DRUG-INDUCED MYOSITIS

KEY CLUES:

Variable presentation!

Drug history (any drug has potential to cause myopathy!)

- fairly uncommon, but always consider!
- IMPORTANT AS MAY BE REVERSIBLE ON WITHDRAWAL OF CAUSATIVE AGENT, REDUCTION OF DOSE, OR PERHAPS EVEN SWITCHING TO AN ALTERNATE DAY REGIMEN.

- presentation is very variable - from an isolated raised CK or myalgia/cramps, to profound weakness or severe rhabdomyolysis.

- SYNERGISTIC MYOTOXICITY = increased risk of myopathy if patient is taking combination of myotoxic drugs, or has another risk factor for myopathy e.g. high alcohol consumption

  In some situations these interactions can be lethal! E.g. an elderly patient on a statin may develop cancer and start chemotherapy. They may then be given prophylactic anti fungal drugs - very quickly they are on 3 myotoxic drugs!

LIPID-LOWERING DRUGS MYOPATHY

- inflammatory myopathy
- myopathy occurs in only a small amount of patients - suggesting susceptibility in certain individuals (most people fine until another myotoxic agent used in combination)
- however, risk is becoming more important as lots of people now on these medications
- isolated raised CK to acute rhabdomyolysis
- increased risk in elderly patients, diabetic patients, hypothyroid patients, CKD patients, those on high-dose statin, those using drugs which interact with statin metabolism (e.g. anti fungal agents)

STEROID MYOPATHY

- more muscle dysfunction than inflammation or damage
- predictable dose-related effect - all individuals receiving sufficient dose for long enough will develop myopathy
- daily doses of prednisolone >40mg most likely to cause myopathy, however lower doses for a long period can also have an impact
- weakness and atrophy of proximal muscles, especially quadriceps
- CK level usually normal/low

NOTE:

Patients can have steroid-induced myositis alongside another myopathy (e.g. polymyositis) if high-dose steroid treatment is continued long term - DO NOT SIMPLY IGNORE A DETERIORATION