE-specific antibodies***	
Psychosis	3	Anti-dsDNA antibody* OR	
Seizure	5	Anti-Smith antibody	6
Mucocutaneous			
Non-scarring alopecia	2		
Oral ulcers	2		
Subacute cutaneous OR discoid lupus	4		
Acute cutaneous lupus	6		
Serosal			
Pleural or pericardial effusion	5		
Acute pericarditis	6		
Musculoskeletal			
Joint involvement	6		
Renal			
Proteinuria >0.5g/24h	4		
Renal biopsy Class II or V lupus nephritis	8		
Renal biopsy Class III or IV lupus nephritis	10		

Total score:

↓

Classify as Systemic Lupus Erythematosus with a score of 10 or more if entry criterion fulfilled.

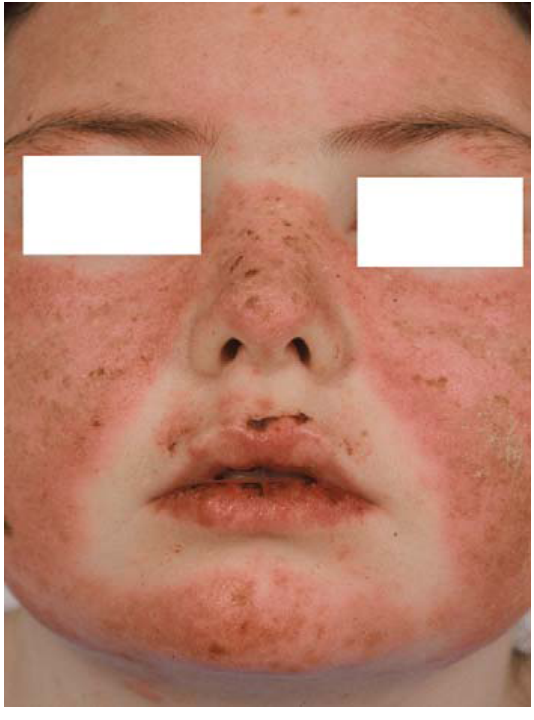
Figure 2 Classification criteria for systemic lupus erythematosus.
§Additional criteria items within the same domain will not be counted.
*Note: In an assay with at least 90% specificity against relevant disease

CLINICAL CRITERIA

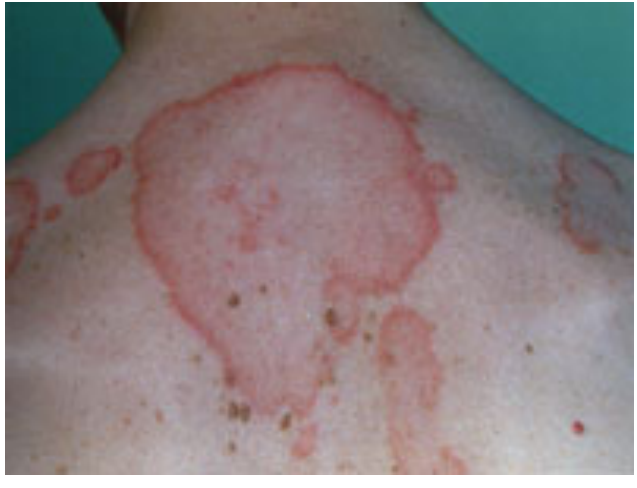
Acute Cutaneous Lupus :

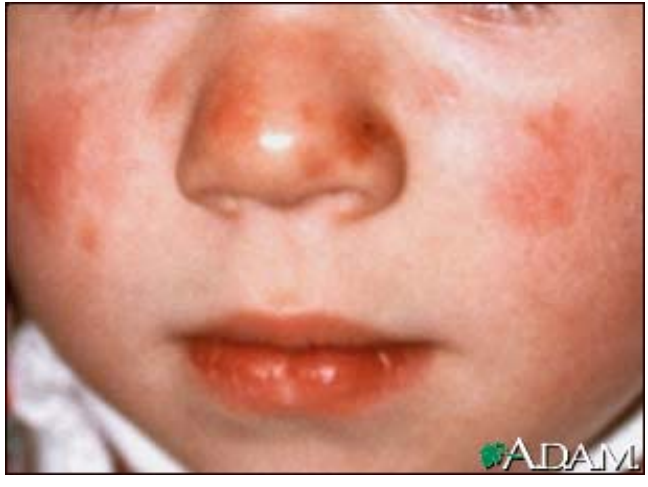
malar rash

Sparing nasolabial folds and this is a sort of characteristics of malar rash related to lupus



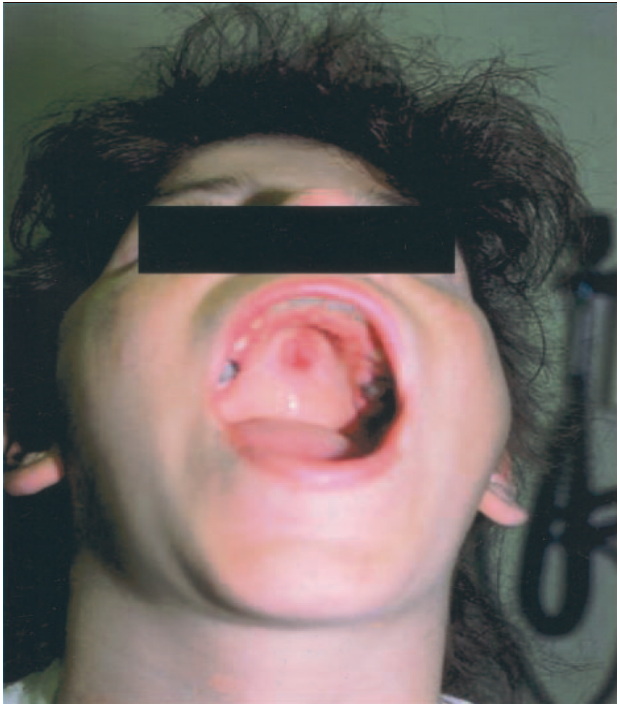
Subacute cutaneous lupus:



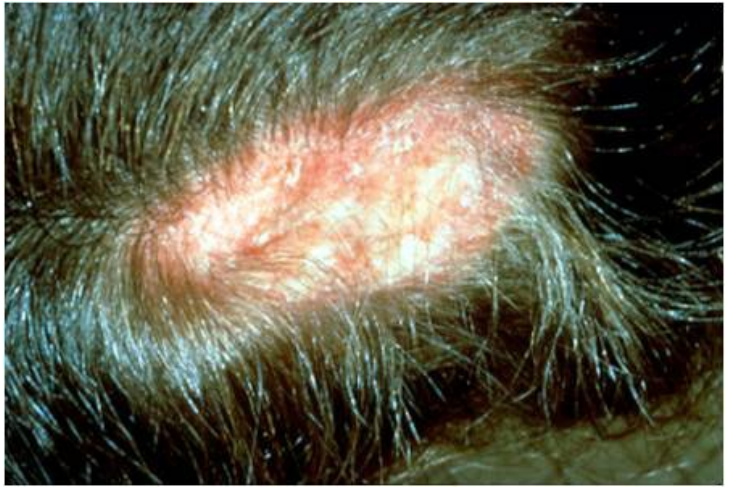


Chronic Cutaneous Lupus
discoid rash

Oral Ulcers Usually painless
OR
Nasal Ulcers

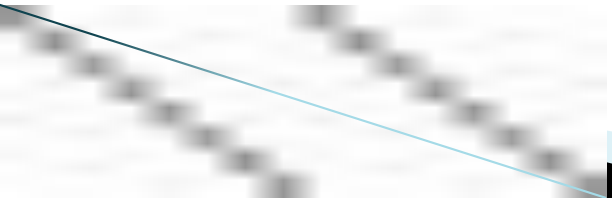


Ask about significant hair loss or alopecia



Non-scarring alopecia

Arthritis involving 2 or more joints



Serositis

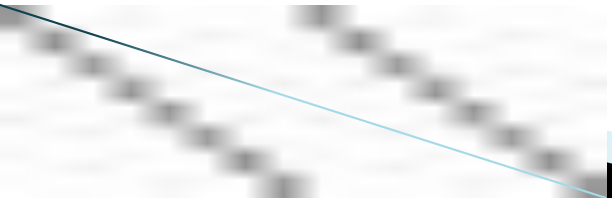
pleural effusions

pericardial effusion

pericarditis by electrocardiography

In the absence of other causes, such as infection, uremia.

Or abdominal pain due to peritonitis bc serositis

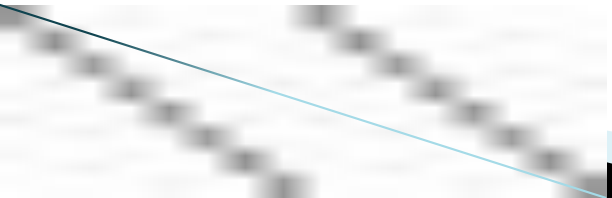


Renal

Urine protein–to-creatinine ratio (or 24-hour urine protein) representing 500 mg protein/24 hours

OR

red blood cell casts



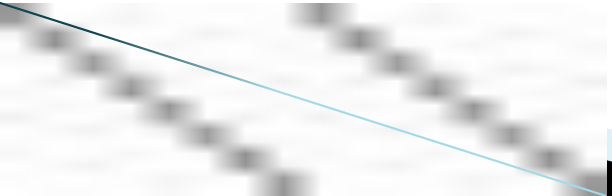
Neurologic

- Seizures
- Psychosis
- Mononeuritis multiplex(in the absence of other known causes)
- Myelitis
- Peripheral or cranial neuropathy (in the absence of other known causes)
- Acute confusional state (in the absence of other causes).

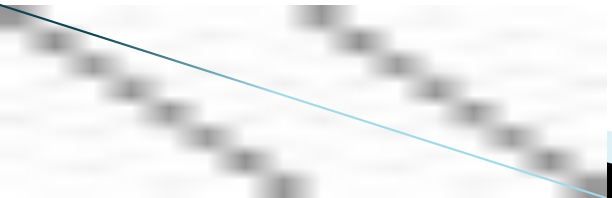
Looks like Peripheral neuropathy

Inflammation of spinal cord

So it's important In clinic or ER to ask about school performance



Hemolytic anemia (Sudden drop of hemoglobins, Jaundice and dark urine)

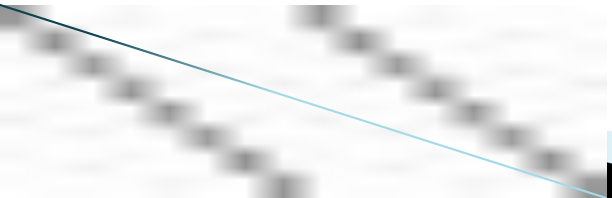


Leukopenia (<4000/mm3)

OR

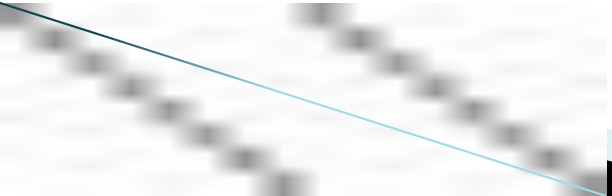
Lymphopenia (<1000/mm3)

Particularly



Thrombocytopenia (<100,000/mm3)

At least once in the absence of other known causes.



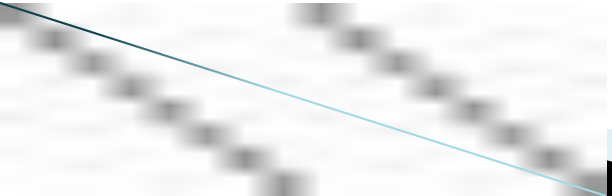
IMMUNOLOGIY

No single lupus pt has negative ANA

(1) ANA level above laboratory reference range. Almost

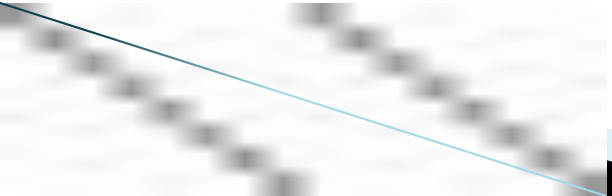
(2) Anti-dsDNA antibody level above laboratory reference range . Most of pt but not all

(3) Anti-Smith



(4) Antiphospholipid antibody

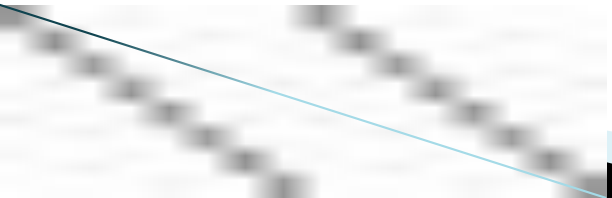
Pt with lupus is prone to have anti phospholipid syndrome and it called Secondary antiphospholipid syndrome bc it is associated with it
Ask for :
anticardiolipin, beta-2 glycoprotein I (β2GPI), and lupus anticoagulant
 Don’t bother yourself about names just have an idea



Specially in renal involvment

(5) Low complement (C3, C4, or CH50)

(6) Direct Coombs' test (in the absence of hemolytic anemia)

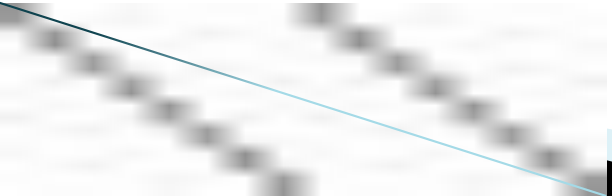


- Treatment:

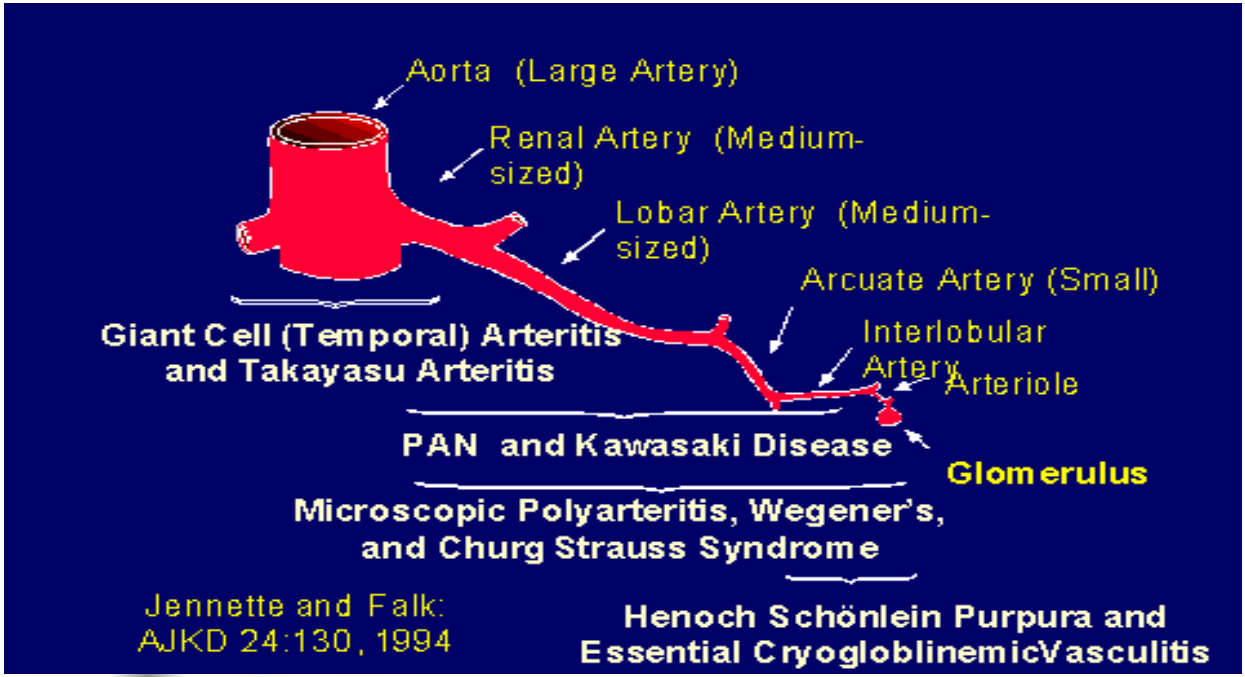
  General :

  Team approach.
  - Counseling.
  - Education.
  - Appropriate nutrition.
  - Use of sun protection.
  - Immunization.
  - Prompt management of infection.

- Nonsteroidal Anti-inflammatory.
- Hydroxychloroquine. Specially in skin and hematology problems
- Glucocorticoids. The Main treatment specially in the beginning IV in cns, renal and active
- Immunosuppressives. In bad cns or renal



Henoch-Schonlein purpura

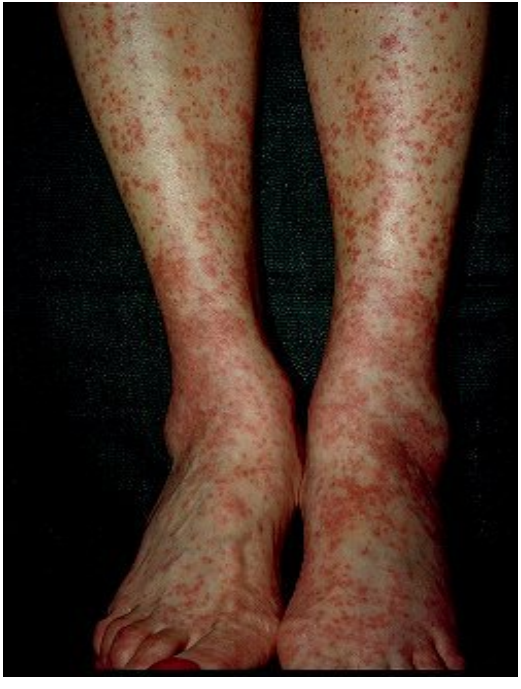


Henoch-Schonlein purpura

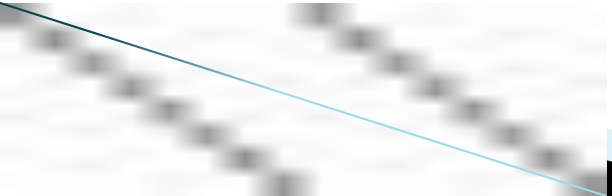
HSP is the most common pediatric vasculitis. Involves small arteries

Classically presents with the triad of:

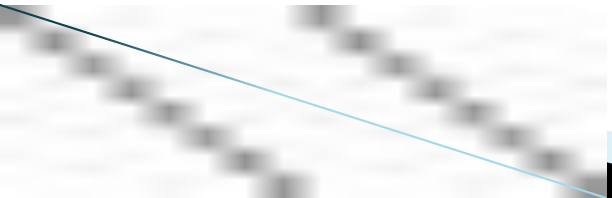
- Non-thrombocytopenic palpable purpura.
- Colicky abdominal pain.
- Arthritis.



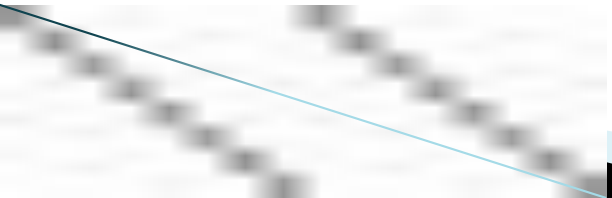
- Pathophysiology
  - Immunoglobulin A (IgA) immune complexes deposition.



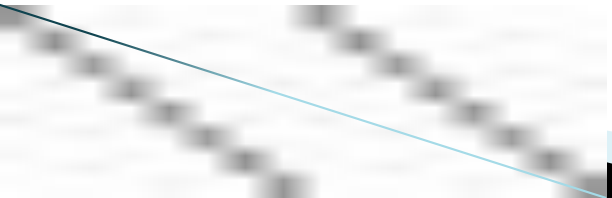
- The major cause of morbidity is renal involvement.
- 3-15 years.
- A wide variety of infections may trigger HSP.
  It's not a must but it could happen



- Skin involvement (100%) in HSP may begin as urticaria, but in most cases it progresses to dramatic purple, non-blanching lesions .
- Gastrointestinal involvement (75%)ranges from colicky abdominal pain to profuse bleeding, intussusception. HSP in ER don't forget the possibility of intussusception so we do radiological investigation to rule it out you may end up with gut gangrene !
- The arthritis of HSP (50%) is usually transient, and it does not cause chronic joint changes.



- Renal Disease
- The most serious sequela of Henoch-Schonlein purpura is renal involvement.
- This complication occurs in about 25 percent of children .



Diagnosis:

Purpura (mandatory criterion)

Skin rash is a mandatory

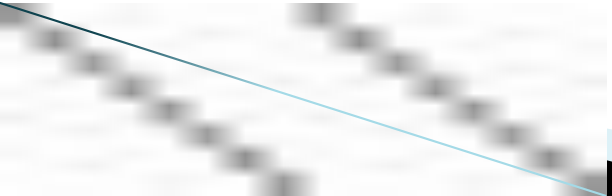
- 1. Abdominal pain.
- 2. Histopathology; vasculitis with predominant IgA deposit.
- 3. Arthritis or arthralgia.
- 4. Renal involvement.

Sometimes we go for biopsy and the pic goes with HSP nephritis

- Therapy of HSP is primarily supportive, aiming for symptomatic relief of arthritis and abdominal pain.
- Use of steroids in children who do not respond to NSAIDs or in those thought to be at highest risk of developing renal

compromise continues to be controversial.

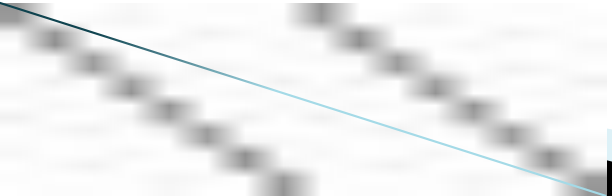
Juvenile Dermatomyositis



- Idiopathic inflammatory myopathies (IIMs), collectively known as myositis, are heterogeneous disorders characterized by muscle weakness and muscle inflammation.
- The most common subgroups in children, juvenile DM (JDM).

Incidence:

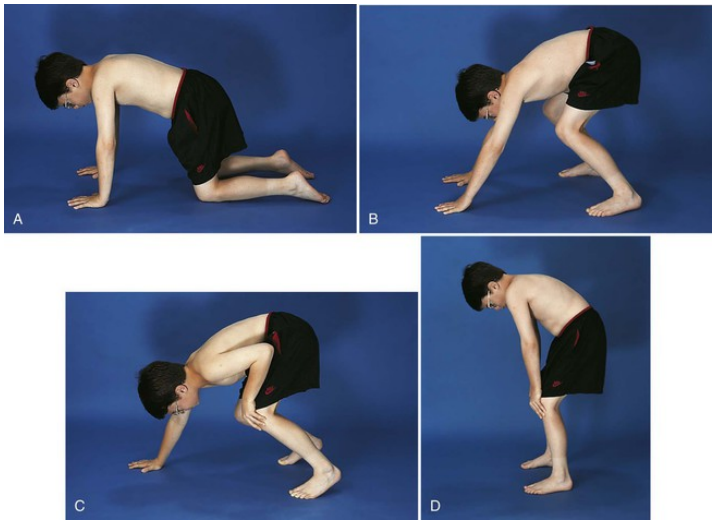
- In population-based studies, JDM has a reported annual incidence that ranges from two to four cases per one million children.
- The peak incidence is from 5 to 10 years of age.



JDM - Etiology & Pathogenesis

- Cause unknown
- Likely autoimmune angiopathy
- Environmental and genetic factors implicated
  - A history of infection prior to onset is common
    - 65- 70% of patients have a history of a significant infection during the three months prior to first onset of symptoms
  - Proposed triggers include various infectious agents, vaccines, medications, UV light
- Cellular and humoral immunity implicated
- Complement-mediated injury important
- Innate immune response: type I interferons and dendritic cells

Can’t stand without the support of the hand
Sign called Gowers' sign, this reflects muscle weakness specially proximal



Don’t remember the details but I want to tell you that muscle weakness can present in other disease not only JDM

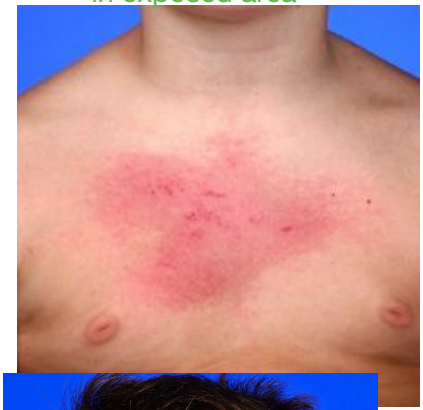
Differential Diagnosis of Juvenile Idiopathic Inflammatory Myopathies

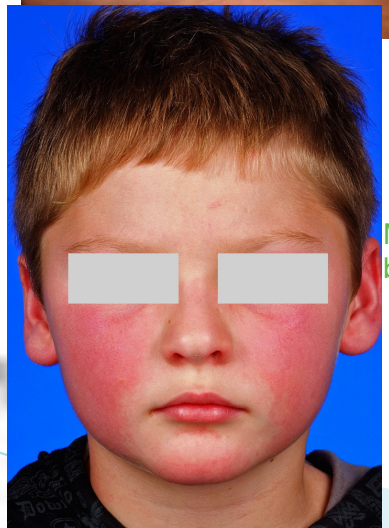
	Condition
Weakness alone	
Muscular dystrophies	Limb-girdle dystrophies, dystrophinopathies, facioscapulohumeral dystrophy, other dystrophies
Metabolic myopathies	Muscle glycogenoses (glycogen-storage diseases), lipid-storage disorders, mitochondrial myopathies
Endocrine myopathies	Hypothyroidism, hyperthyroidism, Cushing's syndrome or exogenous steroid myopathy, diabetes mellitus
Drug-induced myopathy	Consider for patients taking any of the following drugs or biological treatments: statins, interferon α, glucocorticoids, hydroxychloroquine, diuretics, amphotericin b, caine anaesthetics, growth hormone, cimetidine, and vincristine
Neuromuscular transmission disorders	Myasthenia gravis
Motor neuron disorder	Spinal muscular atrophy
Weakness with or without rash	
Viral	Enterovirus, influenza, coxsackievirus, echovirus, parvovirus, poliovirus, hepatitis B, human T-lymphotropic virus 1
Bacterial and parasitic organisms	Staphylococcus, streptococcus, toxoplasmosis, trichinosis, *Lyme borreliosis*
Other rheumatic conditions	Systemic lupus erythematosus, scleroderma, juvenile idiopathic arthritis, mixed connective-tissue disease, idiopathic vasculitis
Other inflammatory conditions	Inflammatory bowel disease, coeliac disease
Rash without weakness	Psoriasis, eczema, allergy

In many of these conditions, diagnosis is facilitated by muscle biopsy; muscle biopsy should be strongly considered in the absence of rashes of typical juvenile dermatomyositis.

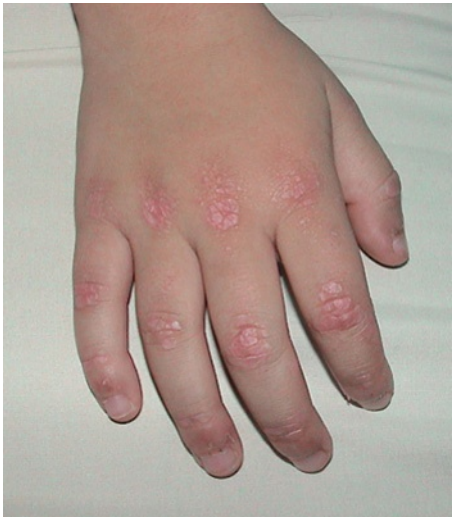
Feldman et al, Lancet 2008; 371, 2201-12

Skin involvement
in exposed area



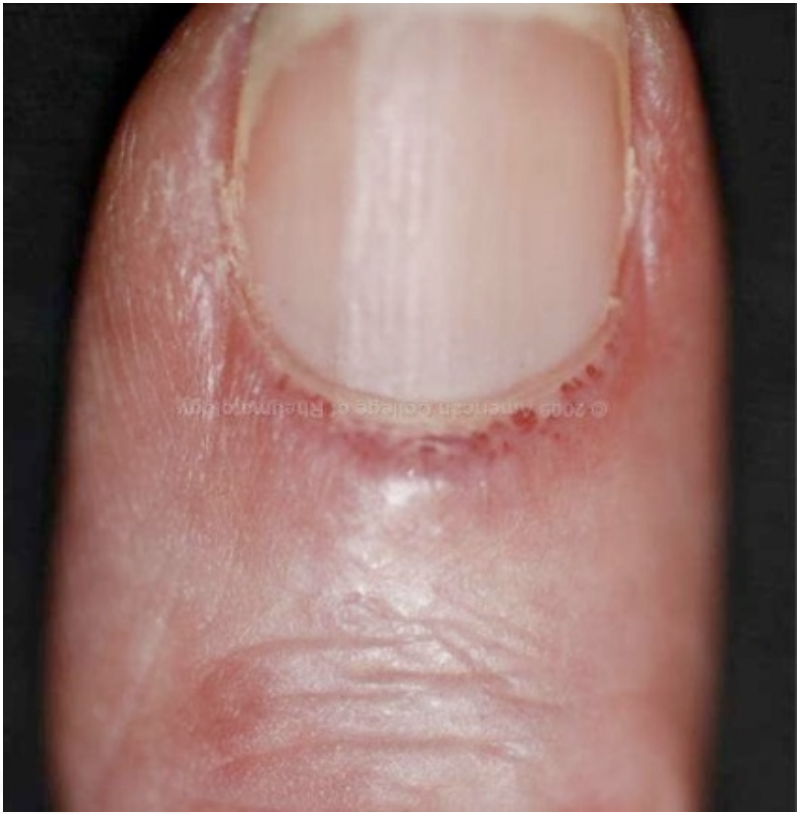


Gottron's papule

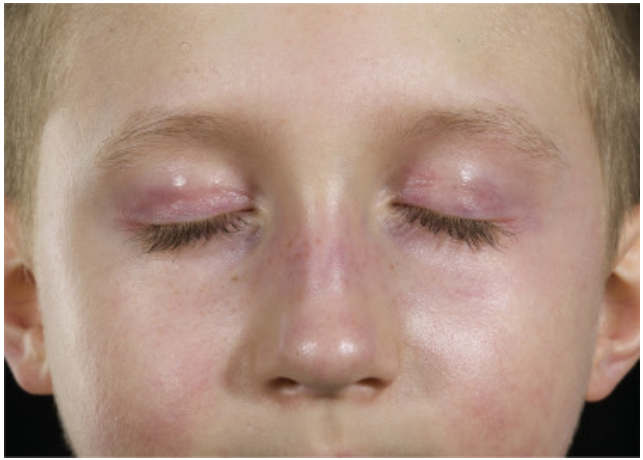


Malar rash is not confide to lupus so you may see it Here but keep in mind that it does not spare nasolabial folds

Red spot... the JDM is a sort of Vasculopathy at the level of the nail bed



Heliotrope “rash around eyes” and gottron’s sign are pathognomonic



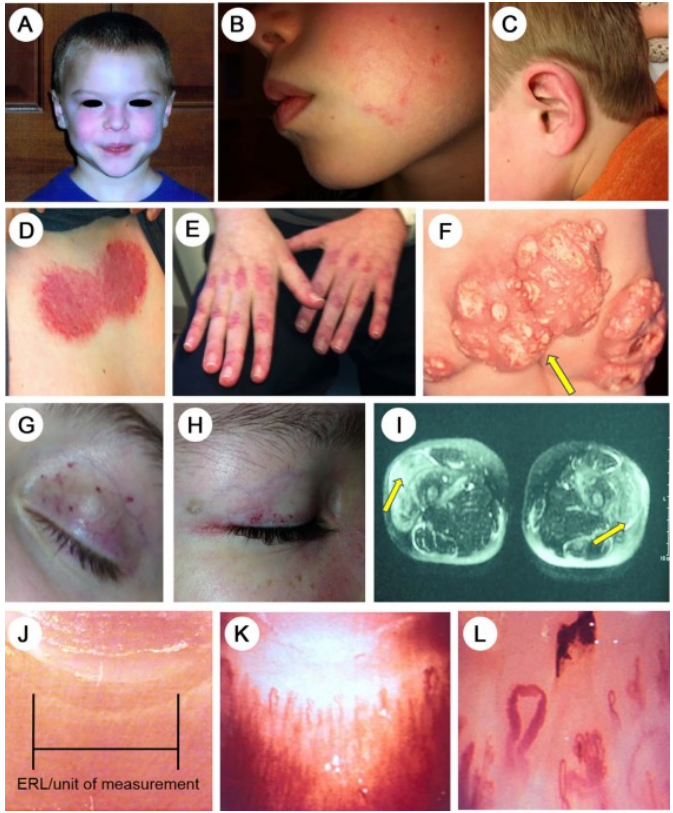


Table 1

Bohan and Peter Diagnostic Criteria[21,22]

A	Proximal and symmetrical muscle weakness of the pelvic and scapular girdle, anterior flexors of the neck, progressing for weeks to months, with or without dysphagia or involvement of reparatory muscles.
B	Elevation of the serum levels of skeletal muscle enzymes: creatine phosphokinase, aspartate aminotransferase, lactate dehydrogenase, and aldolase.
C	Electromyography characteristic of myopathy (short and small motor units, fibrillations, positive pointy waves, insertional irritability and repetitive high-frequency firing).
D	Muscle biopsy showing necrosis, phagocytosis, regeneration, perifascicular atrophy, perivascular inflammatory exudate.
E	Typical cutaneous changes: • heliotrope with periorbital edema and violaceous erythema; • Gottron's sign: vasculitis in the elbow, metacarpophalangeal, and proximal iterphalangeal joints.

Criteria for DM	
Definitive	Three criteria (A, B, C or D) + E
Probable	Two criteria (A, B, C or D) + E
Possible	One criterion (A, B, C or D) + E

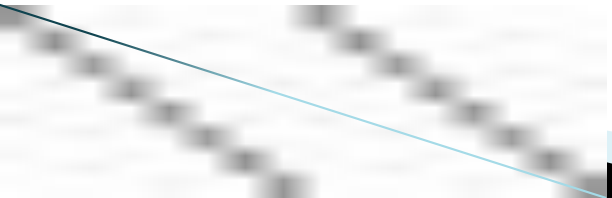
Table 2. The European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) classification criteria for adult and juvenile idiopathic inflammatory myopathies (IIMs)

When no better explanation for the symptoms and signs exists, these classification criteria can be used

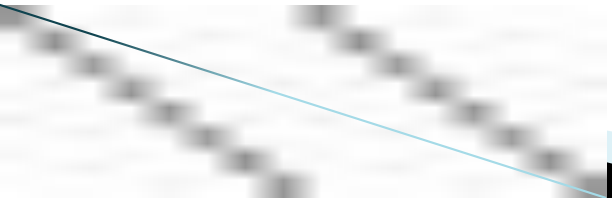
Variable	Score points: Without muscle biopsy	Score points: With muscle biopsy	Definition
Age of onset			
Age of onset of first symptom assumed to be related to the disease ≥18 years and <40 years	1.3	1.5	18 ≤ age (years) at onset of first symptom assumed to be related to the disease <40
Age of onset of first symptom assumed to be related to the disease ≥40 years	2.1	2.2	Age (years) at onset of first symptom assumed to be related to the disease ≥40
Muscle weakness			
Objective symmetric weakness, usually progressive, of the proximal upper extremities	0.7	0.7	Weakness of proximal upper extremities as defined by manual muscle testing or other objective strength testing, which is present on both sides and is usually progressive over time
Objective symmetric weakness, usually progressive, of the proximal lower extremities	0.8	0.5	Weakness of proximal lower extremities as defined by manual muscle testing or other objective strength testing, which is present on both sides and is usually progressive over time
Neck flexors are relatively weaker than neck extensors	1.9	1.6	Muscle grades for neck flexors are relatively lower than neck extensors as defined by manual muscle testing or other objective strength testing
In the legs, proximal muscles are relatively weaker than distal muscles	0.9	1.2	Muscle grades for proximal muscles in the legs are relatively lower than distal muscles in the legs as defined by manual muscle testing or other objective strength testing
Skin manifestations			
Heliotrope rash	3.1	3.2	Purple, lilac-colored, or erythematous patches over the eyelids or in a periorbital distribution, often associated with periorbital edema
Gottron's papules	2.1	2.7	Erythematous to violaceous papules over the extensor surfaces of joints, which are sometimes scaly. May occur over the finger joints, elbows, knees, malleoli, and toes
Gottron's sign	3.3	3.7	Erythematous to violaceous macules over the extensor surfaces of joints, which are not palpable
Other clinical manifestations			
Dysphagia or esophageal dysmotility	0.7	0.6	Difficulty in swallowing or objective evidence of abnormal motility of the esophagus
Laboratory measurements			
Anti–Jo-1 (anti–histidyl–transfer RNA synthetase) autoantibody present	3.9	3.8	Autoantibody testing in serum performed with standardized and validated test, showing positive result
Elevated serum levels of creatine kinase (CK)* *or* lactate dehydrogenase (LDH)* *or* aspartate aminotransferase (ASAT/AST/SGOT)* *or* alanine aminotransferase (ALAT/ALT/SGPT)*	1.3	1.4	The most abnormal test values during the disease course (highest absolute level of enzyme) above the relevant upper limit of normal
Muscle biopsy features—presence of:			
Endomysial infiltration of mononuclear cells surrounding, but not invading, myofibers		1.7	Muscle biopsy reveals endomysial mononuclear cells abutting the sarcolemma of otherwise healthy, non-necrotic muscle fibers, but there is no clear invasion of the muscle fibers
Perimysial and/or perivascular infiltration of mononuclear cells		1.2	Mononuclear cells are located in the perimysium and/or located around blood vessels (in either perimysial or endomysial vessels)
Perifascicular atrophy		1.9	Muscle biopsy reveals several rows of muscle fibers, which are smaller in the perifascicular region than fibers more centrally located
Rimmed vacuoles		3.1	Rimmed vacuoles are bluish by hematoxylin and eosin staining and reddish by modified Gomori trichrome stain

* Serum levels above the upper limit of normal.

- Patients with pathognomonic skin rashes (heliotrope rash, Gottron's papules, and/or Gottron's sign) of JDM or DM are accurately classified with the EULAR/ACR classification criteria without including muscle biopsy data.
- For patients without these skin manifestations, muscle biopsy is recommended.
- For DM patients without muscle involvement, a skin biopsy is recommended.

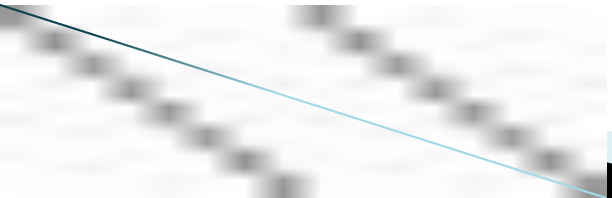


- The EULAR/ACR classification criteria provide a score and a corresponding probability of having IIM.
- A probable IIM :
  - For a total score of ≥5.5 and ≤5.7) for the criteria not including muscle biopsy data, and a score ≥6.7 and ≤7.6 when including muscle biopsies.
- Definite IIM :
  - For a total aggregate score of 7.5 or more without muscle biopsy and 8.7 with muscle biopsy.



Investigations:

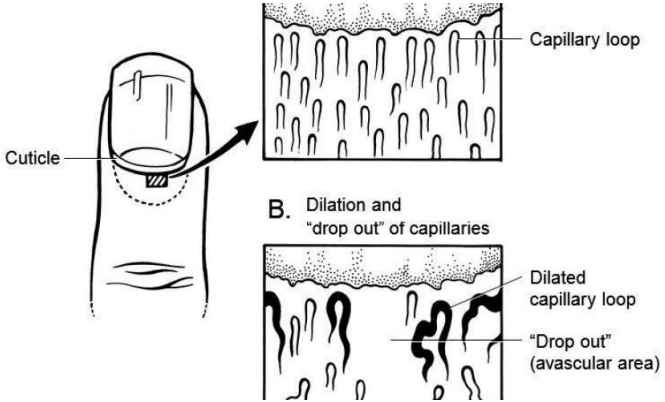
- Muscle enzymes—including creatinine phosphokinase (CPK), LDH, AST (SGOT), ALT (SGPT), adolase (if available)
- Full blood count and blood film
- ESR and CRP
- Myositis-specific and myositis-associated antibodies
- Renal function and liver function tests
- Infection screen (for differential diagnosis)
- Investigations for alternative systemic causes of myopathy including endocrine disorders (especially thyroid function), electrolyte disturbances, vitamin D deficiency



- Further tests for metabolic/mitochondrial myopathies (especially in the absence of rash/atypical presentation)
- Urine dipstick (with further evaluation if positive for protein)
- Nailfold capillaroscopy
- Echocardiogram and ECG
- Pulmonary function tests (chest X-ray and HRCT if concern)
- MRI of muscles.
- EMG (particularly if suspicion of neuropathy/disorder of neuromuscular junction)
- Muscle biopsy (especially in the absence of rash/atypical presentation)
- MRI brain if neurological involvement suspected.

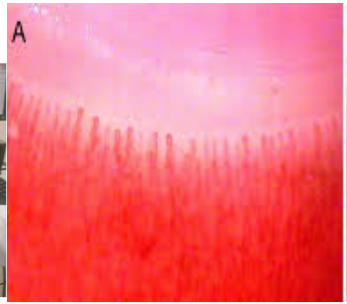
Capillaroscopy

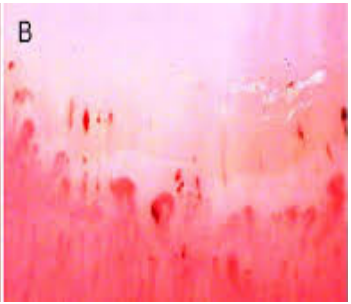
Latest way



B

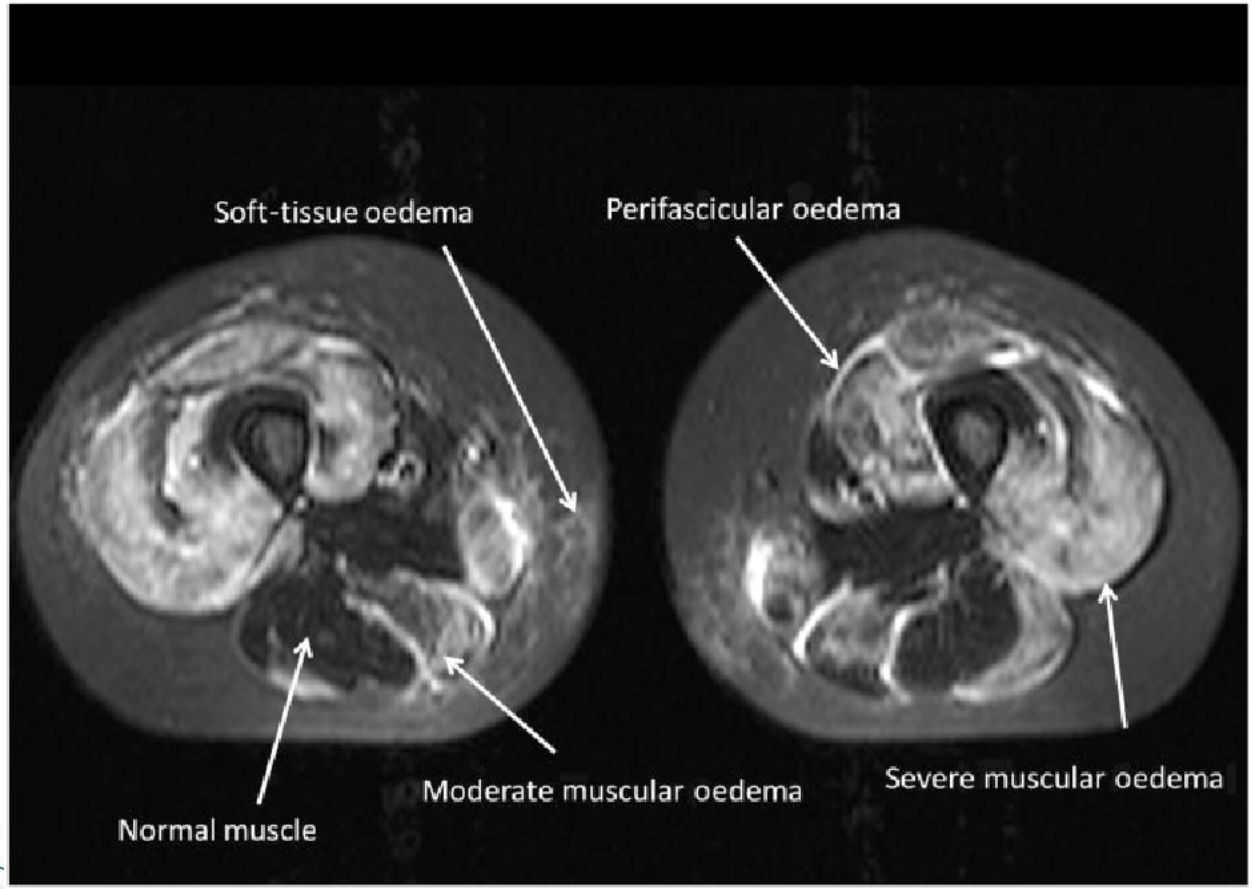
C





Old way

MRI shows Bright area which is an inflammation of the muscle we normally see muscle dark. It involves patchy muscles and bilateral



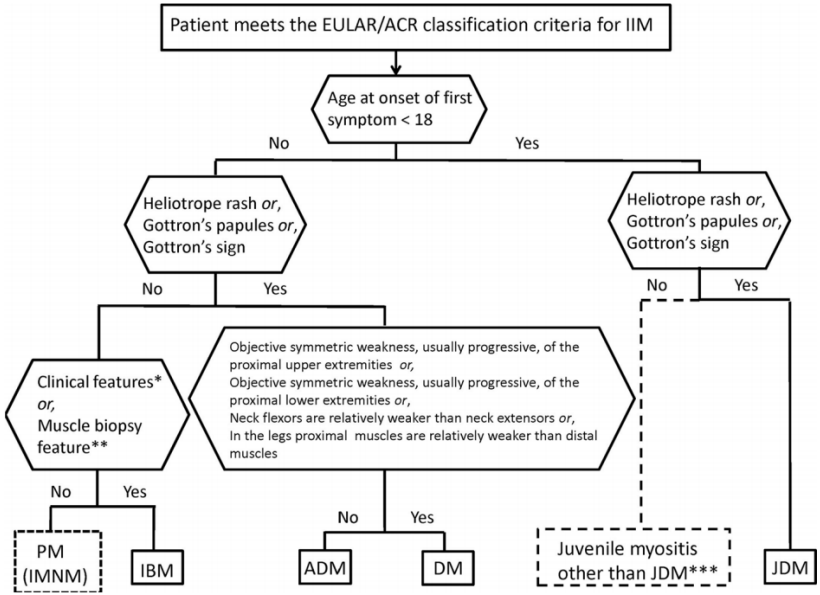


Figure 2. Classification tree for subgroups of idiopathic inflammatory myopathies (IIMs). A patient must first meet the European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) classification criteria for IIM (probability of IIM ≥55%). The patient can then be subclassified using the classification tree. The subgroup of polymyositis (PM) patients includes patients with immune-mediated necrotizing myopathy (IMNM). For inclusion body myositis (IBM) classification, one of the following is required for classification: finger flexor weakness and response to treatment: not improved (*), or muscle biopsy: rimmed vacuoles (**). *** = Juvenile myositis other than juvenile dermatomyositis (JDM) was developed based on expert opinion. IMNM and hypomyopathic dermatomyositis were too few to allow subclassification. ADM = amyopathic dermatomyositis; DM = dermatomyositis.

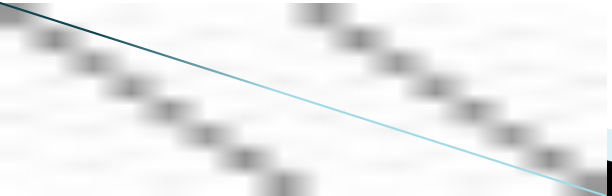
Dermatomyositis – other organ involvement

- Gastrointestinal vasculitis- gut wall perforation
- Arthritis - common but usually early and mild, non-erosive
- Cardiac - inflammation, fibrosis, conduction defects
- Renal - glomerular hypercellularity
- Pulmonary - fibrosis, pneumothorax
- Central nervous system - behavior changes, seizures
- Alopecia
- Eyes - exudative vasculitis of retina
- Derm – calcinosis, subcutaneous nodules, ulcerations
- Lipodystrophy

Calcification of subcutaneous tissue can cause disfiguration oozing

Treatment: Combine them

- Steroid. Orally
- Methotrexate (subcutaneous). If not available, use oral




THANK
YOU