Polymyositis and dermatomyositis: no persistence of enterovirus or encephalomyocarditis virus RNA in muscle


Abstract

Objectives—A persistent infection of enteroviruses and cardioviruses has been implicated in polymyositis and dermatomyositis, but conventional hybridisation studies of the presence of enterovirus RNA and encephalomyocarditis (EMC) virus RNA in affected muscle have yielded conflicting results. To investigate further the possibility of viral persistence, the presence of viral RNA in muscle from patients with adult onset polymyositis and dermatomyositis was investigated using a polymerase chain reaction (PCR) technique.

Methods—Muscle tissue was obtained from 10 patients with polymyositis and five patients with dermatomyositis, all with adult onset active disease. A PCR was performed using primers with high specificity for enterovirus and EMC virus RNA, followed by Southern blot hybridisation with an oligonucleotide probe directed against the internal portion of the amplified product. A PCR directed against the Abelson tyrosine kinase mRNA served as an internal control for the presence and quality of RNA.

Results—A specific amplification for enterovirus or for EMC virus could not be seen in any of the muscle biopsy samples, despite a sensitivity of about 30 plaque forming units for enterovirus and of 100 plaque forming units for EMC virus. Southern blot hybridisation confirmed these results in that positive controls hybridised with the oligonucleotide probe, but no signal was obtained with the muscle specimens.

Conclusion—A sensitive and specific PCR technique showed no evidence of the presence of enterovirus or EMC virus RNA in muscle samples from patients with polymyositis or dermatomyositis. These data do not support the proposal that viral RNA persistence plays a part in these idiopathic inflammatory myopathies.

Patients and methods

PATIENTS
We studied 10 patients with adult onset polymyositis and five patients with adult onset dermatomyositis attending the centre for neuromuscular diseases of the University of Nijmegen. All patients fulfilled the diagnostic criteria for definite polymyositis or definite dermatomyositis, as formulated by Dalakas.1 Of the patients with polymyositis five were men and five were women; their ages ranged from 34 to 73 years. The patients with autisme origin is supported by the presence of various autoantibodies, the evidence of myotoxicity mediated by cytotoxic T cells or complement mediated microangiopathy, their response to immunotherapies, and their association with diseases of which the autoimmune character has been established more firmly.1,2 The agents initiating self sensitisation and the specific antigens against which the immune reactions are directed are unknown, however.

Viruses can induce autoimmunity in mice3,4 and, probably, in humans.4,5 Electron microscopic6 and serological9 studies have implicated the enterovirus and cardiovirus subgroup of picornaviruses in polymyositis and dermatomyositis, but reports of the isolation of the viruses from muscle tissue are rare.1 Dot spot hybridisation studies of the presence of enterovirus specific RNA in affected muscle have yielded conflicting results. Bowles et al found coxsackievirus B specific RNA in muscle tissues from patients with polymyositis or dermatomyositis,14 whereas Bunn and Walport could not detect this virus in patients with polymyositis.12 Unconfirmed in situ hybridisation studies in patients with polymyositis and dermatomyositis have found enterovirus specific13 or encephalomyocarditis (EMC) virus specific RNA.14 Persistent infection of enterovirus and EMC virus as a pathogenic factor in polymyositis and dermatomyositis is therefore a subject of controversy. To investigate further the possibility of viral RNA persistence in polymyositis and dermatomyositis, we extracted RNA from muscle biopsy samples from patients with active disease, and used a highly specific and sensitive polymerase chain reaction (PCR) technique for the detection of enterovirus and EMC virus RNA.
Diagnosis, age, sex, duration of symptoms, and associated diseases of the patients with polymyositis (PM) and dermatomyositis (DM)

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Diagnosis</th>
<th>Age (years)*</th>
<th>Sex</th>
<th>Disease duration*</th>
<th>Associated disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PM</td>
<td>66</td>
<td>F</td>
<td>Four years</td>
<td>Primary biliary cirrhosis</td>
</tr>
<tr>
<td>2</td>
<td>PM</td>
<td>70</td>
<td>F</td>
<td>One month</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>PM</td>
<td>59</td>
<td>M</td>
<td>Six weeks</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>PM</td>
<td>73</td>
<td>M</td>
<td>16 years</td>
<td>Dilated cardiomyopathy</td>
</tr>
<tr>
<td>5</td>
<td>PM</td>
<td>63</td>
<td>M</td>
<td>Three months</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>PM</td>
<td>51</td>
<td>M</td>
<td>One year</td>
<td>Adenocarcinoma (site unknown)</td>
</tr>
<tr>
<td>7</td>
<td>PM</td>
<td>73</td>
<td>F</td>
<td>2.5 months</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>PM</td>
<td>59</td>
<td>F</td>
<td>13 years</td>
<td>-</td>
</tr>
<tr>
<td>9</td>
<td>PM</td>
<td>54</td>
<td>M</td>
<td>34 years</td>
<td>-</td>
</tr>
<tr>
<td>10</td>
<td>PM</td>
<td>58</td>
<td>F</td>
<td>Nine years</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>DM</td>
<td>63</td>
<td>F</td>
<td>One month</td>
<td>Interstitial lung fibrosis</td>
</tr>
<tr>
<td>12</td>
<td>DM</td>
<td>24</td>
<td>F</td>
<td>Three months</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>DM</td>
<td>34</td>
<td>F</td>
<td>Eight years</td>
<td>-</td>
</tr>
<tr>
<td>14</td>
<td>DM</td>
<td>42</td>
<td>F</td>
<td>Five years</td>
<td>-</td>
</tr>
<tr>
<td>15</td>
<td>DM</td>
<td>22</td>
<td>F</td>
<td>Seven years</td>
<td>-</td>
</tr>
</tbody>
</table>

*At time of muscle biopsy.

dermatomyositis were all women; their ages ranged from 22 to 63 years. The table gives the diagnosis, age, sex, duration of symptoms at time of examination, and associated diseases of the patients. Biopsy samples were obtained from a quadriceps muscle for diagnostic reasons. At the time of examination all patients had progressive muscle weakness and increased serum creatine kinase concentrations. For RNA extraction and viral RNA detection, tissue samples of approximately 25–30 mm² were immediately frozen in liquid nitrogen and stored at −80°C until use. Fifteen patients with non-inflammatory non-immune mediated neuromuscular disorders were studied as controls.

SAMPLE PROCESSING

RNA from muscle samples was purified using a single extraction with guanidinium thiocyanate-phenol-chloroform according to the method of Chomczynski and Sacchi. RNA was dissolved in 50 μl distilled water treated with diethylpyrocarbonate. To all samples, human placenta RNAse inhibitor (RNasin; Promega) was added to a concentration of 0.4 U/μl. The samples were stored at −80°C. The reverse transcriptase PCR and determination of the amplified products were performed as described previously. In brief, for enteroviral RNA amplification, the RNA was transcribed in cDNA using reverse transcriptase and an antisense primer (3'ATTGTCCACCATAGCGACCA). After completing the reverse transcriptase reaction, the buffer conditions were adapted for the PCR, and the sense primer (5'TTCTCCTGGGCCCTGATGCG3') was added. RNA/cDNA hybrids were denatured at 94°C for five minutes. The thermal profile included 40 cycles of denaturation at 94°C for one minute, primer annealing at 42°C for one minute, and primer extension at 72°C for two minutes. The reactions were analysed by electrophoresis on a 2% agarose gel stained with ethidium bromide, and by Southern blot analysis using an endlabelled oligonucleotide probe (5'AAACACGGACCACCCAAAGTA3'). A positive PCR generates a fragment of 155 base pairs. The primers were selected in the conserved 5'NCR of enterovirus and have been shown to detect 60 of the 66 different enterovirus types tested. For amplification of EMC RNA we used an antisense primer (5'CACGTGGCTTTTGGCCGCAGAGG3') and a sense primer (5'CAGAGCCGCCTTGAAGA3') specific for cardioviruses and Theiler’s murine encephalomyocarditis virus (TMEV) (Zoll G J, Galama J M D, Melcher W J G, unpublished data). For Southern blot analysis we used an EMC/TMEV specific oligonucleotide probe (5'CGGATTACGAGGCGG3'). A fragment of 282 base pairs is obtained with positive specimens.

As an internal control for the presence and quality of RNA, we performed a PCR directed against the Abelson tyrosine kinase mRNA, which is expressed in muscles. A positive PCR results in a fragment of 218 base pairs.

Results

When a titrated stock of virus was serially diluted and added to negative muscle samples before RNA extraction, we obtained a sensitivity of approximately 30 plaque forming units for enterovirus (fig 1A) and of 100 plaque forming units for EMC (fig 1B). A specific amplification for enterovirus (fig 2A) or for EMC virus (fig 2B) was not observed in any of the muscle biopsy samples. A specific amplification product of 155 base pairs was seen from enterovirus RNA and from enterovirus cDNA, and of 282 base pairs from EMC virus RNA, which were used as positive controls. In all samples the reverse transcriptase PCR on the non-relevant mRNA of the Abelson tyrosine kinase gene resulted in a specific amplification product of 218 base pairs, confirming the presence of adequate RNA in the tissues. Southern blot hybridisation with an oligonucleotide probe directed against the internal portion of the amplified product confirmed the results as observed directly on gel electrophoresis: the positive controls hybridised with the oligonucleotide probe, but no signal was obtained with the muscle specimens.

Discussion

The aetiology of polymyositis and dermatomyositis is unknown, but evidence is accumulating that viruses belonging to the enterovirus and cardioviruses subgroup of picornaviruses play a part. Immuno-pathogenic studies in experimental murine myositis support the idea of viral persistence: in coxsackievirus B induced myositis and in EMC virus induced myositis, hybridisation studies showed viral RNA in affected muscle, at times when cultures for the virus were negative. In various human disorders viral persistence has been established. Conventional hybridisation as well as PCR studies detected coxsackievirus B RNA in endomyocardial biopsy samples from patients with dilated cardiomyopathy and myocarditis. Muscle from patients with chronic fatigue
The discrepancies between these reports, including ours, may result from the different methods used, or from differences between patient groups. Although the sensitivity of the RNA PCR may be limited by the efficiency of RNA extraction and reverse transcription, the PCR technique has been described as superior to conventional hybridisation techniques for the detection of enteroviral RNA (Zoll GJ, Galama J M D, Melchers W J G, unpublished data). In our study the positive Abelson band confirmed the quality of the RNA samples for PCR. As all muscle cells express the Abelson gene, however, it cannot be excluded that negative viral results could be obtained from Abelson positive samples if the virus was present in only a few cells.

We obtained a sensitivity of 30 plaque forming units for enterovirus and of 100 plaque forming units for EMC virus, which is within the range of values reported elsewhere. It should be remembered, however, that virus preparations may contain an excess of non-infectious to infectious particles and thus small amounts of virus may not be detected in spite of an apparently high sensitivity. On the other hand, pathogenic changes, which are clinically relevant, are not likely to result from minute amounts of viral RNA. Moreover, our previous finding of enterovirus RNA in a cardiac muscle biopsy sample from a patient with dilated cardiomyopathy and in muscle from mice with coxsackievirus B induced myositis indicates an adequate sensitivity of the PCR for the detection of persistent viral RNA.

Our approach does not preclude the possibility that we have missed enterovirus and EMC virus RNA sequences not detectable by the primers used. As viral RNA without the highly conserved 5' NCR is incapable of translation and replication, however, a persistent infection with such RNA sequences is not likely to occur. Likewise, picornaviruses not belonging to the enterovirus or cardiovirus subgroup could have been missed with our primers owing to their type specificity. There is little evidence, however, that other picornavirus subgroups are involved in polymyositis or dermatomyositis.

As has been reported elsewhere, most studies of viral persistence in myositis have been of children. In view of the differences between adult and childhood dermatomyositis, it cannot be excluded that in childhood myositis viral RNA does persist. For comparison, coxsackievirus B1 induces chronic myositis in mice only if inoculated within 48 hours of birth. It is possible that immature immune systems do not completely clear the enterovirus, and thus predispose to the development of dermatomyositis or polymyositis.

Another possible explanation for the discrepant results may be genuine geographical differences in the aetio-pathogenesis in that viruses may play a part in patients in some countries or regions, but not in others.

To summarise, with the use of a sensitive and specific PCR technique we did not detect enterovirus and EMC virus RNA in muscle tissues from adult patients with polymyositis or dermatomyositis.

syndrome have shown evidence of enterovirus RNA on PCR. Bowles et al, using quantitative dot blot hybridisation, found coxsackievirus B specific RNA in muscle tissues from five of nine patients with polymyositis or dermatomyositis, whereas control biopsy samples were all negative. With an in situ hybridisation technique, Youset et al detected enterovirus specific RNA in biopsy samples from six of 13 patients with polymyositis or dermatomyositis, and Rosenberg et al found evidence for an EMC-like virus in three patients with dermatomyositis.

Using a highly specific and sensitive PCR assay, we were unable to detect enteroviral or EMC RNA in muscle samples from patients with active polymyositis or dermatomyositis. Our results are in agreement with some conventional hybridisation studies, which reported the absence of enteroviral RNA in polymyositis and dermatomyositis. Thus Rosenberg et al did not detect enteroviral RNA in five such patients, and Bunn and Walport, using slot blot hybridisation, could not find coxsackievirus B RNA in 15 patients with polymyositis. Our results are also in agreement with other PCR studies, which did not detect viral RNA for coxsackievirus B, EMC virus, mumps virus, adenovirus, or enteroviral RNA in muscle tissues from adult patients with polymyositis or dermatomyositis.


We thank Inge Bergmann for excellent technical assistance, Drs C. W. G. M. Frenken and M. J. J. Prick, neurologists at the Canisius-Wilhelmina Ziekenhuis, Nijmegen, for referring their patients, Th Polder for taking the muscle biopsy samples, and P Jap for the use of muscle samples. This study was supported by grants from the Prinses Beatrixfonds (grant numbers 88-29099 and 89-3137).