

2017 European League Against Rheumatism/ American College of Rheumatology classification criteria for adult and juvenile idiopathic inflammatory myopathies and their major subgroups

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ABSTRACT

Objective To develop and validate new classification criteria for adult and juvenile idiopathic inflammatory myopathies (IIM) and their major subgroups.

Methods Candidate variables were assembled from published criteria and expert opinion using consensus methodology. Data were collected from 47 rheumatology, dermatology, neurology and paediatric clinics worldwide. Several statistical methods were used to derive the classification criteria.

Results Based on data from 976 IIM patients (74% adults; 26% children) and 624 non-IIM patients with mimicking conditions (82% adults; 18% children), new criteria were derived. Each item is assigned a weighted score. The total score corresponds to a probability of having IIM. Subclassification is performed using a classification tree. A probability cut-off of 55%, corresponding to a score of 5.5 (6.7 with muscle biopsy) 'probable IIM', had best sensitivity/specificity (87%/82% without biopsies, 93%/88% with biopsies) and is recommended as a minimum to classify a patient as having IIM. A probability of $\geq 90\%$, corresponding to a score of ≥ 7.5 (≥ 8.7 with muscle biopsy), corresponds to 'definite IIM'. A probability of $< 50\%$, corresponding to a score of < 5.3 (< 6.5 with muscle biopsy), rules out IIM, leaving a probability of ≥ 50 to $< 55\%$ as 'possible IIM'.

Conclusions The European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) classification criteria for IIM have been endorsed

by international rheumatology, dermatology, neurology and paediatric groups. They employ easily accessible and operationally defined elements, and have been partially validated. They allow classification of 'definite', 'probable' and 'possible' IIM, in addition to the major subgroups of IIM, including juvenile IIM. They generally perform better than existing criteria.

INTRODUCTION

Idiopathic inflammatory myopathies (IIM), collectively known as myositis, are heterogeneous disorders characterised by muscle weakness and muscle inflammation.¹ The most common subgroups in adults are dermatomyositis (DM), polymyositis (PM) and inclusion body myositis (IBM),² and in children, juvenile DM (JDM).

The International Myositis Assessment and Clinical Studies (IMACS) Group has developed consensus on outcome measures and definitions of improvement to be used in clinical trials for myositis.^{3 4} A prerequisite for clinical trials and other clinical studies is the inclusion of well-defined patient groups. A wide variety of diagnostic or classification criteria for myositis are used,^{2 5–16} but are generally derived empirically and not validated. The criteria of Bohan and Peter^{7 8} are most widely used, but have limitations. Because they do

This criteria set has been approved by the European League Against Rheumatism (EULAR) Executive Committee and the American College of Rheumatology (ACR) Board of Directors as Provisional. This signifies that the criteria set has been quantitatively validated using patient data, but it has not undergone full validation based on an independent dataset, using both cases and controls. This validation step is still needed before the criteria are fully validated.

Criteria

not clearly specify how to exclude other forms of myopathy, they may misclassify IBM patients as PM,^{13 17–19} and muscular dystrophies with inflammation as myositis, and each criterion is not defined explicitly. New discoveries in the last decade, such as myositis-specific autoantibodies that are associated with distinct clinical phenotypes,^{2 20–22} may provide opportunities to improve the precision of classification, but have not been tested adequately.^{11 23}

The aim of this project was to develop classification criteria for adult and juvenile IIM. The specific goal was to define the minimum essential, easily available clinical and laboratory features to (1) distinguish IIM from mimicking conditions with high sensitivity and specificity, and (2) distinguish the major subgroups of IIM.

METHODS

Study design

The International Myositis Classification Criteria Project (IMCCP), an international collaboration with experts from adult and paediatric rheumatology, neurology, dermatology, epidemiology and biostatistics, was established in 2004 and followed at our best the European League Against Rheumatism (EULAR) and American College of Rheumatology (ACR) recommendations for development of classification criteria from that time or published soon thereafter.^{24 25} A steering committee (online supplementary 1) and a larger working committee with experts in IIM were formed (see online supplementary appendix).

Using the nominal group technique, experts in IIM from the steering committee and the working committee^{26–29} designed the study and validation experiments, assembled and defined candidate criteria from published myositis criteria^{2 5–16} and other characteristics of myositis, and determined and assembled the IIM subgroup diagnoses and comparator conditions that were studied. A pilot study to assess the practicality of capturing the items showed a fair agreement of data availability from IIM and non-IIM cases (online supplementary 2). Input was obtained from myositis experts, by email to the IMACS network and requesting comments on the items, to maximise face and content validity.^{24 25} The steering committee revised the list of variables based on the comments and further suggestions from the IMACS network and 93 variables (online supplementary 3) were selected by the steering committee for study in cases and comparators. A glossary and definitions were developed according to an ACR glossary^{30 31} (online supplementary 4). Data were abstracted from patients' records and entered into a web-based database.

Inclusion criteria for cases and comparators were (1) diagnosis for at least 6 months prior to study inclusion; (2) physician certainty of diagnosis—either known IIM or, as comparators, known non-IIM cases where myositis was considered in the initial differential diagnosis; and (3) patients with the most recent and complete data were prioritised to acquire the most complete data in a consistent manner. A maximum of 40 cases and an equal number of comparators were collected from each centre.

The study was approved by the ethics committees at each site.

Data analysis and candidate criteria selection

The association of each variable with the diagnosis (IIM, non-IIM) was assessed by ORs and tested with Fisher's exact test. The treating physician diagnosis was considered the gold standard for analysis. Three classification techniques were explored: (1) a sum-of-items model in which a patient was classified as a case if the patient had a specified number of

items from a set of items, (2) a probability-score model and (3) a classification tree. The ensuing candidate criteria were examined with respect to statistical performance and clinical relevance. Due to the observed superior discriminating performance of the probability-score model, the other models were set aside.

Criteria development

The probability-score model summed score points associated with the signs and symptoms present. The score points were obtained as coefficients of a logistic regression model used to combine multiple variables for predicting IIM. The statistical significance of the resulting increase in the goodness-of-fit of the model was assessed using the Wald test. The improvement in predictive ability was measured by the increment in specificity and sensitivity and summarised by the area under the receiver operating characteristic curve (AUC).

Paediatric experts are using fewer muscle biopsies for classification of JDM in clinical practice than adult rheumatologists. Thus, a second model not including biopsy variables was developed. Assessment of statistical performance for each score/probability cut-off value provided the basis for a recommendation of a cut-off value for IIM classification by the steering committee. The proposed cut-offs were then defined as possible, probable and definite IIM. To facilitate use of the new criteria, a web-based calculator for the probability-score model was developed.

The new classification criteria were compared with previous IIM criteria. Their statistical performance, and number of patients per IIM subdiagnosis classified as IIM by the different criteria sets, were calculated.

To distinguish subgroups of patients classified with IIM according to the new criteria, a classification tree was developed. The tree was based on the variables in the new classification criteria, statistical analyses, as described in a separate methodology paper and on expert opinion.

Validation

The new criteria were internally cross-validated. Samples of equal size to the original sample were drawn from the entire population at random with replacement, so-called 'bootstrap' samples.³² The bootstrap sample represented the training sample, and the remaining subjects not contained in the bootstrap sample constituted the validation sample. The probability score was applied to each bootstrap training sample separately and then used to predict IIM in the validation sample. The procedure was repeated in over 200 bootstrap samples, and the average AUC was calculated.

The performance of the new criteria for IIM including the subgroups was tested for sensitivity in two independent cohorts, the Euromyositis Register (<https://euromyositis.eu/>) and the Juvenile Dermatomyositis Cohort Biomarker Study and Repository (JDRG) (UK and Ireland) (<https://www.juveniledermatomyositis.org.uk/>).

The program Stata V.13 (StataCorp) was used for data management and statistical analyses. The statistical program R (R Core Team (2014). R: a language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL <http://www.R-project.org/>) was used for some analyses.

A report detailing the methodology will be submitted as a separate publication (manuscript submitted).

Table 1 Demographic data of the International Myositis Classification Criteria Project cohort

	IIM (n=976)	Comparators (n=624)
Sex, n (%)		
Female	652 (66.8)	369 (59.1)
Male	324 (33.2)	255 (40.9)
Adult onset disease*, n (%)	727 (74.5)	509 (81.6)
Childhood onset disease*, n (%)	249 (25.5)	115 (18.4)
Age at onset of symptoms, median (IQR), years	44.0 (14.7–57.0)	41.0 (20.0–56.0)
Age at diagnosis, median (IQR), years	45.5 (16.2–59.3)	45.0 (25.8–58.0)
Disease duration from time of first symptom†, median (IQR), years	4.0 (2.0–8.0)	4.0 (1.0–9.0)
Disease duration from time of diagnosis‡, median (IQR), years	3.0 (1.0–6.0)	1.8 (0.0–4.5)
Ethnicity, n (%)		
Caucasian	611 (62.6)	360 (57.7)
Asian	177 (18.1)	156 (25.0)
Hispanic	51 (5.2)	25 (4.0)
African	40 (4.1)	28 (4.5)
Native American	18 (1.8)	4 (0.6)
Pacific Islander	3 (0.3)	1 (0.2)
Mixed	37 (3.8)	22 (3.5)
Unknown	54 (5.5)	32 (5.1)
Disease onset§, n (%)		
Acute (days to 2 weeks)	45 (4.6)	64 (10.3)
Subacute (>2 weeks to ≤2 months)	237 (24.3)	88 (14.1)
Insidious (>2 months to years)	648 (66.4)	444 (71.2)
NA	46 (4.7)	28 (4.5)

*Onset of first symptoms assumed to be related to the disease.

†Time from first symptom to last clinical evaluation.

‡Time from diagnosis to last clinical evaluation.

§Onset and progression of the first symptoms of the syndrome to the full disease presentation.

IIM, idiopathic inflammatory myopathies; NA, information not available.

RESULTS

Study population

Data from 976 IIM patients (74.5% adults; 25.5% children) (table 1) were collected between 2008 and 2011 from 23 European, 17 North American, 1 South American and 6 Asian sites, representing IIM subgroups of JDM (n=248), PM (n=245), DM (n=239), IBM (n=176), amyopathic DM (ADM) (n=44), hypomyopathic DM (n=12), immune-mediated necrotising myopathy (IMNM) (n=11) and juvenile PM (n=1). A total of 624 comparators (81.6% adults; 18.4% children) (table 1) representing a broad spectrum of conditions that can mimic IIM were included, comprising systemic inflammatory diseases (36.5%), muscle dystrophies (16.0%), drug-associated or toxin-associated myopathies (7.9%), motor neuron diseases/neuropathies (7.7%), metabolic myopathies (6.9%), myalgias (4.5%), dermatological diseases (3.7%), endocrine myopathies (3.7%), infectious myopathies (4.5%), mitochondrial myopathies (2.4%), neuromuscular diseases (2.6%), other myopathies (1.9%), immune-mediated skin conditions (0.5%) as well as other diagnoses (1.3%) (online supplementary 5 and 6).

CANDIDATE CRITERIA SELECTION AND CRITERIA DEVELOPMENT

Based on statistical models, 16 variables from six categories best distinguished IIM cases from comparators (table 2), and each

variable was assigned a weight (score) based on its influence to discriminate IIM from non-IIM. A total score was computed by adding score points corresponding to each criterion being present. The score can be converted into a probability of IIM (figure 1A,B) by:

Probability of IIM including muscle biopsy = $1/[1 + \text{exponential}(5.33 - \text{score})]$

or,

Probability of IIM without muscle biopsy = $1/[1 + \text{exponential}(6.49 - \text{score})]$

or by using the online web calculator (www.imm.ki.se/biostatistics/calculators/iim).

Sensitivity and specificity for varying probability cut-offs are shown in figure 1C,D.

Cut-points for classification

The best balance between sensitivity and specificity was found for a probability of 55%–60% for the criteria not including muscle biopsy data, and 55%–75% when including muscle biopsies, or a total aggregated score of score of ≥ 5.5 and ≤ 5.7 (≥ 6.7 and ≤ 7.6 if biopsy is available). The IMCCP proposes that a patient may be classified as IIM if the probability exceeds a predetermined cut-off of at least 55% (corresponding to a score of ≥ 5.5 , or ≥ 6.7 if biopsies are included) based on maximisation of statistical performance and best balance between sensitivity and specificity. The level of probability $\geq 55\%$ and $< 90\%$ was defined as ‘probable IIM’. The steering committee recommends, based on expert opinion, that ‘definite IIM’ should equal a probability of $\geq 90\%$, corresponding to having total aggregate score of ≥ 7.5 without muscle biopsy and ≥ 8.7 with muscle biopsy.

Patients falling in the probability range $\geq 50\%$ and $< 55\%$ will be classified as ‘possible IIM’. For a patient to be classified as a non-IIM patient, the probability would have to be $< 50\%$ (score of < 5.3 without biopsies; < 6.5 with biopsies).

As suggested by paediatric experts and dermatologists, for patients with pathognomonic skin rashes of DM or JDM, classification criteria were developed, which did not include muscle biopsy data (table 2). However, where no skin rash is present, a muscle biopsy is required for classification, as determined by a consensus of expert opinion within the IMCCP steering and working committees. Both sets apply equally well to adult IIM patients and to juvenile patients with DM and should be used when IIM is suspected and no better explanation for the symptoms exists, as agreed on by expert opinion. Definitions for the criteria items are presented in table 2.

IDENTIFICATION OF SUBGROUPS

A patient classified with IIM by the EULAR/ACR classification criteria (probability of IIM $\geq 55\%$) can be further subclassified with a classification tree (figure 2). Age at onset of first symptom (≥ 18 years of age) distinguishes adult from juvenile IIM. Thereafter, clinical findings and muscle biopsy features subclassify adult IIM patients into PM, IBM, ADM or DM. Based on our dataset, juvenile patients with skin rash can be classified into JDM. Three subgroups cannot be further separated using our criteria because of small sample sizes: juvenile PM, IMNM and hypomyopathic DM.

Among patients with IIM by the EULAR/ACR classification criteria (probability of IIM $\geq 55\%$), and with sufficient data to allow subclassification (n=703), the number of cases in the subgroups as defined according to the classification tree was

Criteria

Table 2 The European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) classification criteria for adult and juvenile idiopathic inflammatory myopathies (IIMs)

When no better explanation for the symptoms and signs exists, these classification criteria can be used

Variable	Score points		Definition
	Without muscle biopsy	With muscle biopsy	
Age of onset			
Age of onset of first symptom assumed to be related to the disease ≥ 18 years and < 40 years	1.3	1.5	$18 \leq$ Age (years) at onset of first symptom assumed to be related to the disease < 40
Age of onset of first symptom assumed to be related to the disease ≥ 40 years	2.1	2.2	Age (years) at onset of first symptom assumed to be related to the disease ≥ 40
Muscle weakness			
Objective symmetric weakness, usually progressive, of the proximal upper extremities	0.7	0.7	Weakness of proximal upper extremities as defined by manual muscle testing or other objective strength testing, which is present on both sides and is usually progressive over time
Objective symmetric weakness, usually progressive, of the proximal lower extremities	0.8	0.5	Weakness of proximal lower extremities as defined by manual muscle testing or other objective strength testing, which is present on both sides and is usually progressive over time
Neck flexors are relatively weaker than neck extensors	1.9	1.6	Muscle grades for neck flexors are relatively lower than neck extensors as defined by manual muscle testing or other objective strength testing
In the legs, proximal muscles are relatively weaker than distal muscles	0.9	1.2	Muscle grades for proximal muscles in the legs are relatively lower than distal muscles in the legs as defined by manual muscle testing or other objective strength testing
Skin manifestations			
Heliotrope rash	3.1	3.2	Purple, lilac-coloured or erythematous patches over the eyelids or in a periorbital distribution, often associated with periorbital oedema
Gottron's papules	2.1	2.7	Erythematous to violaceous papules over the extensor surfaces of joints, which are sometimes scaly. May occur over the finger joints, elbows, knees, malleoli and toes
Gottron's sign	3.3	3.7	Erythematous to violaceous macules over the extensor surfaces of joints, which are not palpable
Other clinical manifestations			
Dysphagia or oesophageal dysmotility	0.7	0.6	Difficulty in swallowing or objective evidence of abnormal motility of the oesophagus
Laboratory measurements			
Anti-Jo-1 (anti-histidyl-tRNA synthetase) autoantibody present	3.9	3.8	Autoantibody testing in serum performed with standardised and validated test, showing positive result
Elevated serum levels of creatine kinase (CK)* or lactate dehydrogenase (LD)* or aspartate aminotransferase (ASAT/AST/SGOT)* or alanine aminotransferase (ALAT/ALT/SGPT)*	1.3	1.4	The most abnormal test values during the disease course (highest absolute level of enzyme) above the relevant upper limit of normal
Muscle biopsy features—presence of:			
Endomysial infiltration of mononuclear cells surrounding, but not invading, myofibres		1.7	Muscle biopsy reveals endomysial mononuclear cells abutting the sarcolemma of otherwise healthy, non-necrotic muscle fibres, but there is no clear invasion of the muscle fibres
Perimysial and/or perivascular infiltration of mononuclear cells		1.2	Mononuclear cells are located in the perimysium and/or located around blood vessels (in either perimysial or endomysial vessels)
Perifascicular atrophy		1.9	Muscle biopsy reveals several rows of muscle fibres, which are smaller in the perifascicular region than fibres more centrally located
Rimmed vacuoles		3.1	Rimmed vacuoles are bluish by H&E staining and reddish by modified Gomori trichrome stains

*Serum levels above the upper limit of normal.

enumerated (table 3). The agreement between the classification tree subgroups and the physician-diagnosed subgroups in the dataset was high (92.6% agreement, kappa=0.90, $p < 0.00001$). The agreement proportions, with a probability of 55%, were 1.00 for JDM, 0.89 for DM, 0.94 for ADM, 0.92 for IBM and 0.93 for PM. Raising the probability cut-off of IIM to 90% yielded 94.9% agreement, kappa=0.93, $p < 0.00001$. With a probability cut-off of 90%, the agreement proportions were 1.00 for JDM, 0.96 for DM, 0.95 for ADM, 0.93 for IBM and 0.88 for PM.

Performance of EULAR/ACR criteria compared with published criteria

Performance of the EULAR/ACR criteria was compared with published criteria for IIM^{7 8 10 11 14 15} using the IMCCP dataset (table 4). The new criteria including muscle biopsy features displayed high sensitivity (93%) and specificity (88%). There was slightly lower performance without biopsy variables (sensitivity and specificity 87% and 82%, respectively). Among the assessed criteria, the Targoff criteria¹¹ showed the highest sensitivity (93%) and specificity (89%). Other criteria had either high

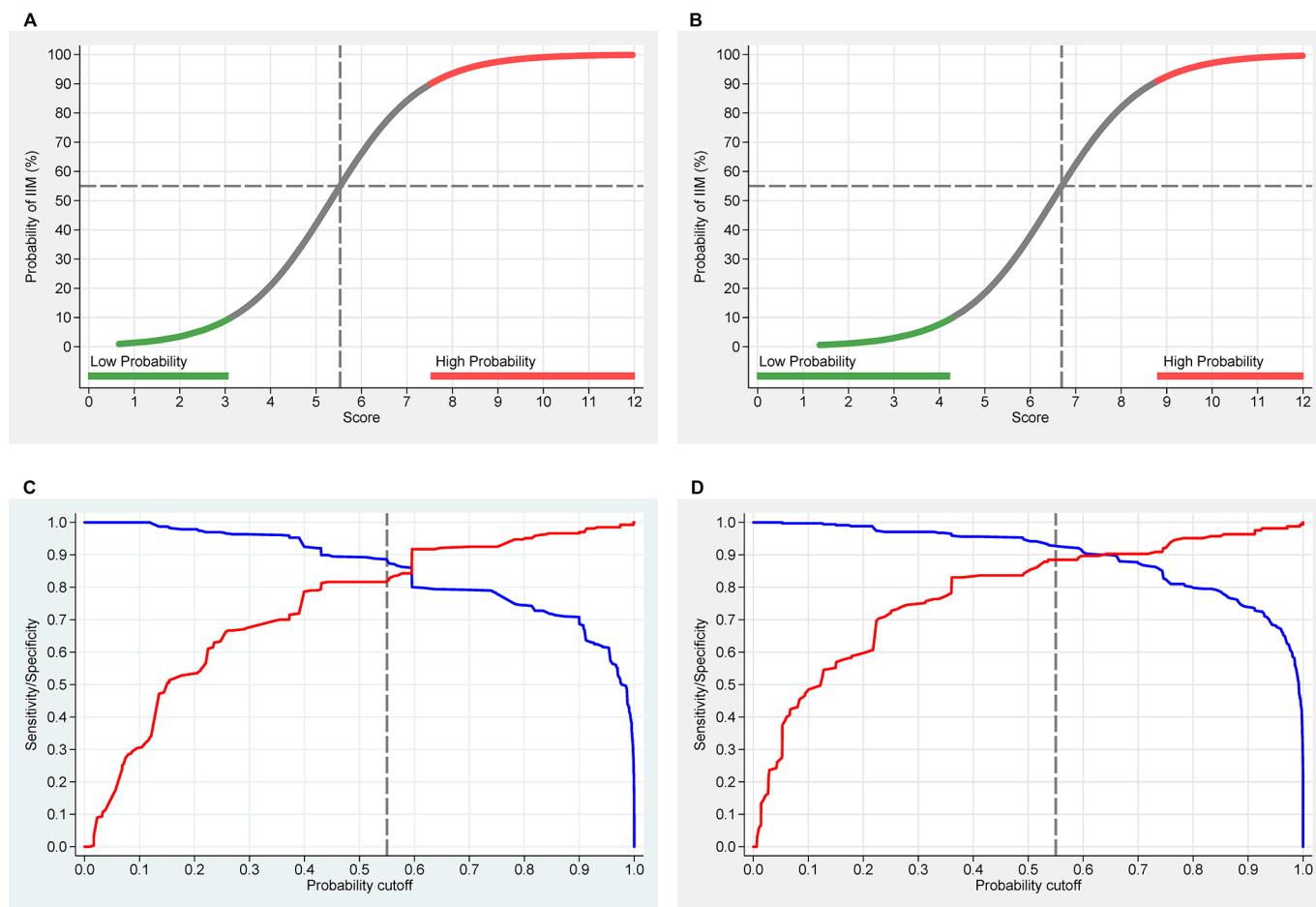


Figure 1 Probability of having idiopathic inflammatory myopathies (IIM) based on the EULAR/ACR classification criteria for IIM. Each score obtained from the classification criteria corresponds to a probability of having the disease, without muscle biopsy data (A) or with muscle biopsy data (B). Each score and probability of disease display a unique set of sensitivity (blue line) and specificity (red line) measurements for the classification criteria not including muscle biopsy data (C) or including muscle biopsy data (D). The most optimal point of accuracy should be stated in publications and be appropriate to the intended purpose, with the recommendation of using a minimum of 55% probability (score of 5.5 without biopsies; 6.7 with biopsies) for classifying a case as IIM ('probable IIM') (dotted line). 'Definite IIM' corresponds to a probability of at least 90% (score of ≥ 7.5 without biopsies; ≥ 8.7 with biopsies). ACR, American College of Rheumatology; EULAR, European League Against Rheumatism.

sensitivity and low specificity (Bohan and Peter^{7,8} and Tanimoto criteria¹⁰), or low sensitivity and high specificity (Dalakas and Hohlfeld¹⁴ and ENMC criteria¹⁵).

We studied how different criteria could classify patients with diverse IIM subdiagnoses in the IMCCP dataset (table 4). The EULAR/ACR classification criteria correctly classified most patients with all IIM subdiagnoses. When biopsy data were used, the performance improved for IBM (94% with biopsy data vs 58% without biopsy data) and PM (86% with biopsy data vs 79% without biopsy data). The Bohan and Peter,^{7,8} Tanimoto¹⁰ and Targoff¹¹ criteria correctly classified all IIM subdiagnoses except ADM, a diagnosis not included in those criteria. The Dalakas and Hohlfeld criteria¹⁴ could not classify any subdiagnoses. The ENMC criteria¹⁵ correctly classified DM and JDM cases but no other subdiagnoses.

A comparison between the EULAR/ACR classification criteria (55% probability cut-off) and the Bohan and Peter criteria^{7,8} showed 89% agreement ($\kappa=0.71$, $p<0.00001$) without including muscle biopsy data, and 93% agreement ($\kappa=0.73$, $p<0.00001$) using muscle biopsy findings. Comparison between the newly developed criteria and the Targoff criteria¹¹ demonstrated that the agreement was 89% ($\kappa=0.74$, $p<0.00001$) and 93% ($\kappa=0.82$, $p<0.00001$) without or with inclusion of muscle biopsy data, respectively.

VALIDATION

Internal validation

Using the criteria without muscle biopsy data, 733 observations were used, resulting in $AUC=0.942$ and cross-validated area= 0.933 . Using the criteria with muscle biopsy data, 507 observations were included, resulting in $AUC=0.962$ and cross-validated area= 0.942 .

External validation for sensitivity

Data from 592 cases (PM=281, DM=256, IBM=33, JDM=18 and ADM=4) in the Euromyositis register were used where clinical, laboratory and muscle biopsy data were available (Karolinska University Hospital, Stockholm, Sweden; Prague Hospital, Prague, Czech Republic; Oslo University Hospital, Oslo, Norway) (online supplementary 7). When there was sufficient information available, the EULAR/ACR classification criteria confirmed IIM diagnosis using a 55% probability cut-off for classification of IIM with no misclassification, yielding 100% sensitivity. Using the criteria without muscle biopsies, 489 (83%) patients were classified as IIM, and 103 (17%) patients could not be classified due to missing data. For the criteria with biopsies, 204 (34%) were classified as IIM and 388 (66%) could not be classified due to missing muscle biopsy data in the register.

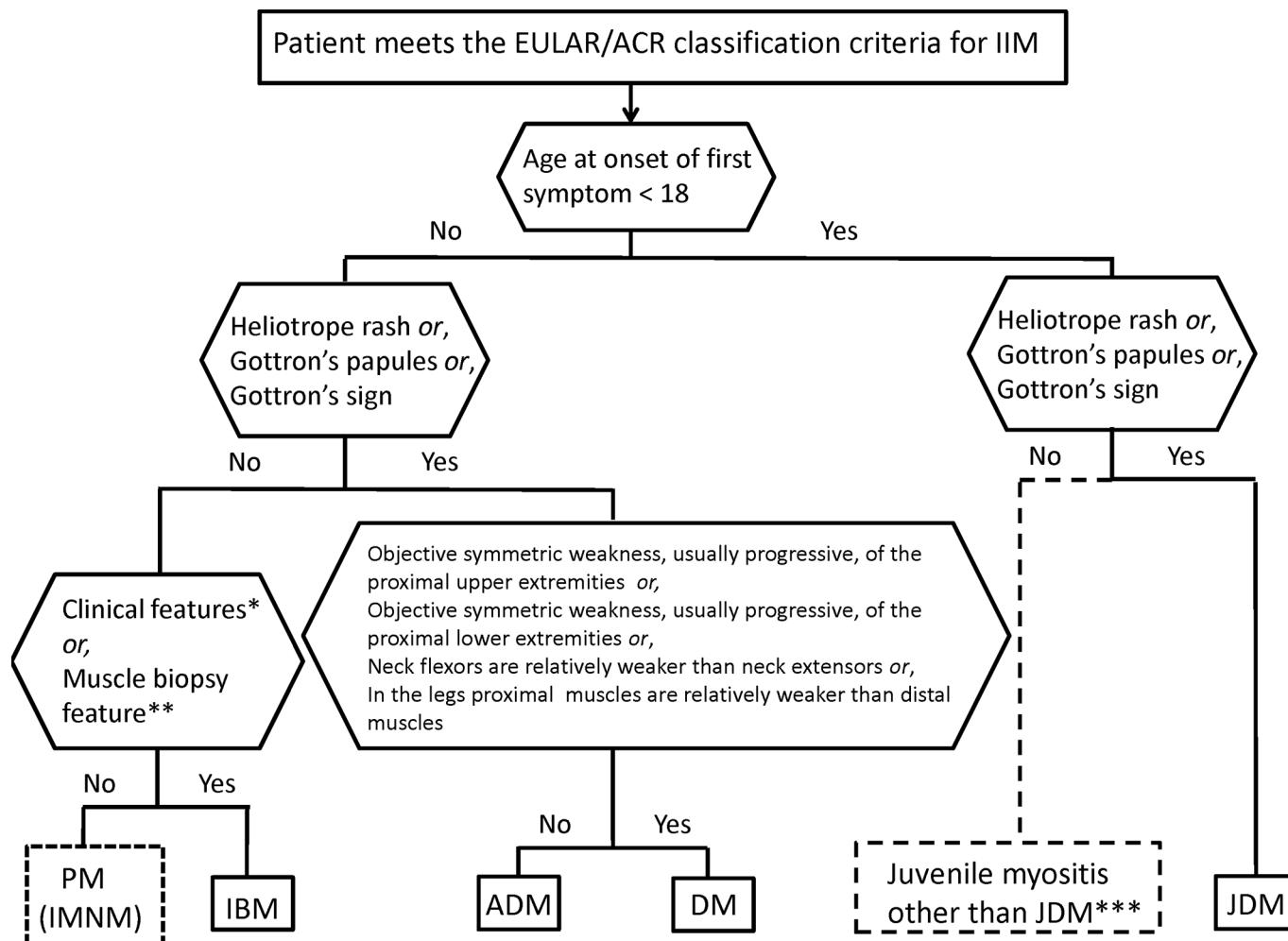


Figure 2 Classification tree for subgroups of IIM. A patient must first meet the EULAR/ACR classification criteria for IIM (probability of IIM $\geq 55\%$). The patient can then be subclassified using the classification tree. The subgroup of PM patients includes patients with IMNM. For IBM classification, one of the following, *finger flexor weakness and response to treatment: not improved, or **muscle biopsy: rimmed vacuoles, is required for classification. ***Juvenile myositis other than JDM was developed based on expert opinion. IMNM and hypomyopathic DM were too few to allow subclassification. ACR, American College of Rheumatology; ADM, amyopathic dermatomyositis; DM, dermatomyositis; EULAR, European League Against Rheumatism; IBM, inclusion body myositis; IIM, idiopathic inflammatory myopathies; IMNM, immune-mediated necrotising myopathy; JDM, juvenile dermatomyositis; PM, polymyositis.

Results for the IBM and PM subgroups improved when biopsy data were included: 97% of IBM cases could be classified compared with 73% when biopsy data were not included. For PM, 80% and 76%, respectively, could be classified. Raising the IIM classification cut-off from 55% to 90% decreased the total number of cases that could be classified to only 63% (not including muscle biopsies) or 28% (including muscle biopsies) due to absence of some muscle biopsy variables in the Euromyositis registry database.

The Juvenile Dermatomyositis Biomarker Study and Repository (UK and Ireland)

The JDRG register included 332 juvenile IIM cases in the study (definite JDM=292, probable JDM=20, definite juvenile PM=4, probable juvenile PM=2, focal myositis=6 and other IIM=8) (online supplementary 8). Muscle biopsy data were not available for all, thus the EULAR/ACR classification criteria without muscle biopsy data were used to test sensitivity in this dataset. Three hundred and seven (92%) cases could be classified using the 55% cut-off and no case was misclassified, yielding 100% sensitivity. The remaining 25 cases (8%) could not be classified

due to missing data. Raising the cut-off stepwise to 60%, 70%, 80% or 90% yielded classification of 92%, 88%, 87% or 64% cases, respectively, where classification was possible.

Web calculator

A web calculator was developed (www.imm.ki.se/biostatistics/calculators/iim) as an aid to use the EULAR/ACR classification criteria. A probability range of classification can be obtained, providing the minimum and maximum probability. In addition to the probabilities acquired, the aggregated scores will be displayed. Whenever sufficient data are entered, the subclassification will be displayed.

DISCUSSION

Classification criteria are essential for inclusion of comparable patients in studies. No validated classification criteria for IIM currently exist. The EULAR/ACR classification criteria for IIM offer advantages that previous criteria lack. They are data driven, exhibit high sensitivity and specificity, and use a limited number of accessible, defined clinical and laboratory variables. Internal

Table 3 Comparison of physician-diagnosed IIM subgroups with IIM subgroups defined according to the classification tree among patients meeting the EULAR/ACR classification criteria for IIM

Physician-diagnosed subgroups	Classification tree subgroups*					Total
	JDM	DM	ADM	IBM	PM	
JDM	235	0	0	0	0	235
DM	0	191	6	2	15	214
ADM	1	1	30	0	0	32
IBM	0	0	0	66	5	71
PM	0	7	0	3	131	141
IMNM	0	0	0	0	10	10
Total	236	199	36	71	161	703
% of all IIM	33.6	28.3	5.1	10.1	22.9	
% of adult IIM	–	42.6	7.7	15.2	34.5	

*Classification of IIM by the EULAR/ACR classification criteria for IIM, using a 55% probability cut-off for classification, followed by the classification tree for subclassification.

ACR, American College of Rheumatology; ADM, amyopathic dermatomyositis; DM, dermatomyositis; EULAR, European League Against Rheumatism; IBM, inclusion body myositis; IIM, idiopathic inflammatory myopathies; IMNM, immune-mediated necrotising myopathy; JDM, juvenile dermatomyositis; PM, polymyositis.

validation and testing in external cohorts confirmed excellent performance. Importantly, the new criteria capture the most frequent IIM subgroups and can be used for both adults and children for research studies and clinical trials.

The new EULAR/ACR classification criteria provide a score with a corresponding probability of having IIM. This provides investigators flexibility in inclusion criteria for different types of studies, for example, clinical trials requiring high specificity would warrant a high probability of IIM in the inclusion criteria, whereas epidemiological studies requiring high sensitivity would need inclusion criteria with lower probability of IIM.

The new criteria are based on data from children and adults with different ethnicities from centres in Europe, America and Asia, and use symptoms, signs and other measures that are routinely assessed. A limitation is still that a majority of the patients were Caucasian, and even though we included data from 298 patients from Asia, we cannot exclude that there can be differences in manifestations between different ethnic groups, hence we still need to validate the criteria in Asian and African populations. Importantly, in patients with a typical DM skin rash, the criteria can be used without muscle biopsy data. For JDM, 97% of patients were correctly classified using the new criteria without muscle biopsy data. The new criteria also offer practical advantages in the number of variables needed to be tested. If a sufficient probability is reached, there is no requirement to test all items. Each criterion is well defined, lessening the opportunities for ad hoc interpretation. The skin rash typical of DM contributed with high weights in the probability score. Skin biopsy is recommended in the absence of muscle symptoms.^{33 34} The EULAR/ACR classification criteria are the first myositis criteria to be validated and tested for sensitivity in other cohorts and revealed no misclassification.

Compared with most previous criteria, the new criteria are superior in sensitivity, specificity and classification accuracy. Classification criteria should have high sensitivity and specificity. The EULAR/ACR criteria demonstrated sensitivity and specificity of 87% and 82%, respectively, with even higher accuracy when muscle biopsies were included, 93% and 88%, respectively. Correctly classified patients were 86% and 91%, respectively, with and without inclusion of biopsies, and the criteria performed equally well for adult and juvenile cases. The Targoff criteria¹¹ also showed good statistical properties, but were not able to capture all subgroups of IIM as ADM patients were not included. Furthermore, the variables were not clearly defined in the Targoff criteria, and testing of more variables is required,

Table 4 Performance of the EULAR/ACR classification criteria for IIM and existing classification and diagnostic criteria for IIM

Performance (%)	EULAR/ACR classification criteria for IIM*		Bohan and Peter ^{7 8}	Tanimoto <i>et al</i> ¹⁰	Targoff <i>et al</i> ¹¹	Dalakas and Hohlfeld ¹⁴	ENMC Hoogendijk <i>et al</i> ¹⁵
	Without muscle biopsy	With muscle biopsy					
Mean (95% CI)							
Sensitivity	87 (84 to 90)	93 (89 to 95)	98 (96 to 99)	96 (94 to 97)	93 (90 to 95)	6 (5 to 8)	52 (48 to 55)
Specificity	82 (77 to 87)	88 (83 to 93)	55 (50 to 61)	31 (25 to 37)	89 (84 to 92)	99 (98 to 100)	97 (95 to 98)
Mean							
Positive predictive value	90	94	85	80	95	92	96
Negative predictive value	79	85	90	73	85	43	57
Correctly classified	86	91	86	79	91	45	70
Correct classification of IIM per subgroup‡ (%)							
Amyopathic dermatomyositis	94	60	25	14	0	0	0
Dermatomyositis	96	98	100	96	99	7	83
Hypomyopathic dermatomyositis	83	100	80	40	67	0	20
Immune-mediated necrotising myopathy	100	100	100	100	100	0	10
Inclusion body myositis	58	94	97	97	91	1	1
Juvenile dermatomyositis	97	96	100	96	98	5	86
Polymyositis	79	86	95	100	85	11	9

*Cut-off for probability: 55%.

†Definite and probable polymyositis and dermatomyositis.

‡Classification as idiopathic inflammatory myopathy per subgroup out of total number of cases per subgroup, expressed as mean.

ACR, American College of Rheumatology; ENMC, European Neuromuscular Centre; EULAR, European League Against Rheumatism; IIM, idiopathic inflammatory myopathies.

Criteria

including electromyography, which is not always easily accessible and may be painful for patients. Importantly, the EULAR/ACR criteria can be applied to patients with myositis with overlap diagnoses, such as mixed connective tissue disease or systemic lupus erythematosus with myositis, since these patients were included among IIM cases.

There are limitations of the study; no controls or comparators were included in the external validation cohort since the IMCCP study was designed before those recommendations from ACR/EULAR were in place, requiring future validation. A validation study using comparators is underway, but we encourage additional validation studies in different populations. Another limitation largely unavoidable in observational data is the high frequency of missing data in the derivation dataset and validation samples, reflecting differences in practice patterns in evaluating patients. Nevertheless, 80% of cases and comparators had muscle biopsy data available, whereas MRI data and electromyography were only available for 38% and 29% of cases, respectively, reflecting their limited usage in clinical diagnosis. However, MRI data and electromyography examination are still important for diagnostic purposes of IIM. Patients studied had to have their disease for at least 6 months, which did not allow us to study new-onset patients. Importantly, these criteria are proposed as classification criteria in research and in clinical trials, not as diagnostic criteria.³⁵ There is also some possibility that the cut-points established for probable and definite myositis will need adjustment when tested with new populations of patients.

It took almost 10 years to assemble sufficient numbers of patients with these rare diseases, and three subgroups did not have enough subjects to study adequately. During this period, a new IIM subgroup became recognised, IMNM,³⁶ of which only a few cases were included into the study. IMNM cases could thus not be distinguished from PM in the subclassification tree. Another subgroup with few cases was juvenile PM, making a data-derived distinction from JDM impossible. However, paediatric rheumatology experts in the IMCCP recommended that the adult subclassification of IIM could be used for juvenile PM by extrapolation (figure 2). IBM cases were identified in the subclassification tree by the clinical features of finger flexor weakness and no response to treatment, or by the presence of rimmed vacuoles in muscle biopsies.³⁷

Another limitation was the low frequency of myositis-specific autoantibodies documented. Five myositis-specific autoantibodies were included: anti-Jo-1, anti-Mi-2, anti-SRP, anti-PL7 and anti-PL12 antibodies, and all were strongly associated with IIM. However, only anti-Jo-1 autoantibody had a significant number of observations (n=1062) to permit analyses and inclusion in the classification criteria. A future update of the EULAR/ACR classification criteria should include the more recently identified myositis-specific autoantibodies,^{21 22} in addition to more patients with IMNM, ADM, hypomyopathic DM and juvenile cases other than JDM.

RECOMMENDATIONS

- ▶ Patients with pathognomonic skin rashes (heliotrope rash, Gottron's papules and/or Gottron's sign) of JDM or DM are accurately classified with the EULAR/ACR classification criteria without including muscle biopsy data. For patients without these skin manifestations, muscle biopsy is recommended. For DM patients without muscle involvement, a skin biopsy is recommended.
- ▶ The EULAR/ACR classification criteria provide a score and a corresponding probability of having IIM. Each probability

displays a unique sensitivity and specificity. The best balance between sensitivity and specificity can be found for a probability of 55%–60% (total aggregated score of ≥ 5.5 and ≤ 5.7) for the criteria not including muscle biopsy data, and 55%–75% (total aggregated score ≥ 6.7 and ≤ 7.6) when including muscle biopsies. These cases are designated 'probable IIM'. The recommended cut-off needed for classifying a patient as IIM is $\geq 55\%$.

- ▶ 'Definite IIM' corresponds to a probability of $\geq 90\%$ or a total aggregate score of 7.5 or more without muscle biopsy and 8.7 with muscle biopsy, and is recommended in studies where a high specificity is required.
- ▶ A patient is termed 'possible IIM' if the probability is $\geq 50\%$ and $< 55\%$ (a minimum score of 5.3 without biopsies and 6.5 with biopsies).
- ▶ For clarity and transparency, both the descriptive term ('possible', 'probable' or 'definite') and the probability and the aggregated score should be reported in studies.

CONCLUSIONS

New classification criteria for IIM and the major IIM subgroups have been developed. These data-driven criteria have a good feasibility, high sensitivity and specificity, have been partly validated in external cohorts and are superior to previous criteria in capturing different subgroups of IIM. Revision of the criteria in the future will be important when additional validated myositis autoantibody tests, imaging and other tests are available in more IIM cases and comparator cases without IIM.

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REFERENCES

- Plotz PH, Rider LG, Targoff IN, *et al.* NIH conference. Myositis: immunologic contributions to understanding cause, pathogenesis, and therapy. *Ann Intern Med* 1995;122:715–24.
- Dalakas MC. Inflammatory muscle diseases. *N Engl J Med Overseas Ed* 2015;372:1734–47.
- Rider LG, Giannini EH, Brunner HI, *et al.* International consensus on preliminary definitions of improvement in adult and juvenile myositis. *Arthritis Rheum* 2004;50:2281–90.
- Oddis CV, Rider LG, Reed AM, *et al.* International consensus guidelines for trials of therapies in the idiopathic inflammatory myopathies. *Arthritis Rheum* 2005;52:2607–15.
- Medsker TA, Dawson WN, Masi AT. The epidemiology of polymyositis. *Am J Med* 1970;48:715–23.
- DeVere R, Bradley WG. Polymyositis: its presentation, morbidity and mortality. *Brain* 1975;98:637–66.
- Bohan A, Peter JB. Polymyositis and dermatomyositis (first of two parts). *N Engl J Med* 1975;292:344–7.
- Bohan A, Peter JB. Polymyositis and dermatomyositis (second of two parts). *N Engl J Med* 1975;292:403–7.
- Griggs RC, Askanas V, DiMauro S, *et al.* Inclusion body myositis and myopathies. *Ann Neurol* 1995;38:705–13.
- Tanimoto K, Nakano K, Kano S, *et al.* Classification criteria for polymyositis and dermatomyositis. *J Rheumatol* 1995;22:668–74.
- Targoff IN, Miller FW, Medsker TA, *et al.* Classification criteria for the idiopathic inflammatory myopathies. *Curr Opin Rheumatol* 1997;9:527–35.
- Mastaglia FL, Phillips BA. Idiopathic inflammatory myopathies: epidemiology, classification, and diagnostic criteria. *Rheum Dis Clin North Am* 2002;28:723–41.
- van der Meulen MF, Bronner IM, Hoogendijk JE, *et al.* Polymyositis: an overdiagnosed entity. *Neurology* 2003;61:316–21.
- Dalakas MC, Hohlfeld R. Polymyositis and dermatomyositis. *Lancet* 2003;362:971–82.
- Hoogendijk JE, Amato AA, Lecky BR, *et al.* 119th ENMC international workshop: trial design in adult idiopathic inflammatory myopathies, with the exception of inclusion body myositis, 10–12 October 2003, Naarden, The Netherlands. *Neuromuscul Disord* 2004;14:337–45.
- Troyanov Y, Targoff IN, Tremblay JL, *et al.* Novel classification of idiopathic inflammatory myopathies based on overlap syndrome features and autoantibodies: analysis of 100 French Canadian patients. *Medicine* 2005;84:231–49.
- Miller FW, Rider LG, Plotz PH, *et al.* Polymyositis: an overdiagnosed entity. *Neurology* 2004;63:402–3.
- Bradley WG. Polymyositis: an overdiagnosed entity. *Neurology* 2004;63:402.
- Hengstman GJ, van Engelen BG. Polymyositis: an overdiagnosed entity. *Neurology* 2004;63:402–3.
- Engel AG, Arahata K. Mononuclear cells in myopathies: quantitation of functionally distinct subsets, recognition of antigen-specific cell-mediated cytotoxicity in some diseases, and implications for the pathogenesis of the different inflammatory myopathies. *Hum Pathol* 1986;17:704–21.
- Betteridge Z, McHugh N. Myositis-specific autoantibodies: an important tool to support diagnosis of myositis. *J Intern Med* 2016;280:8–23.
- Rider LG, Nistala K. The juvenile idiopathic inflammatory myopathies: pathogenesis, clinical and autoantibody phenotypes, and outcomes. *J Intern Med* 2016;280:24–38.
- Love LA, Leff RL, Fraser DD, *et al.* A new approach to the classification of idiopathic inflammatory myopathy: myositis-specific autoantibodies define useful homogeneous patient groups. *Medicine* 1991;70:360–74.
- Singh JA, Solomon DH, Dougados M, *et al.* Development of classification and response criteria for rheumatic diseases. *Arthritis Rheum* 2006;55:348–52.
- Dougados M, Gossec L. Classification criteria for rheumatic diseases: why and how? *Arthritis Rheum* 2007;57:1112–5.
- Van de AH, Delbecq AL. The effectiveness of nominal, delphi, and interacting group decision making processes. *Acad Manage J* 1974;17:605–21.
- Fink A, Kosecoff J, Chassin M, *et al.* Consensus methods: characteristics and guidelines for use. *Am J Public Health* 1984;74:979–83.
- Ruperto N, Meiorin S, Iusan SM, *et al.* Consensus procedures and their role in pediatric rheumatology. *Curr Rheumatol Rep* 2008;10:142–6.
- Totikidis V. Applying the Nominal Group Technique (NGT) in Community Based Action Research for Health Promotion and Disease Prevention. *Aust Community Psychol* 2010;22:18–29.
- ARA Glossary Committee. Dictionary of the rheumatic diseases, Vol I. *Signs and symptoms [monograph]*. New York, NY: Contact Associates International Ltd, 1982.
- ARA Glossary Committee. Dictionary of the rheumatic diseases, Vol II. *Diagnostic testing [monograph]*. New York, NY: Contact Associates International Ltd, 1985.
- Efron B, Tibshirani R. Improvements on cross-validation: the 632+ bootstrap method. *J Am Stat Assoc* 1997;92:548–60.
- Hsiung SH, Chan EF, Elenitsas R, *et al.* Multicentric reticulohistiocytosis presenting with clinical features of dermatomyositis. *J Am Acad Dermatol* 2003;48(Suppl 2):S11–14.

Criteria

- 34 Fett N, Liu RH. Multicentric reticulohistiocytosis with dermatomyositis-like features: a more common disease presentation than previously thought. *Dermatology* 2011;222:102–8.
- 35 Aggarwal R, Ringold S, Khanna D, *et al.* Distinctions between diagnostic and classification criteria? *Arthritis Care Res* 2015;67:891–7.
- 36 Casciola-Rosen L, Mammen AL. Myositis autoantibodies. *Curr Opin Rheumatol* 2012;24:602–8.
- 37 Lloyd TE, Mammen AL, Amato AA, *et al.* Evaluation and construction of diagnostic criteria for inclusion body myositis. *Neurology* 2014;83:426–33.



2017 European League Against Rheumatism/American College of Rheumatology classification criteria for adult and juvenile idiopathic inflammatory myopathies and their major subgroups

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