

INFLAMMATORY MYOPATHIES

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1. Bohan A, Peter JB. Polymyositis and dermatomyositis (parts I and 2). N Engl J Med 292:344-347, and 403-407, 1975

A classic report that defined practical operational criteria and suggested the major clinical divisions still in use today.

2. Lotz BP, Engel AG, Nishino H, et al. Inclusion body myositis. Observations in 40 patients. Brain 112:727-747, 1989

A clinical and pathologic description of the largest cohort of patients with this relatively recently described form of myositis. Inclusion body myositis could be differentiated from polymyositis on the basis of an insidious onset, slow progression of weakness, and minimal or no response to therapy.

3. Dalakas MC. Polymyositis, dermatomyositis and inclusion- body myositis. N Engl J Med 325:1487-1498, 1991

A good review of the clinical features, pathogenesis, and treatment with emphasis on pathologic distinctions among the three major clinical groups. There are 143 references.

4. Love LA, Leff RL, Fraser DD, et al. A new approach to the classification of idiopathic inflammatory myopathy: myositis-specific autoantibodies. Distinct clinical features, prognoses, HLA associations, and responses define useful homogeneous patient groups. Medicine 70:360-374, 1991

Analysis of patient subsets by the antibodies seen only in myositis patients (anti-synthetase, -SRP, Mi-2 autoantibodies). Distinct clinical features, prognoses, HLA associations, and responses to treatment suggest that these serologic groups are likely to be different diseases.

5. Love LA, Miller FW. Noninfectious environmental agents associated with myopathies. Curr Opin Rheum 5:712-718, 1993

A review of the many drugs, medical devices, occupational and other toxic exposures that have been associated with inflammatory and other myopathies.

6. Miller FW. Myositis-specific autoantibodies. Touchstones for understanding the inflammatory myopathies. JAMA 270:1846-1849, 1993

A brief review of the clinico-pathologic groups, systemic manifestations, and assessment of these disorders. Emphasizes the usefulness of the myositis-specific autoantibodies in research and the clinical care of myositis patients.

7. Pachman LM. Inflammatory myopathy in children. Rheum Dis Clin N Am 20:919-942, 1994

Excellent review of the clinical features, pathogenesis, and treatment of the childhood forms of these diseases. Includes 125 references.

8. Adams EM, Plotz PH. The treatment of myositis: How to approach resistant disease. *Rheum Dis Clin N Am* 21:179- 202,1995

A very readable review of the risks and benefits of therapies in the context of current options.

9. Rider LG. Assessment of disease activity and its sequelae in children and adults with myositis. *Curr Opin Rheum* 8:495-506, 1996

A comprehensive evaluation of the advantages and disadvantages of current modalities of assessing myositis disease activity and damage.

10. Hicks JE. Role of rehabilitation in the management of myopathies. *Curr Opin Rheumatol* 10:54855, 1998

Overview of the critical role of rehabilitation in improving the function and quality of life of myositis patients.

11. Oddis C: Current Approach to the Treatment of Polymyositis and Dermatomyositis. *Curr Opin Rheum*, 12:492-497, 2000.

Update on treatment of polymyositis and dermatomyositis.

12. Hirakata M and Nagai S: Interstitial Lung Diseases in Polymyositis and Dermatomyositis. *Curr Opin Rheum*, 12:501-508, 2000.

Update on diagnosis and treatment of ILD in polymyositis and dermatomyositis.

13. Buchbinder R, Forbes A, Hall S, et al: Incidence of Malignant Disease in Biopsy-Proven Inflammatory Myopathy. A Population-Based Cohort Study. *Ann Intern Med* 134: 1087-1095, 2001.

A retrospective cohort study of 537 patients with idiopathic inflammatory myopathy. One hundred and four patients were found to have malignancy. This study shows increased risk of malignancy in dermatomyositis and polymyositis. The risk was highest in the first 3 years after diagnosis of myositis.