The lymphoid follicle variant of dermatomyositis

ABSTRACT

Objective: To investigate the clinical and morphologic spectrum of early adult-onset dermatomyositis (DM), an inflammatory disease that affects small vessels of the muscle and the skin.

Methods: Histologic evaluation of frozen muscle samples was employed to visualize the cellular organization of ectopic lymphoid structures in muscle biopsies obtained from 2 patients diagnosed with DM. Clinical presentation and morphologic features, as well as treatment and follow-up, were assessed and documented. Electron microscopy was used to confirm the light microscopic diagnosis of DM. Clonality analysis of B-cell populations using PCR was performed.

Results: Muscle biopsy of both patients fulfilled the morphologic European Neuromuscular Centre criteria of DM. Analyses of muscle biopsy samples revealed ectopic lymphoid follicle-like structures that showed a remarkable similarity to secondary lymphoid organs (SLOs) with distinct T- and B-cell compartmentalization. Our 2 patients exhibited an atypical and mild clinical presentation and responded favorably to therapy.

Conclusions: The clinical and histopathologic features of DM can be atypical, and the presence of SLOs is not inevitably linked to an unfavorable prognosis.

 METHODS  Histologic, enzyme histochemical, and immunohistochemical studies. Histologic, immunohistochemical, and enzyme histochemical stains were performed on 9-μm cryostat sections. Hematoxylin & eosin and Gomori trichrome stains were prepared according to standard procedures. Immunohistochemistry and enzyme histochemical stains were performed as previously described. Primary antibodies used in this study are listed in table e-1 at Neurology.org/nn. Omission of the primary antibody resulted in no staining.

GLOSSARY

CK = creatine kinase; COX = cytochrome c oxidase; DM = dermatomyositis; GC = germinal center; IIM = idiopathic inflammatory myopathy; IVig = IV immunoglobulin; jDM = juvenile dermatomyositis; LFLS = lymphoid follicle-like structures; MAC = membrane attack complex; MHC = major histocompatibility complex; SLO = secondary lymphoid organ.

Dermatomyositis (DM) is considered a complement-mediated vasculopathy. Diagnostic criteria have been defined and include characteristic skin findings, subacute onset of proximal symmetrical muscle weakness, and histologically membrane attack complex (MAC) deposition on capillary walls, or reduced capillary density, or major histocompatibility complex (MHC) class I expression of perifascicular fibers associated with perivascular, perimysial inflammatory cell infiltrate consisting of macrophages and CD4+ lymphocytes as well as ultrastructurally undulating tubules in endothelial cells. Although regularly mentioned as being involved in pathogenicity of DM, the precise role of B lymphocytes is not fully understood and not used as an individual diagnostic criterion. Recently it has been suggested that the presence of ectopic lymphoid structures in juvenile DM (jDM) was associated with adverse disease outcome.
Electron microscopy. Muscle specimens were also examined by electron microscopy, which was performed as described previously.4

B-cell clonality analysis. B-cell clonality was assessed in both patients’ specimens by PCR amplification using a set of BIOMED-2 assays (InVivoScribe Technologies, San Diego, CA). Loci for IGH [IGHA: FR1 (variable region framework 1)-J; IGHB: FR2-J; IGHc: FR3-J] and for IGL (V-J) were targeted.5

RESULTS Patient 1, a 27-year-old woman, had a 7-year history of unilateral swelling of her left biceps muscle and hand as well as wrist pain and morning stiffness of her finger joints. A contrast-enhanced MRI of her left biceps showed diffuse gadolinium uptake, thickening of the muscle fascia, and muscle edema (figure 1). On neurologic examination she showed normal symmetrical muscle strength and normal fine motor skills. Thorough examination of the skin did not reveal any abnormalities. Laboratory examination of her blood serum showed elevated immunoglobulin E, C-reactive protein, and antinuclear and anti-cyclic citrullinated peptide antibodies. Serum creatine kinase (CK) was normal. There was no evidence of rheumatoid arthritis. Based on the international consensus criteria,1 biopsy of the left biceps gave a diagnosis of DM with accompanying B-cell-rich follicle-like structures. An initial high-dose (1 mg/kg/d) prednisolone treatment over 4 weeks followed by a low-dose treatment (5 mg/d) led to rapid improvement and persistent resolution of her symptoms over a 1-year period.

Patient 2, a 17-year-old girl, was referred because of a 5-month history of painful reddish swellings of the left upper arm followed by similar symptoms in her right upper arm. There were no alterations of the skin or muscle weakness. Three weeks prior to referral she had arthralgia of the hands, knees, and feet, and morning stiffness. On neurologic examination no additional abnormalities were found. She had a normal serum CK and erythrocyte sedimentation rate and a positive anti-nuclear antibody titer. MRI of the upper arms revealed hyperintensity in the right deltoid and left triceps muscles (figure 1, A and B). A biopsy of the left triceps showed a picture consistent with DM1 with accompanying B-cell-rich follicle-like structures. She was treated with methylprednisolone pulse therapy (1,000 mg for 3 consecutive days) and monthly IV immunoglobulin (IVlg) and subsequently received 60 mg prednisone daily and methotrexate (17.5 mg) weekly. Shortly after initiation of treatment she developed Gottron papules. Otherwise she responded favorably to therapy. Both IVlg and prednisone were successfully tapered, and currently she receives subcutaneous methotrexate and hydroxychloroquine, which has led to sustained improvement of her symptoms. Except for some minor alterations of the skin there remained no signs of active disease.

Muscle morphology. Muscle biopsies of both patients revealed extensive infiltration by inflammatory cells mainly in the perimysium and endomysium (figure 2, A–D). In addition, the infiltrates were located at perivascular sites. CD68+ macrophages (figure 2F) were diffusely distributed throughout the perimysium. MAC (C5b-9) deposition was mainly found on small capillaries and on the sarcolemma of single muscle fibers (figure 2G, arrowhead). MHC class II was expressed by the lymphoid cells and was found on numerous muscle fibers, predominantly in the perifascicular area (figure 2I). Sarcolemmal MHC class I expression was detected on all muscle fibers with perifascicular enhancement (figure 2J). Combined cytochrome c oxidase (COX)/succinate dehydrogenase histochemistry revealed scattered COX-negative fibers as a sign of accompanying mitochondrial dysfunction (figure 2K). CD123+ dendritic cells (figure 2L) and CD138+ plasma cells (figure 2M) were found in close proximity to T- and B-cell areas. The lymphoid follicle-like structures (LFLS) were mainly composed of CD45+ leukocytes (figure 2E) with CD8+ (figure 2N) and CD4+ (figure 2O) T cells distributed around CD79+ B cells (figure 2P). Expression patterns of peripheral Bcl-2 (figure 2Q), central Bcl-6 (figure 2R), and BOB.1 (figure 2S) paralleled the specific lymphoid follicle-like B-cell pattern. The Ki67/Mib-1 proliferation index was increased within the center of the follicle-like structures (figure 2T).

Electron microscopy revealed undulating tubules in endothelial cells of both patients, which supported the light microscopic diagnosis of DM (figure 2H, arrowheads).

To exclude the presence of a neoplastic B-cell population as described for B-cell lymphomas within skeletal muscles (A, B).
Serial sections of muscle biopsy stained with hematoxylin & eosin revealed ectopic lymphoid follicle-like structures (patient 1: A and B; patient 2: C and D). Sections were stained with an antibody against CD45^+ leukocytes (E) to highlight the follicle-like inflammatory infiltrate. CD68^+ macrophages (F) were diffusely distributed throughout the perimysium. C5b-9 was mainly found in walls of small capillaries and on the sarcolemma of single muscle fibers (G, arrowhead). Electron microscopy revealed ultrastructural evidence of undulating tubules (patient 1: H, arrowheads, 50,000 ×; patient 2: not shown). Major histocompatibility complex (MHC) class II was expressed by the lymphoid cells and was found on numerous muscle fibers, predominantly in the perifascicular area (I). Sarcolemmal MHC class I expression was detected on all muscle fibers (J). Combined cytochrome c oxidase (COX)/succinate dehydrogenase staining revealed blue-stained fibers indicating reduced COX activity (K). The lymphoid follicle-like structures consisted
Our observations illustrate the presence of LFLS in early adult–onset DM, which to our knowledge has not been reported yet. We show that the presence of LFLS is not necessarily evidence of an unfavorable prognosis in adult DM as opposed to reports in jDM. In conclusion, this report enlarges the nosologic spectrum of DM.

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