

**Comment on:
Cancer-associated myositis
before and after the COVID-19
pandemic onset**

Sirs,

We thank Dr Daungsupawong and Dr Wiwanitkit for their interest in our article (1) and for their constructive comments regarding our work (2). We appreciate the opportunity to clarify the aspects raised in their comment.

Firstly, a concern was raised regarding the fact that the criteria used for the inflammatory idiopathic myopathies (IIM) diagnosis and cancer-associated myositis (CAM) were not sufficiently clear. Regarding this point, we would like to emphasise that we included adult patients who were diagnosed with IIM by their assisting rheumatologist and fulfilled the European Alliance of Associations for Rheumatology (EULAR)/American College of Rheumatology (ACR) 2017 classification criteria (3). Despite their limitations (4, 5), these are the most widely accepted and validated classification criteria for IIM, integrating clinical, laboratory and histopathological features to ensure homogeneous cohorts for IIM clinical studies. The application of these criteria was essential to ensure the reliability and reproducibility of our findings. Also in the Methods section, we defined CAM as the occurrence of neoplasia within three years before or after the diagnosis of IIM. This definition follows the consensus established in IIM literature and aligns with previous studies investigating the temporal association between IIM and malignancy (6-8). Our study applied this definition uniformly across all included patients to avoid bias in classifying CAM patients.

We agree that our sample size is relatively small, as our work was conducted with a single-centre registry-based cohort (9). However, the involvement of the same physicians in diagnosing patients both before and after the pandemic onset, coupled with the comprehensive nature of the patient data, strengthens the robustness of our findings. Despite the limited sample size, our findings were statistically significant, which emphasises the strength of the effect size

of the reported changes. Additionally, our findings are consistent with reports from other cohorts that identified an increase in CAM cases after the pandemic onset (10). As we discussed in the manuscript, factors other than the COVID-19 infection, such as changes in healthcare access and delays in cancer screening, may have contributed to this observation.

We appreciate the suggestion to further investigate potential confounding variables such as treatment schedules and disease severity.

In conclusion, our study did follow the EULAR/ACR 2017 classification criteria for IIM and used a standard definition for CAM. We appreciate the opportunity to clarify these points and to contribute to an ongoing discussion on this relevant topic.

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