Diagnostic delay of myositis: protocol for an integrated systematic review

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ABSTRACT

Introduction

Idiopathic inflammatory myopathies (IIM), described as ‘inflammatory myositis’, are a heterogeneous group of rare muscular autoimmune diseases characterised by skeletal muscle inflammation. Its complex characteristics with lack of accurate diagnostic tests, unified classification system and comprehensive widely used diagnostic criteria could lead to diagnostic delay. This study will review diagnostic delay in myositis and provide an overview and clearer insight of patients’ experiences, causes and consequences of diagnostic delay in myositis.

Methods and analysis

The literature source will be a systematic search of PubMed/MEDLINE, Scopus, ProQuest and sources of grey literature, conducted from database inception to December 2021 without restrictions on publication date. All study types (qualitative and quantitative) except review articles, examining diagnostic delay, incorrect diagnosis, missed diagnosis or slow diagnosis of all types of myositis in all ages will be included. Evidence of patients’ experiences associated with diagnostic delay will also be examined. Studies in languages other than English, German and Indonesian will be excluded. Outcomes will be diagnostic delay time, patients’ experiences, and causes and consequences associated with diagnostic delay in myositis. Two review authors will independently screen the titles and abstracts for eligibility. Two independent authors will extract data using a prepiloted data extraction tool. If sufficient quantitative data is available, a meta-analysis will be conducted along with subgroup analysis including pooled diagnostic delay in each type of myositis. Qualitative data will be analysed in line with meta-aggregation methods. If data is insufficient, a narrative synthesis will be conducted.

Ethics and dissemination

As this work is a systematic review, ethical approval was not required. Findings of the study will be disseminated through publications in peer-reviewed journals, conferences and symposia.

PROSPERO registration number CRD42022289830.

INTRODUCTION

Idiopathic inflammatory myopathies (IIM), commonly described as ‘inflammatory myositis’, are a heterogeneous group of rare muscular diseases characterised as skeletal muscle inflammation and other extramuscular features such as skin manifestations. There are several subtypes of IIM, including dermatomyositis (DM), polymyositis (PM), inclusion body myositis (IBM) and other specified idiopathic myositis (ie, immune-mediated necrotising myopathy (IMNM), juvenile myositis (JM), juvenile dermatomyositis (JDM), amyopathic dermatomyositis (AMD) and antisynthetase syndrome (ASS)), and unspecified idiopathic inflammatory myositis.

IIM is characterised as a rare disease as its prevalence is relatively low compared with other disorders. A recent systematic review of 16 articles reported an overall estimated incidence rate of 78 cases/100,000 per year for IIM. IIM has broad clinical characteristic features involving both muscular and extra-muscular systems with acute or progressive onset depending on the myositis subtype. All subtypes of IIM can present with dysphagia (39%), lung involvement causing interstitial lung disease (30%), malignancy (13%) and cardiac disease (9%). General clinical features include muscle weakness leading to difficulty with tasks such as getting up from a chair, climbing stairs or lifting. However, IBM and other subtypes have different clinical features. In PM, DM and other subtypes,
proximal muscle weakness is commonly seen while
distal muscle weakness or atrophy is seen early in IBM.
Histologically, IBM has distinct pathological features
consisting of cytoplasmic intranuclear inclusion bodies
compared with other subtypes of myositis. Therefore,
IBM and non-IBM subtypes of IIM are often discussed
separately.

There has been significant promising progress on
myositis-specific autoantibodies in the last decade. The
presence of these antibodies assists the suspected
diagnosis of IIM. Additionally, MRI can reveal specific
changes in the involved muscle and therefore aids the
diagnostic process of IIM. However, there is a lack of
conclusive diagnostic tests and commonly used compre-
prehensive diagnostic criteria. The most widely used criteria
is Bohan and Peter’s criteria which recognises PM and
DM as IIM. Later, Dalakas introduced different criteria
which take into account AMD. However, these two
criteria both still exclude IBM as an individual type of
IIM.

In 2017, the European League Against Rheumatism
(EULAR) and the American College of Rheumatism
(ACR) developed diagnostic and classification criteria
based on the data from 976 IIM cases and 624 compar-
ators. The EULAR/ACR criteria permit specialists to
differentiate between all possible IIM subgroups that are
not mentioned in previously used criteria, including JM,
JDM and IMNM.

Due to the low prevalence, broad range of clinical
features, lack of conclusive diagnostic testing and
comprehensive globally accepted criteria, timely diag-
nosis of IIM can be challenging and result in significant
diagnostic delays. Some studies have reported diagnostic
delay of 4–5.6 years in cases of IBM. However, studies
examining the overall diagnostic delay, factors associated
with diagnostic delay and people’s experience of diag-
nostic delay in IIM are scarce. Further studies are crucial
for gaining clearer insight into diagnostic delays. This
will inform future studies, interventions, tools and health
policies directed at enhancing diagnostic efficiency and
patient experience of myositis.

**Objectives**

The aim of this integrated systematic review is to review
the evidence regarding diagnostic delay in myositis. To
this end, the systematic review will aim to answer the
following research questions:

- What are the causes and consequences of diagnostic
delay of myositis?
- What evidence is there about patients’ experience of
myositis diagnostic delay?

**METHODS AND ANALYSIS**

**Protocol development**

This study protocol is based on the Preferred Reporting
Items for Systematic Review and Meta-Analysis Protocols
(PRISMA-P) and the Cochrane Handbook for Systematic
Reviews.13 14

**Search strategy**

The search strategy was developed to ensure reproduc-
ibility and increase transparency following the PRISMA-P
checklist.15 Research questions and search terms were
developed using the PICO (Population/Intervention/
Comparison Outcomes/Study Design) tool to enhance the
scientific literature by ensuring reliability and homog-
geney of search results.16 The study is registered with
PROSPERO (CRD42022289830). The primary source
of literature will be a systematic search of multiple elec-
tronic databases (from inception onwards): PubMed/
MEDLINE, Scopus and ProQuest. Sources of grey litera-
ture will also be searched. The grey literature search will
be conducted through Open Access Theses and Disserta-
tion, ProQuest thesis and dissertations, The National
Library of Australia and The Myositis Association Australia
website. Additionally, reference lists of selected studies
and review articles will be searched. All settings and study
design will be considered.

Search terms were developed in collaboration with
research team members (TN, AP, JD). Search terms were
combined using Boolean operators ‘AND’ and ‘OR’. A
preliminary exploratory search on PubMed/MEDLINE
was undertaken (15 October 2021) as shown in table 1
to inform the final search strategy and determine outcomes.
This search strategy was updated and peer reviewed (MC,
CP) using the PRESS checklist. The final search terms
included myositis AND (‘delay in diagnosis’ OR ‘diag-
nostic delay’ OR ‘misdiagnosis’ OR ‘time to diagnosis’ OR
‘incorrect diagnosis’ OR ‘missed diagnosis’ OR ‘delayed
diagnosis’) without restrictions on study type, date and
language.

The final search string used for the literature search
conducted on 9 December 2021 is included in online
supplemental table 1.

**Study selection**

The literature search results will be imported to Cov-
idence, an internet-based software that facilitates collab-
oration between reviewers and ensures independent
review of the literature.17

Studies will be selected according to the predeveloped
PICOS eligibility criteria outlined in table 2. We will
include all types of studies, including both qualitative
and quantitative, examining diagnostic delay, incorrect
diagnosis, missed diagnosis or slow diagnosis of all types
of myositis including DM, PM, necrotising myositis, JDM,
IBM, mixed connective tissue diseases, overlap myositis,
interstitial myositis, orbital myositis and ASS in all age
groups. Evidence of patients’ experiences associated with
diagnostic delay will also be examined. There will be
no comparison group given the nature of the study. No
setting or publication date restrictions will be imposed.
However, review studies and studies in languages other
than English, German and Indonesian will be excluded.
First, two review authors (TN and AP) will inde-
pendently screen the titles and abstract of the literature
search results against the predeveloped inclusion criteria.
Any conflict in the title and abstract screening process will be discussed among the review team and will be resolved by a third reviewer (JD).

Full reports for all studies that meet the inclusion criteria or where there is any uncertainty will be obtained. Review authors (TN and AP) will then screen full text reports according to the inclusion criteria. Any conflicts will be resolved by a third reviewer (JD). The reasons for excluding studies will be recorded. Authors will not be blinded to the study types, journals and authors during this process.

**Data extraction**

After the study selection process is complete, a data extraction tool will be designed, peer reviewed and piloted. To pilot the tool, two independent reviewers (TN and AP) will extract data independently and in duplicate from five studies each and compare their results to establish agreement and validity of the data extraction tool.

Data items to be extracted include:

1. Identification of the study (journal, authors, year, citation, research centre/university/hospital/organisation, conflict of interest, funding/sponsorship).
2. Methods (study aim, study design, participant demographics, recruitment process, inclusion, exclusion criteria, statistical analysis).
3. Main findings (exposure details, diagnostic delays, causes and consequences of delay, patients’ experience and other relevant outcomes).

In cases of missing diagnostic delay, date of symptom onset and date of diagnosis may be used to calculate...
diagnostic delay. The correct diagnosis is defined as diagnosis of myositis regardless of the type. Any disagreements will be resolved through discussion and conflicts resolved by a third reviewer (JD). We will contact study authors to resolve any uncertainties about extracted data.

The primary outcome of the review is diagnostic delay time (time from symptom onset to correct diagnosis) in people living with myositis. Additional secondary outcomes include patient’s experiences, causes and consequences of diagnostic delay in myositis.

Quality appraisal
The selected studies will be assessed for methodological quality or risk of bias using the Mixed Methods Appraisal Tool (MMAT) designed to critically appraise mixed method studies included in systematic reviews. Two independent review authors (TN and AP) will conduct the quality appraisal. Any conflicts will be resolved with discussion and a third reviewer’s vote (JD).

Data synthesis and meta-analysis
A systematic narrative synthesis will be undertaken to explore the findings of included studies in relation to time from symptom onset to diagnosis, and people’s experiences related to delayed diagnosis in line with guidance from the Centre for Reviews and Dissemination.

If extracted quantitative data are homogeneous, a meta-analysis will be conducted using a random-effects model along with subgroup analysis, including pooled diagnostic delay in each type of myositis (DM, PM, JDM, IBM, ASS and others). Extracted qualitative data will be metasynthesised using meta-aggregation. In line with meta-aggregation methods, findings (processed data) from qualitative studies will be extracted and aggregated into a single set of categories, which will then be further aggregated and synthesised into a set of statements that are meaningful for clinical practice.

Further methods and stages of meta-analysis will be discussed if collected data is quantitatively synthesizable. The findings from the quantitative and qualitative studies will be reported separately; however, the discussion will be integrative of both.

Quality of evidence
If a meta-analysis is conducted, the quality/certainty of evidence for all quantitative outcomes will be judged using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) working group methodology. Certainty of the body of evidence will be assessed across domains of risk of bias, consistency of effect, imprecision, indirectness and publication bias. The certainty will be reported in four levels: high, moderate, low, and very low.

Amendments
In the event of protocol amendments prior to study commencement, date, explanation and rationale of the amendment will be described in the final protocol. The record will be in tabular format as recommended by the Cochrane Collaboration.

Patient and public involvement
We follow a co-production approach in all our research. The research team includes two members with myositis, an immunologist, a general practitioner and a registered nurse.

ETHICS AND DISSEMINATION
As this work is a systematic review, there is no requirement for ethical approval. Findings of the study will be disseminated through publications in peer-reviewed journals, conferences and symposia.

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