NB Medical education

KISS: Polymyalgia Rheumatica

Based on Lancet October 2023 & BSR 2010

Diagnosis/Assessment:

- Suspect PMR if > 50 years old (although most >60) with ≥ 2 weeks of core symptoms:
  - Bilateral shoulder and/or pelvic girdle pain & stiffness AND
  - Stiffness lasting >45 minutes after waking or periods of rest.
- Additional systemic symptoms may be present (in 40-50%) - low-grade fever, fatigue, weight loss, anorexia, depression.
- Exclude/consider other conditions that can 'mimic' or be associated with PMR:
  - Giant cell arteritis - present in 15-20% with PMR; consider if more prominent systemic features or very high ESR/CRP.
  - Infections - consider viral, osteomyelitis, TB, infective endocarditis.
  - Cancer - myeloma, leukaemia, lymphoma, lung carcinoma; consider if more significant systemic symptoms or more widespread (i.e. not predominantly proximal) pain.
  - Endocrine disease - thyroid or parathyroid disease.
  - Other inflammatory diseases - RA, SLE, spondyloarthropathy.
  - Degenerative conditions - OA or bilateral impingement/frozen shoulder; usually mechanical pain (i.e. worse with activity) rather than inflammatory pain (improves with activity) and normal ESR/CRP.
  - Others - myositis/myalgia from statins, osteomalacia, fibromyalgia, CFS.
- Investigations to be done before starting corticosteroids:
  - In all cases - FBC, ESR/CRP, U&E, LFT, Ca, CK, TSH, protein electrophoresis, rheumatoid factor, dip urine.
  - Consider (depending on clinical features) - ANA, anti-CCP antibodies, CXR, and urine BJP.
- If PMR is the most likely diagnosis give a trial of treatment:
  - Prednisolone 15mg daily and review at 1 week - expect ≥ 70% improvement in symptoms within 1 week (typically many symptoms resolve within 24-72 hours).
  - If lesser response, consider increasing dose to 20mg, but if response still <70% refer.
- PMR diagnosis can be confirmed if core symptoms present, other 'mimic' conditions excluded and there is a typical response to oral corticosteroids; ESR/CRP are typically raised but a diagnosis can be made if normal (but these patients need referring, see below).
- Refer if atypical features of PMR/concern about alternative diagnosis:
  - Red flags e.g. weight loss, night pain, neurological features.
  - Younger than 60 years old or chronic onset of symptoms.
  - Normal inflammatory markers or ESR >100 +/- very high CRP.
  - <70% symptom response to 15-20mg prednisolone daily.

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Ongoing Management:

- Flexible approach, individually tailored, most will need 1-2 years of treatment;
  - Consider referral if unable to reduce doses at reasonable intervals, possible relapse or on steroids > 2 years.
- Suggested prednisolone regimen (remember to give blue steroid card/warn of risks):
  - 15mg OD 3 weeks, then 12.5 mg OD 3 weeks, then 10mg for 4-6 weeks.
  - Thereafter reduce by 1mg every 4-8 weeks.
- Bone protection (updated **NOGG guidance 2021**):
  - People on ≥7.5 mg prednisolone for ≥3 months are considered very high risk of fractures and should be considered for urgent specialist review, but start bisphosphonate in the meantime.
  - For all others assess risk with FRAX (**click here**)
  - However, bone loss can occur early in steroid treatment so if DEXA is recommended (as it will in most cases) bisphosphonates should be started whilst awaiting DEXA scan if:
    - Woman aged >70, previous fragility fracture, FRAX score exceeding intervention threshold.
- Monitoring - Review 1 week after dose changes and at least every 3 months in 1st year, or urgently if they develop symptoms of GCA.
- Patient information - **NHS Patient information sheet** and **Versus Arthritis**