Abstract

Polymyositis is an inflammatory autoimmune muscle disease, mainly affecting the skeletal muscles. However, it may progress into multisystem organ involvement such as lungs, heart and oesophagus. It is differentiated clinically from dermatomyositis in the absence of typical skin manifestations such as heliotrope rash, Gottron papules and shawl sign. Association of malignancies along with polymyositis and dermatomyositis has been clearly described and must be evaluated in all patients. Proximal myopathy, elevated creatinine phosphokinase (CPK), erythrocyte sediment ratio (ESR) and transaminases are common findings of idiopathic inflammatory myopathies. However, the best diagnostic yield can be achieved by a combination of nerve conduction studies NCS/EMG (electromyography), Magnetic resonance imaging (MRI) and the muscle biopsy; which is the gold standard. Immunosuppressants particularly glucocorticoids, play a major role in disease control and progression. Second-line treatments such as biological agents – rituximab are used when conventional therapies are failed or contraindicated. Exclusion of other aetiologies for proximal myopathy should be performed while myopathy related complications are identifying or screening. This case demonstrates a teenage girl with proximal myopathy with poor response to glucocorticoids and immunosuppressants.