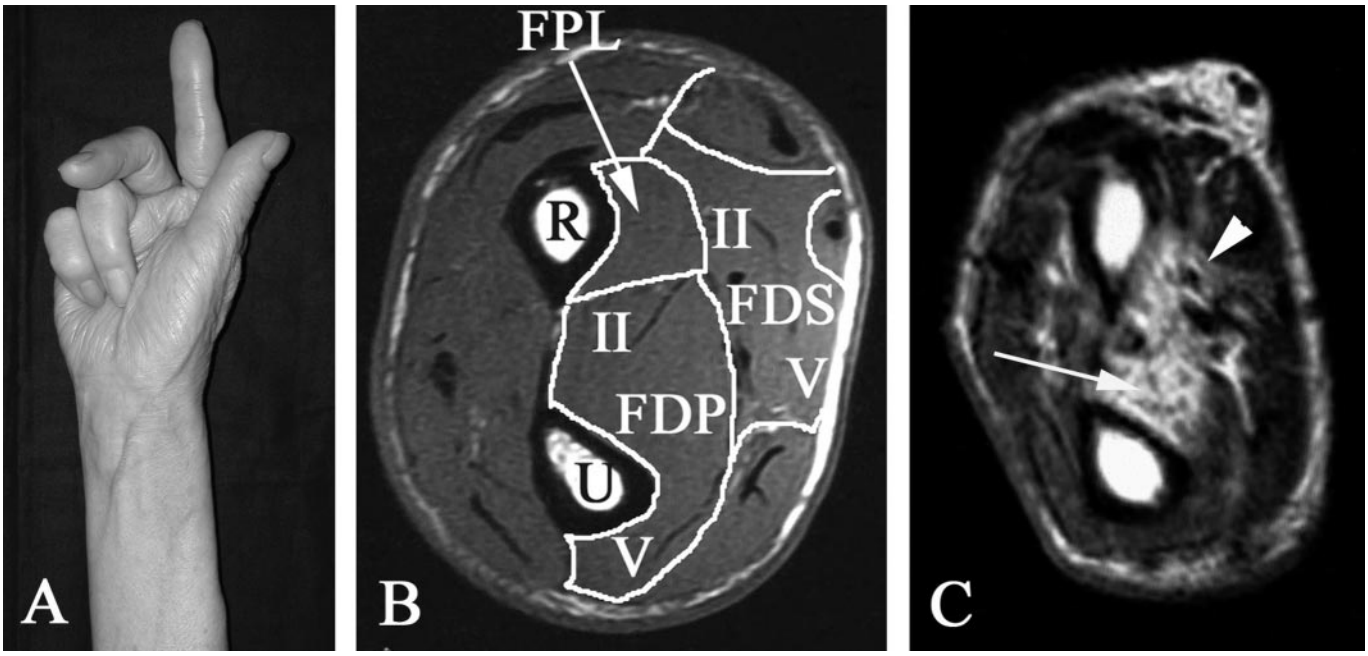

Figure. (A) Incomplete closure of the hand due to weakness in finger flexion, which is predominant in the first and second digits. (B) A forearm MRI of a normal control muscle demonstrating the normal anatomy of the finger flexor muscles. FPL = flexor pollicis longus; FDP = flexor digitorum profundus; FDS = flexor digitorum superficialis; II and V = muscle portion of second and fifth digit, respectively. (C) A forearm T1-weighted image showing hyperintensity in the FPL, FDP, and FDS. T1 hyperintensities, indicating fatty replacement, were observed mainly in the area around the volar aspect of the interosseous membrane, the second digit portion of the FDP (arrow). Hyperintensity was observed also in the second digit portion of the FDS (arrowhead).

Finger flexor weakness in inclusion body myositis

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A 72-year-old woman with sporadic inclusion body myositis presented with slowly progressive weakness in her finger flexors and proximal lower limb. She was unable to flex her bilateral first digits and second digits at the proximal and distal interphalangeal joints, whereas the fourth and fifth digits were relatively spared (figure, A). Neither a sensory disturbance nor contractures were observed. The differences in muscle weakness between each digit correlated with the presence of fatty infiltrations, showing T1 hyperintensity, to the flexor pollicis longus and the specific areas within the flexor digitorum profundus and flexor digitorum superficialis[1] (figure, B and C). These observations indicate that the disease process may progress patchily, not diffusely, within the involved muscles in inclusion body myositis.

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