

# **Myositis and acute kidney injury in bacterial atypical pneumonia: systematic literature review**

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## **ABSTRACT**

**Background:** Bacterial community-acquired atypical pneumonia is sometimes complicated by a myositis or by a renal parenchymal disease. Available reviews do not mention the concurrent occurrence of both myositis and acute kidney injury.

**Methods:** In order to characterize the link between bacterial community-acquired atypical pneumonia and both myositis and a renal parenchymal disease, we reviewed the literature (United States National Library of Medicine and Excerpta Medica databases).

**Results:** We identified 42 previously healthy subjects (35 males and 7 females aged from 2 to 76, median 42 years) with a bacterial atypical pneumonia associated both with myositis (muscle pain and creatine kinase  $\geq 5$  times the upper limit of normal) and acute kidney injury (increase in creatinine to  $\geq 1.5$  times baseline or increase by  $\geq 27$   $\mu\text{mol/L}$  above the upper limit of normal). Thirty-six cases were caused by Legionella species (N=27) and by Mycoplasma pneumoniae (N=9). Further germs accounted for the remaining 6 cases. The vast majority of cases (N=36) presented a diffuse myalgia. Only a minority of cases (N=3) were affected by a calf myositis. The diagnosis of rhabdomyolysis-associated kidney injury was retained in 37 and that of acute interstitial nephritis in the remaining 5 cases.

**Conclusion:** Bacterial atypical pneumonia may occasionally induce myositis and secondary kidney damage.

**Key words:** Mycoplasma; Chlamydia; rhabdomyolysis; acute kidney injury; acute renal failure.

**Abbreviations:** none.

**Funding:** This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

# 1. Introduction

Bacterial community-acquired atypical pneumonia is usually caused by non-zoonotic pathogens such as *Chlamydomphila pneumoniae*, *Legionella* species or *Mycoplasma pneumoniae*. More rarely, this pneumonia is caused by zoonotic pathogens such as *Chlamydomphila psittaci*, *Coxiella burnetii* or *Francisella tularensis* [1, 2].

There are cases of atypical pneumonia that are associated with a myositis and present with muscle weakness, pain or swelling and elevated muscle enzymes [3, 4]. A renal parenchymal disease may also occasionally occur in bacterial community-acquired atypical pneumonia [1, 2].

Myositis releases intracellular muscle constituents into the circulation and may subsequently cause an acute kidney damage [5]. Available reviews on atypical pneumonia, however, do not or only marginally mention the concurrent occurrence of both myositis and acute kidney injury [1, 2]. To investigate the possible association between myositis and acute kidney injury in patients affected by bacterial atypical pneumonia, we systematically reviewed the literature.

## 2. Methods

### 2.1. Literature search strategy

We recently (April 2020) realized a systematic literature review on myositis, acute kidney injury and bacterial community-acquired atypical pneumonia, as per Preferred Reporting Items for Systematic Reviews and Meta-Analyses standards. The United States National Library of Medicine and Excerpta Medica databases were searched using the Medical Subject Heading terms: (atypical pneumonia OR *Chlamydomphila* OR

Chlamydia OR Coxiella OR Francisella OR Legionella OR Mycoplasma) AND (myalgia OR myositis OR rhabdomyolysis OR acute kidney injury OR acute renal failure).

The literature search was carried out independently by two investigators (CS, PC). Conflicts in study identification were resolved in conjunction with a third investigator (MGB).

## **2.2. Selection criteria**

Original articles published up to March 31, 2020 that reported on cases of community-acquired atypical pneumonia caused by *Chlamydia pneumoniae*, *Chlamydia psittaci*, *Coxiella burnetii*, *Francisella tularensis*, *Legionella* species or *Mycoplasma pneumoniae* associated both with new-onset myositis and acute kidney injury were sorted. Patients with a pre-existing pulmonary, muscular or renal condition or without an acute respiratory disease were not included. Cases characterized by an impairment of more than two systems (e.g.: brain, cardiovascular, hematology, and liver) in addition to the respiratory, muscle and kidney were also excluded to avoid the possible inclusion of individuals affected by multiple organ dysfunction [6].

"Myositides" possibly triggered by intense exercise or potentially myotoxic drugs were not included. Cases with findings consistent with a glomerulonephritis (including Henoch-Schönlein purpura nephritis), with a thrombotic microangiopathy syndrome, or with acute kidney disease induced by hemolysis or drugs [7] were excluded. Cases associated with an atypical pneumonia of viral origin (including among others Coronavirus disease 2019) were also excluded.

The diagnosis of bacterial community-acquired atypical pneumonia was based on a distinctive presentation and an appropriate microbiology laboratory testing. The diagnosis of myositis [3-5] was made in subjects with acute onset of muscle weakness, pain or swelling and a total creatine kinase level at least five times the upper limit of normal and no signs

consistent with an ischemic myocardial disease. Because the reference range for creatine kinase depends on sex, age, and laboratory's own normal values, the measured level was divided by the upper limit of normal to calculate the creatine kinase ratio [3-5]. Circulating creatinine was used to define acute kidney injury using the criteria definition proposed by the KDIGO Acute Kidney Injury Work Group [8].

### **2.3. Data extraction and case assessment**

From each included case, following information was sought using a piloted form and transcribed into an ad-hoc database: demographics; pre-existing chronic conditions; hematologic, hepatic, cardiac, cerebral or cutaneous compromise and multiple organ dysfunction; clinical and laboratory features with emphasis on the temporal relationship between respiratory symptoms and onset of muscular disease, the respiratory, the muscular and the renal disease (investigations such as muscle ultrasound, electromyography and muscle or renal biopsy were also excerpted); and outcome. If needed, attempts were also made to contact authors of original reports to provide additional information.

The temporal relationship between respiratory symptoms and onset of muscular disease was used to classify myositis as intra- (myositis developed concurrently with the respiratory symptoms) or post-infectious (myositis developed after clinical resolution). The muscular disease was classified [3, 4] as calf myositis (cases with pain and tenderness affecting exclusively the calves) or diffuse myositis (cases with widespread myalgia or muscular weakness). The remaining cases were considered unclassified.

Circulating creatinine was used to classify acute kidney injury as stage 1, stage 2 or stage 3 as suggested by the KDIGO Acute Kidney Injury Work Group [8]. Urine output was not

used for kidney injury staging. The diagnosis of acute kidney injury associated with rhabdomyolysis [5] was made in cases with one or more of the following: creatine kinases ratio  $\geq 100$ , dark brown urine with a positive ( $\geq +++$ ) orthotolidine test for "blood" but without pathological hematuria on microscopy, dark brown urine with a myoglobin level  $\geq 1000$   $\mu\text{g/L}$ , pigmented granular casts in urine or in a kidney biopsy specimen (also disclosing an acute tubular injury with normal glomeruli). The diagnosis of kidney injury associated with acute interstitial nephritis was made in cases not fulfilling the above-mentioned criteria for rhabdomyolysis-associated kidney disease and in cases with a kidney biopsy disclosing the characteristic features of an interstitial nephritis.

The possible occurrence of the following compromise was also addressed: hemolytic anemia, leukopenia ( $\leq 4.5 \times 10^9/\text{L}$ ), thrombocytopenia ( $\leq 150 \times 10^9/\text{L}$ ), cardiac, cerebral, hepatic or cutaneous involvement [9].

## **2.4. Statistical analysis**

Continuous variables are given as median and interquartile range ( $\geq 6$  cases) or as individual values ( $< 6$  cases), and categorical variables as frequency. The Cohen coefficient was used to assess the agreement between investigators on the application of exclusion and inclusion criteria, the two-tailed Kruskal-Wallis test (with the Dunn post-test) to compare continuous variables, and the two-tailed Fisher exact test for categorical variables. Statistical significance was set at  $P < 0.05$ .

# **3. Results**

## **3.1. Search results**

The literature search process is presented in Figure 1. The agreement between the two investigators on the application of the inclusion and exclusion criteria was 0.88. Nine cases

presenting with myositis and kidney injury associated with a positive microbiology laboratory testing were not included because they did not present any respiratory disease (*Mycoplasma pneumoniae*, N=6; *Chlamydomphila pneumoniae*, N=1; *Francisella tularensis*, N=1; *Legionella pneumoniae*, N=1). For the final analysis, we retained 38 reports [10-47] published between 1974 and 2019 in English (N=34), French (N=2) and Spanish (N=2). They had been reported from the following countries: United States of America (N=16), France (N=3), Australia (N=2), Japan (N=2), the Netherlands (N=2), Spain (N=2), Turkey (N=2), Austria (N=1), Belgium (N=1), China (N=1), Croatia (N=1), Greece (N=1), India (N=1), South Africa (N=1), Tunisia (N=1) and United Kingdom (N=1).

## **3.2. Findings**

### **3.2.1. Demographics - microbiological studies - acute respiratory disease**

The aforementioned communications included 42 previously healthy subjects (35 males and 7 females aged from 2 to 76, median 42 years) with a bacterial community-acquired atypical pneumonia associated both with myositis and acute kidney injury (table 1). Thirty-six cases (85%) of pneumonia were caused by *Legionella* species (N=27; *Legionella pneumophila*, N=26; *Legionella longbeachae*, N=1) and by *Mycoplasma pneumoniae* (N=9). Further germs (*Francisella tularensis*, N=3; *Coxiella burnetii*, N=2; *Chlamydomphila psittaci*, N=1) accounted for the remaining 6 (15%) cases.

The diagnosis of *Legionella pneumophila* infection (N=26) was made by means of a positive urinary antigen test (N=12), a consistent increase in immunoglobulin G antibody titer in paired blood samples (N=9), a positive sputum or tissue culture (N=4), or both an increase in antibody titer in blood and a positive urinary antigen test (N=1). The diagnosis of *Mycoplasma pneumoniae* infection (N=9) was made by means of an increase in antibody titer in paired blood samples (N=6) or a

positive Mycoplasma testing in a respiratory tract sample (N=2). No detailed information was available for the remaining Mycoplasma case. Finally, the diagnosis of Francisella tularensis (N=3), Coxiella burnetii (N=2), Chlamydochila psittaci (N=1), and Legionella longbeachae (N=1) infection was made by means of an increase in antibody titer in paired blood samples.

The respiratory and the muscular disease presented concurrently in 98% of cases. Patients with myositis and acute kidney injury caused by Mycoplasma pneumoniae were significantly ( $P < 0.01$ ) younger than the remaining patients.

### **3.2.2. Myositis**

The creatine kinase ratio was  $\geq 100$  in two thirds of cases and similar in patients with pneumonia caused by Legionella species, Mycoplasma pneumoniae or the remaining germs. The vast majority of cases (84%) presented a diffuse myalgia. Only a small minority of cases (6.7%) were affected by a calf myositis (table 1).

A muscle biopsy was performed in four Mycoplasma [36, 39] and three Legionella [10, 25, 31] cases. Inflammatory muscle lesions were detected in all [10, 25, 31, 36] but one [39] cases. Legionella pneumophila was found to have invaded skeletal muscle tissue in a 65-year-old woman with legionnaires' disease complicated by myositis [31]. No Legionella pneumophila was detected in the case reported by Brivet et al [10]. No attempt to detect microorganisms in the muscle tissue was performed in the remaining cases. Testing for immune deposits was never reported to be positive.

A needle-electromyography evaluation, performed in the case of Mycoplasma associated disease reported by Bennett et al [36], disclosed a myopathic pattern. A muscle ultrasound evaluation was never performed.

### **3.2.3. Kidney disease**



The severity of kidney disease was similar in the three groups of patients: Legionella, Mycoplasma and the one associated with further germs (table 1). The creatine kinase ratio was similar in patients with acute kidney injury stage 1 (149 [62-742]) stage 2 (10, 95, 946) and stage 3 (175 [66-538]). A renal biopsy, performed in two Legionella cases, disclosed the distinctive features of an interstitial nephritis [26, 33]. The microorganism was identified in the biopsy specimens of the mentioned two cases [26, 33].

Using the criteria defined above, the diagnosis of rhabdomyolysis-associated kidney injury was retained in 37 (88%) cases. The mentioned diagnosis was based on a creatine kinase ratio  $\geq 100$  in 30, on urinary findings in five and on a renal biopsy in two cases. Acute interstitial nephritis was diagnosed in the remaining five (12%) cases. Acute interstitial nephritis was always associated with Legionella pneumonia (a tubulointerstitial nephritis was never observed in cases caused by Mycoplasma, Francisella, Coxiella or Chlamydothila).

#### **3.2.4. Further involvement**

In addition to the pulmonary, muscular and renal disease, a further non-pulmonary compromise was observed in more than half of the cases (table 1).

##### **• Outcome**

Three patients with legionnaires' disease [10, 25, 33] and one with Francisella infection [44] died. The remaining patients recovered without sequelae.

## **4. Discussion**

Like in influenza, mild muscle aches (with normal muscle enzymes) are common in atypical pneumonia [1, 2]. Muscle symptoms or signs and a significant increase in creatine kinase level sometimes occur in atypical pneumonia caused by Legionella species or Mycoplasma pneumoniae (but are likely

very rare in cases caused by *Francisella tularensis*, *Coxiella burnetii*, *Chlamydophila pneumoniae* or *Chlamydophila psittaci*). On the other hand, atypical pneumonia is occasionally associated with an intrinsic kidney disease. The results of this careful analysis suggest that in bacterial community-acquired atypical pneumonia, myositis may cause rhabdomyolysis associated kidney injury. Furthermore, the analysis points out that in *Legionella pneumonia* complicated by myositis, acute kidney injury may also result from interstitial nephritis without any rhabdomyolysis-associated kidney injury [31].

The clinical spectrum of acute myositis complicating atypical pneumonia ranges from calf myositis, which is more common and is usually associated with a mildly elevated creatine kinase ratio, to diffuse myositis, which is uncommon and may be associated with a severely elevated creatine kinase ratio ( $\geq 100$ ). The mechanisms underlying acute myositis in atypical pneumonia are still unknown and deserve some discussion. First, bacterial atypical pneumonia and myositis develop concurrently in the vast majority ( $\geq 95\%$ ) of cases. Second, a muscle biopsy, performed in a minority of cases, sometimes disclosed the direct invasion of the microorganism in the skeletal muscle [31]. Finally, testing for immune deposits was always negative. Thus, it is tempting to assume that muscle damage does not result from an autoimmune reaction, but directly from the pathogen or from the release of myotoxic cytokines [9]. Only a few cases of myositis included in this analysis presented with calf myositis, the most frequent infection-associated myositis [3, 4]. This is likely related to the fact that the release of intracellular muscle constituents into the circulation is rather mild in calf myositis and, subsequently, does not cause any kidney injury. Of note, benign calf myositis is generally associated with Influenza infection and shows a stereotypical

presentation [3, 4], distinct from the myositis associated with bacterial atypical pneumonia.

Like many other infections, also atypical pneumonia may lead to a number of hemodynamic derangements that cause acute kidney injury. Kidney injury may also result either from an acute tubulointerstitial nephritis, from a glomerulonephritis (including among others Henoch-Schönlein purpura nephritis and thrombotic microangiopathy syndrome) or from severe intravascular hemolysis [48-55]. The possible causes of acute kidney disease in patients affected by an acute kidney injury associated with bacterial atypical pneumonia are summarized in table 2. Autoimmune conditions such as ANCA-associated systemic diseases or Goodpasture syndrome should also be considered in patients presenting both with an acute kidney disease and with a microbiologically unclear pulmonary disease [56].

The results of this report must be viewed with an understanding of the inherent limitations of the analysis process, which is based on the scanty available literature. Furthermore, available information does not allow documenting the prevalence of acute kidney injury caused by myositis in atypical pneumonia.

## **5. Conclusion**

There are several potential causes of rhabdomyolysis including muscle compression, trauma, exertion, hyperthermia, inborn errors of metabolism, dyselectrolytemias, toxins, drugs and infections. The present analysis points out that the germs underlying bacterial atypical pneumonia may occasionally invade the muscle tissue thereby inducing both myositis and secondary kidney damage.

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## **Figure 1 - Legend**

Myositis and acute kidney injury associated with bacterial atypical pneumonia. Flowchart of the literature search process.

