Dermatomyositis with anti-TIF1-γ antibodies

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DESCRIPTION
We report the case of a 61-year-old Turkish male patient who presented to our dermatology outpatient clinic with a 1-year history of swelling and pruritic erythema rash of the face and trunk. He reported associated myalgia and arthralgia of the knees and wrists. Two months before presentation, he developed muscle weakness of upper limbs and dyspnoea. On review, he was noted to have unintentional weight loss (5 kg over 2 months) and increasing fatigue. His medical and family histories were unremarkable. His medications included omeprazole daily and vitamin B12 injections. Prior to presentation to our clinic, his general practitioner treated the patient with antihistamines, topical steroids (Elocom) and a short course of oral corticosteroid therapy which only provided temporary relief. Laboratory data demonstrated C reactive protein 6 mg/L (normal value (NV) <5 mg/L), haemoglobin 11.9 g/dL (NV 13–18 g/dL), lactate dehydrogenase 467 U/L (NV 135–225 U/L), creatinine phosphokinase 295 U/L (NV 30–190 U/L), Aspartate transaminase (GOT) 75 U/L (NV 8–31 U/L), Glutamate pyruvate transaminase (GPT) 66 U/L (NV 5–31 U/L); white blood count, immunogram, lipid profile, renal function, thyroid function, haemostasis and coagulation were all normal. Hepatitis B and C, and HIV serologies were all negative. Antinuclear antibodies were positive at 1/320. Serum protein immunoelectrophoresis showed a polyclonal raise of IgG up to 21.0 g/L (normal range at 7–15 g/L).

On review of vital signs, the patient was afebrile with a heart rate 86 bpm, blood pressure of 197/95 mm Hg, normal respiratory rate and an oxygen saturation of 98% on room air. On physical examination, the patient was noted to have a bilateral heliotrope oedema including upper and lower eyelids with erythematous papules. Additionally, he was also noted to have pronounced neck swelling (collar of Stokes), diffuse rash on upper chest and back (shawl sign), discrete red papules over finger joints of both hands (Gottron’s papules) as well as over elbows and knees, and a mild periungual erythema. (figure 1A-D). Periungual dermoscopic examination was unremarkable. Lungs and heart sounds were normal. Abdominal and lymph node examination were also normal.

Given the constellation of symptoms, dermatomyositis with discrete and focal vacuolar modification of basal layer, atrophy of epidermis, oedema of dermis with mild interstitial inflammatory infiltrate, and rare eosinophils. (B). Alcian blue staining puts in evidence mucin accumulation in dermis.
in 22%–100% of cancer-associated DM. The most encountered DM-related cancers are ovaries, lungs, pancreas, stomach and colorectal. Haematological malignancies are less frequent. Risk for cancer is particularly increased within the 5 years after diagnosis.1

Thus, screening for cancer is an essential step when making a diagnosis of DM, especially in those with anti-TIF1-γ antibodies. We did not find any cancer in our patient but according to the literature, it is important to maintain a close clinical follow-up and to reassess for cancer if symptoms of DM relapse.

Learning points

► Screening for cancer is essential when making a diagnosis of dermatomyositis (DM), especially in those with anti-transcription intermediary factor 1 gamma antibodies.
► It is important to maintain a close clinical follow-up and to check for cancer if symptoms of DM relapse.

Contributors All authors contributed to the management of the patient. ADG contributed as the first author for the manuscript. HY and MB helped in the writing of the paper. LM helped in the interpretation of the cutaneous biopsies. All authors have read the manuscript and have confirmed that there is no conflict of interest.

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