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Letter to the Editor

Anti-Mi-2 an Anti-2 Ro-52 Positive SARS-Cov-2 Related Myositis Requires Confirmation by Biopsy or Imaging

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The article by Plavsic *et al*. is excellent but raises concerns.
The main limitation of the study is that the patient did not undergo muscle biopsy even during follow-up [1]. Without histological, immune-histological and ultrastructural evaluation of the affected muscle it remains speculative, whether it is an unmasked primary myopathy, myositis, toxic myopathy, or rhabdomyolysis.
It is not comprehensible why no muscle MRI with contrast agent was performed to possibly detect myositis. MRI was feasible during the pandemic and could have been helpful in supporting or ruling out the diagnosis.
Steroid myopathy and azithromycin myopathy [2] were not adequately ruled out. Azithromycin can also cause rhabdomyolysis [2]. An argument for steroid myopathy is that with each administration of steroids there has been a recurrent worsening of the condition.
Another limitation is that the patient was not evaluated for myocarditis. Since troponin was markedly elevated and renal function was normal, it is highly likely that elevated troponin originated in the myocardium.
We disagree with the statement that there is a typical EMG pattern of inflammatory myopathy [1]. There is none.
Since the patient remained positive for anti-Mi-2 and anti-Ro-52 antibodies even after one year of immunosuppressive therapy, it cannot be ruled out that presence of these antibodies was actually an epiphenomenon and that they were present already before the SARS-CoV-2 infection.
We also should know whether the patient received medications after discharge from the hospital after Covid-19.
Another limitation is that no cytokines or chemokines were measured in the serum.

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Keywords: SARS-CoV-2, Covid-19, Myositis, Complication, Immunosuppression

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