Polymyalgia Rheumatica

1 in 7 over 50 yrs

Inclusion criteria for PMR

Diagnosis is based on core inclusion criteria:
Age >50
Rapid onset, duration over two weeks
Bilateral shoulder and/or pelvic girdle pain
Morning stiffness lasting more than 45 minutes
Raised ESR/CRP - but PMR can be diagnosed without raised inflammatory markers if classic symptoms and response to steroids are both present – such patients should be referred for specialist assessment

Exclusion criteria for PMR

Conditions you should exclude before diagnosing PMR:
Active giant cell (temporal) arteritis: PMR and giant cell arteritis (GCA) frequently co-exist. However, if GCA is present, this condition is the priority and urgent treatment is required.
Active cancer
Active infection: this may be the cause of raised inflammatory markers, so any infection should be treated first before repeating bloods and diagnosing PMR.

The presence of the following conditions reduces the probability of PMR, so you should also exclude:
Other inflammatory rheumatic conditions (RA, SLE etc.)
Non-inflammatory causes (e.g.. hip/shoulder/neck osteoarthritis)
Chronic pain syndromes (e.g. fibromyalgia)
Drug-induced myalgia (e.g from statins)
Endocrine and neurological conditions

Recommended baseline investigations in PMR

FBC, ESR/CRP
U&E, LFTs, calcium,CK, TFT
Protein electrophoresis
RhF, Urine Dipstik

Giant cell arteritis

Giant cell arteritis (GCA) has a special place in the PMR guidelines because:
the consequences can be disastrous
there is a very strong association with PMR. Up to 20% of patients with PMR may also develop GCA. Among patients with GCA, up to 50% may also have PMR.

Key features of GCA include:

Abrupt-onset headache (usually temporal) and scalp tenderness
Jaw claudication
Visual disturbance, including diplopia
Temporal arteries may be tender, thickened and nodular

Management of giant cell arteritis

If visual symptoms are present, start prednisolone 60mg and arrange same-day ophthalmology review
If no visual symptoms
Start prednisolone 40-60mg daily (min of 0.7mg/kg)
Start aspirin 75mg unless contraindicated
Start a PPI for gastroprotection
Establish the baseline for the disease, including symptoms, disability and ESR/CRP
Refer urgently for specialist assessment (depending on local protocol)
Advise if visual symptoms develop to seek immediate review
Assess steroid response in 48 hours; if poor consider alternative diagnoses

Practical tip
Visual loss may occur in 20% of patients with giant cell arteritis. This is almost always before treatment is instigated. However, up to 5% of people may suffer visual loss after treatment has commenced, so patients should always be advised to seek immediate advice if visual symptoms occur so that you can arrange an ophthalmology review.

Management of PMR

Start prednisolone 15mg daily
Expect a clinical response within one week
Expect lab resolution within three to four weeks
Continue prednisolone 15mg for three weeks
Then 12.5mg for three weeks
Then 10mg for four to six weeks

Practical tip

Often after starting steroids, patients with PMR describe the pain 'melting away'. However, they should be warned not to expect 100% improvement – the old aches and pains that were there before won't be going anywhere. Look for at least a 70% improvement in pain. If this isn't achieved, the steroid dose may not be adequate, in which case increase it to 20mg daily. If a 70% response is still not reached, there may be an alternative diagnosis and referral may be needed

Duration of Treatment

Generally, after 10mg, the dose should be reduced by only 1mg every four to eight weeks until medication is stopped.
The average length of treatment is one to two years. Initial higher dosing and faster tapering results in increased risk of relapse and more prolonged treatment. However, the guidelines point to inconsistencies in the evidence and so treatment should be tailored to the individual. Patients requiring treatment for longer than two years should be referred to a specialist.

Practical tip
Intramuscular methylprednisolone (IM Depo-Medrone) may be used in milder cases and may reduce steroid-related complications.
Initial dose 120mg every three to four weeks – the guidance does not specify how long this dose should continue but two to three months is probably reasonable
Then reduce by 20mg every two to three months, giving an injection every four weeks

Bone protection in PMR

If over 65 years old OR previous fragility fracture:

Start bisphosphonate with calcium and vitamin D supplementation
DEXA scan is not required

If under 65 AND no fragility fractures:

Start calcium and vitamin D supplementation
Arrange a DEXA scan to assess bone density

When to refer?

Patients with a typical clinical picture who respond to treatment can be safely managed in primary care.

You should refer if there are any atypical features, or features that suggest a possible non-PMR diagnosis:
Age under 60
Chronic onset over a period of over two months or more
Lack of shoulder involvement or inflammatory stiffness
Prominent systemic symptoms or features of other rheumatic disease
Normal or extremely high ESR/CRP
The other situation where referral is warranted, according to the guidelines, is where management dilemmas occur e.g. poor response to treatment, patient still needing treatment after two years, multiple relapses, steroids contraindicated or not tolerated.

End