KISS: Polymyalgia Rheumatica

References: CKS January 2019

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% of people with PMR
  - Infections - consider viral, osteomyelitis, TB, infective endocarditis
  - Cancer - myeloma, leukaemia, lymphoma, lung carcinoma
  - Endocrine disease - thyroid or parathyroid disease
  - Other inflammatory disease - RA, SLE
  - Degenerative conditions - OA or bilateral impingement/frozen shoulder
  - Others - myositis/myalgia from statins, Vit D deficiency, fibromylagia, 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, 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

Ongoing management:

- Flexible approach, individually tailored, **most will need 1-2 years of treatment;** refer if unable to reduce doses at reasonable intervals, 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** (NOGG guidance 2017):
  - Consider bone protection if >70 and on prednisolone ≥7.5mg daily
  - For all others assess risk with FRAX (click here)
- **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 Arthritis UK PMR Info