

Dermatomyositis: The lesser known aspects.

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Introduction

Dermatomyositis is an idiopathic inflammatory myopathy with the diagnostic criteria for the disease being typical cutaneous features, progressive proximal symmetrical muscle weakness, elevated muscle enzymes and abnormal findings from muscle biopsy. Other associations being dysphagia, cardiac disturbances, pulmonary symptoms, subcutaneous calcifications, and symptoms like fever, malaise, weight loss, arthralgia and Raynaud's phenomenon [1]. Various ocular complications and oral cavity involvements are present in dermatomyositis but regrettably, very little information is shared among various specialities regarding these aspects.

Ptosis of the eyelids, diplopia and strabismus due to extraocular muscle involvement can be seen. Other manifestations are conjunctival edema, nystagmus, cotton wool spots, optic atrophy, conjunctival pseudopolyposis and lens abnormalities. In addition, vasculitis involving the conjunctival vessels can produce infarction [2]. Conjunctivitis, episcleritis, uveitis, glaucoma and macular oedema are other known complications. Retinopathy associated with dermatomyositis is a rare complication and it completely resolves without lasting long. Profound visual loss in dermatomyositis is caused by macular haemorrhage or macular oedema, which produces central scotomas [3]. Oral manifestations in the form of gingival telangiectases are an important diagnostic marker of juvenile dermatomyositis [4]. Though very little is known about it. Edema without erythema on the tongue and palate [5] lip ulceration [6] hyposalivation with dental caries [7] and oral candidiasis [8] has also been reported. Oral soft tissues like the tongue, mouth floor, salivary glands, buccal mucosa, and muscles of mastication may show evidence of calcium deposits. Anomalies of root formation have been reported previously, along with calcific obliteration of the pulp canals in both primary and permanent teeth. Minimal root resorption has been noted in the primary dentition [9]. Hence, a mandatory Ophthalmic and Oral cavity examination must be carried out in these patients.

Treatment of dermatomyositis is the administration of high-dose glucocorticoids. About 70% of patients respond initially and move on to the tapering of the glucocorticoids. Other treatment modalities include immunosuppressants like methotrexate, azathioprine, cyclophosphamide and calcineurin inhibitors like ciclosporine A and tacrolimus. Recently, mycophenolate mofetil has come into use and it seems effective for patients who are refractory to other

immunosuppressants, although infection is often a serious side-effect. Based on the assumption that humoral immunity drives inflammation in dermatomyositis, the B cell-depleting monoclonal antibody, rituximab, has been trialed in therapy. Although no randomized studies have yet been carried out, rituximab appeared to be effective in treating dermatomyositis. Use of IV immunoglobulin in treating patients resistant and/or intolerant to other drugs has also been reported [10].

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Conflicts of Interest

The authors declares that there are no competing interest.

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