



Your Questions Answered

POLYMYOSITIS

Q What has been found effective for reducing the muscle inflammation of polymyositis?



DR. ANTHONY A. AMATO RESPONDS:

A Polymyositis and dermatomyositis are muscle diseases known as inflammatory myopathies, which are characterized by muscle inflammation and weakness. People with inflammatory myopathy may also experience arthritis, shortness of breath, difficulty swallowing and speaking, and heart arrhythmias. Onset can be in childhood to late in adult life. Data on the prevalence of polymyositis and dermatomyositis are limited, but estimates from the U.S. and Japan range between 50 and 63 cases per million people.

There are no approved medications for any of the inflammatory myopathies. However, we do use immunosuppressive therapy to treat them in practice. Corticosteroids are effective in most patients and are the first-line treatment in polymyositis and dermatomyositis. Second-line agents include methotrexate, azathioprine, mycophenolate, and intravenous gamma-globulin.

When to start a second-line agent—at the start of treatment, or only if the corticosteroids fail to produce adequate improvement—is unclear. In addition, we don't know which treatment strategy works best, and the various options are considered roughly equal. For example, no one has done a study comparing corticosteroids alone versus corticosteroids plus methotrexate, so we don't have evidence supporting one approach over the other. One needs to weigh the various risks and benefits of all these medications. Some doctors like to start with corticosteroids and see if they can taper the dose to reduce side effects; then, if the dose can't be tapered, they will add a second-line agent. Others prefer to start the two medications at the same time, which might afford faster control but also increases the risk of immunosuppression.

Speak with your neurologist about the risks and benefits of these different approaches.

Anthony A. Amato, M.D., is professor of neurology at Harvard Medical School and Brigham & Women's Hospital in Boston, MA.

SPINAL TAP

Q What is a spinal tap, and why is it done?



DR. ORLY AVITZUR RESPONDS:

A A spinal tap, also called a lumbar puncture, is a procedure performed to remove a small amount of cerebrospinal fluid—the fluid that bathes your brain and spinal cord—for laboratory analysis. It is used to check for bleeding around the brain (subarachnoid hemorrhage), infections such as meningitis or encephalitis, cancers, and other disorders of the brain, spinal cord, and nerves.

During the test, you will be asked to lie on your side in the fetal position, with your legs bent up, your neck bent down toward your chest, and your chin tucked. Sometimes this test is done in the sitting position, and you are then asked to lean forward, neck bent and arms on a tray table. These positions cause the vertebral spaces to open more and allow the needle to pass more easily.

A small area of the skin over the spine at about the level of the top of the pelvic bones is numbed with a local anesthetic (lidocaine). A very thin needle is inserted between the vertebrae to measure the pressure and remove the spinal fluid. There may be some brief, mild discomfort in your lower back after which the fluid is allowed to drip into vials. This procedure usually takes about 10 minutes. It's best to lie flat for a while afterwards to minimize the chances of a headache.

Orly Avitzur, M.D., is a practicing neurologist, an assistant professor at the New York Medical College, and a lecturer at the Yale University School of Medicine.

DO YOU HAVE A QUESTION TO ASK THE EXPERTS?

Send it to neurologynow@lwwny.com