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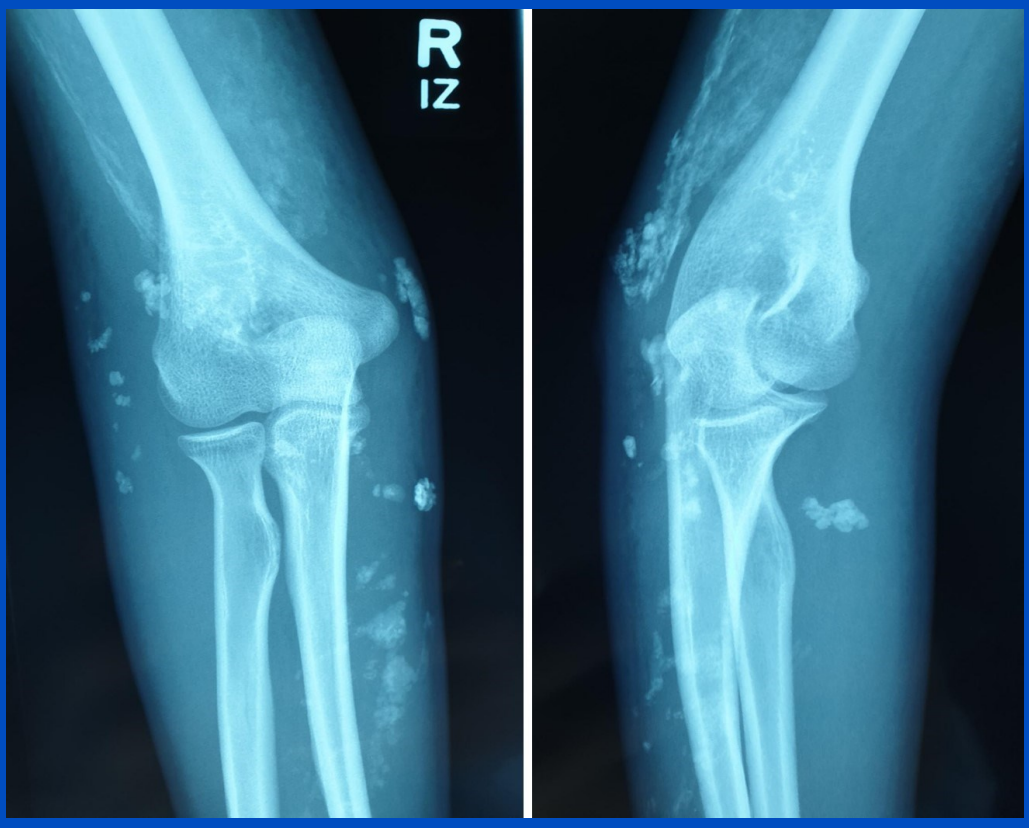

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Aim and Scope of Brunei International Medical Journal

The Brunei International Medical Journal (BIMJ) is a six monthly peer reviewed official publication of the Ministry of Health under the auspices of the Clinical Research Unit, Ministry of Health, Brunei Darussalam.

The BIMJ publishes articles ranging from original research papers, review articles, medical practice papers, special reports, audits, case reports, images of interest, education and technical/innovation papers, editorials, commentaries and letters to the Editor. Topics of interest include all subjects that relate to clinical practice and research in all branches of medicine, basic and clinical including topics related to allied health care fields. The BIMJ welcomes manuscripts from contributors, but usually solicits reviews articles and special reports. Proposals for review papers can be sent to the Managing Editor directly. Please refer to the contact information of the Editorial Office.

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Ethical considerations will be taken into account in the assessment of papers that have experimental investigations of human or animal subjects. Authors should state clearly in the Materials and Methods section of the manuscript that institutional review board has approved the project. Those investigators without such review boards should ensure that the principles outlined in the Declaration of Helsinki have been followed.

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These include controlled trials, interventional studies, studies of screening and diagnostic tests, outcome studies, cost-effectiveness analyses, and large-scale epidemiological studies. Manuscript should include the following; introduction, materials and methods, results and conclusion. The objective should be stated clearly in the introduction. The text should not exceed 2500 words and references not more than 30.

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Designate one corresponding author and provide a complete address, telephone and fax numbers, and e-mail address. The number of authors of each paper should not be more than twelve; a greater number requires justification. Authors may add a publishable footnote explaining order of authorship.

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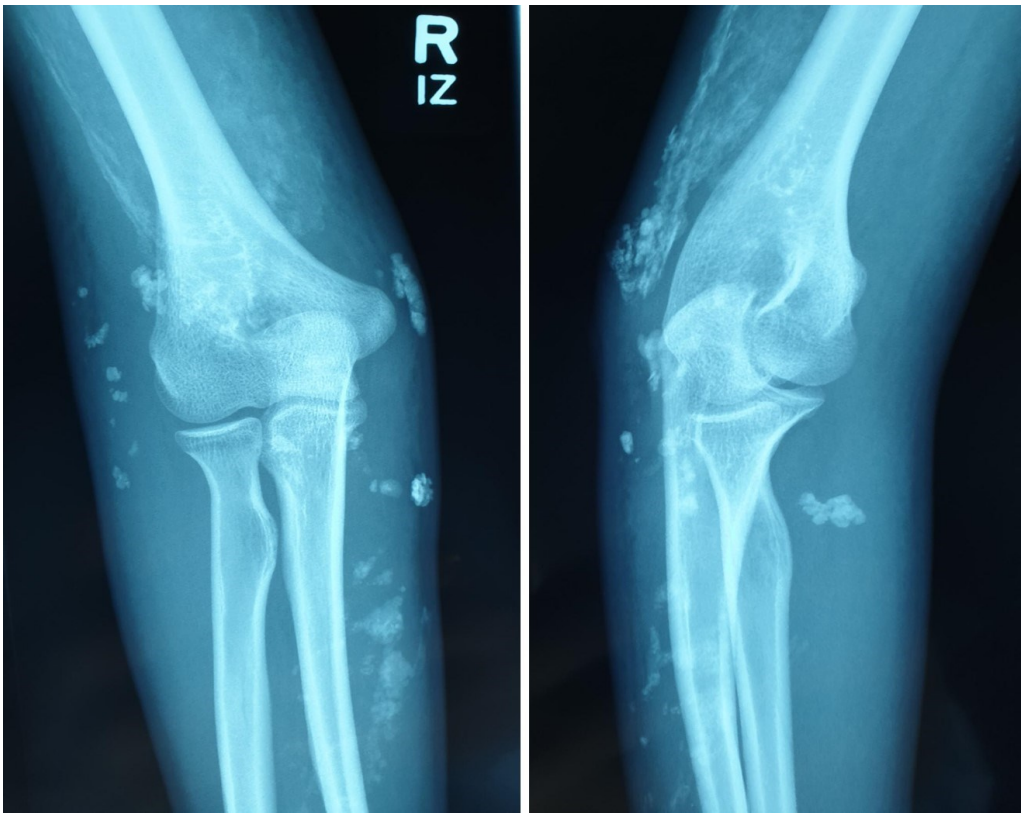

Panel 1

A 16-year-old boy presented with discharge of white chalky material from the lateral aspect of his right elbow. Clinically, two sinuses with discharge of chalky white material were noted with local signs of inflammation. There was painful limitation of the elbow movements. On general examination, he had dusky-red rash over his face. A plain radiograph of right elbow was done (Panel 1).

What is the diagnosis?

***Answer**: refer to page 90*

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DISCLOSURE: All authors have contributed to the manuscript equally. None of the authors have direct or financial conflicts of interest with this paper and material contained herein. Authors also acknowledged that consent has been obtained from patient to publish these images.

(***Refer to page 89***)

ANSWER: JUVENILE DERMATOMYOSITIS (JDM) WITH SOFT TISSUE CALCINOSIS

Juvenile dermatomyositis (JDM) is a rare autoimmune inflammatory disease involving the skin and striated muscles. The peak incidence is from 5 to 14 years of age, with variable female:male ratios depending on geographical distribution. It is estimated that 30-70% of children with JDM will have calcinosis.[1,2]

Clinical features of JDM include characteristic skin rashes (heliotrope rash, Shawl's sign, Gottron's papule) and symmetrical proximal muscle weakness. Muscle enzymes (CK, LDH, AST, ALT, aldolase) may be elevated. [3] Electromyography will show changes compatible with myopathy and muscle biopsy may show necrosis and inflammation, although both of these investigations are rarely used these days.[1] The Bohan and Peter criteria and the newer European League Against Rheumatism and American College Rheumatology (EULAR/ACR) inflammatory idiopathic myositis (IIM) classification criteria are used for diagnosis.[3]

Calcification is usually seen at the site of necrosis, in the chronic phase of the disease and may affect the skin, subcutaneous tissue, fascial planes and muscles. Four different patterns of calcification are recognized. These lead to more disability and limitations than myopathy alone. Superficial calcific masses can lead to discharging sinuses and non-healing ulcers.[2]

On plain radiograph, JDM typically shows calcification in the muscles and soft tissues (calcinosis universalis), classically seen affecting the thigh muscles. MRI T2-weighted sequences has been used to assess the affected muscles and calcified areas and to determine the disease activity and as a guide for muscle biopsy.[3]

Treatment for JDM includes high dose corticosteroid initially with disease-modifying drugs like methotrexate or cyclosporin A. Early and aggressive treatment may prevent complications like calcinosis. Various medications like bisphosphonates, calcium channel blockers and high dose steroids have been used for treatment of calcinosis.[1,2]

The present patient is under the joint care of dermatology and rheumatology since the diagnosis of JDM in 2015. He has been treated with methotrexate and prednisolone. EMG showed changes of myopathy and typical MRI changes have also been noted in the thigh muscles.

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