Guidelines for the Management of Polymyalgia Rheumatica (PMR)

PMR is one of the most common inflammatory rheumatic diseases of the elderly and represents one of the commonest indications for long-term corticosteroid therapy in the community.

Clinical features Suggestive of PMR

- Age >50 years, duration >2 weeks
- Bilateral shoulder or pelvic girdle aching, or both
- Morning stiffness duration of >45 min
- Evidence of an acute-phase response (e.g. raised ESR, CRP)

Patients with suspected PMR and normal inflammatory markers should be referred to secondary care.

Other mimicking conditions which should be excluded

- Active infection and cancer
- Rheumatic diseases: RA, inflammatory arthropathies, SLE, other connective tissue diseases and inflammatory myopathies
- Drug-induced myalgia, e.g. statins
- Pain syndromes, e.g. fibromyalgia
- Endocrine, e.g. thyroid
- Neurological, e.g. Parkinson's disease

Co-existing conditions that should be noted as a cause of persistent pain are OA, degenerative and other peri-articular conditions of the shoulder, neck and hips.

Patients should be assessed for evidence of GCA (see guideline),

Baseline Investigations

- FBC, U&E, LFT, bone profile, ESR, CRP, plasma viscosity
- Immunoglobulins and electrophoresis (consider Bence Jones protein)
- TFTs
- CK
- Rheumatoid factor (anti-nuclear antibody may also be considered)
- CXR (if prominent systemic symptoms)
- Dipstick urinalysis

Consider early referral to Rheumatology if atypical features or features that increase likelihood of a non-PMR diagnosis such as:

- Younger patient < 60 years
- Chronic onset (>2 weeks)
- Lack of shoulder involvement
- Lack of inflammatory stiffness
- Red flag features: prominent systemic features, weight loss, night pain, neurological signs
- Peripheral arthritis or other features of CTD or muscle disease

For further information refer to British Society for Rheumatology Guidelines for the Management of Polymyalgia Rheumatica

- Normal or very high ESR/CRP
- Treatment dilemmas such as:
    - Incomplete or non-response to corticosteroids
    - Ill-sustained response to corticosteroids
    - Unable to reduce corticosteroids
    - Contraindications to corticosteroid therapy
    - The need for prolonged corticosteroid therapy (>2 years)

However, patients who have no atypical features, who have a complete sustained response to low-dose corticosteroids, and who have no adverse events can be managed by a general practitioner.

Treatment

Corticosteroids should be initiated and tapered as follows

- Daily prednisolone 15mg for 3 weeks
- Then 12.5mg for 3 weeks
- Then 10mg for 4–6 weeks
- Followed by reduction by 1mg every 4–8 weeks

.Early rapid improvement in symptoms is typical of PMR:

- 70% patient global response in 1 week—likely to be PMR
- If <70% response—consider increased dose up to 20mg prednisolone
- If still <70% response—reconsider diagnosis and refer to rheumatology

Usually 1–2 years of steroid treatment is needed.

Bone protection (weekly bisphosphonate and calcium or vitamin D supplementation) should be co-prescribed with glucocorticoid therapy. See NHS Lanarkshire osteoporosis guideline for further details

Assess for corticosteroid-related adverse events: weight gain, diabetes, osteoporosis, hypertension and lipid dysregulation.