Polymyalgia Rheumatica: Diagnosis & Treatment – The Pearls

1. Little evidence, few helpful guidelines, common sense!
2. Age >= 50 only, no exceptions!
3. Normal CRP/ESR in PMR is vanishingly rare – check your DDx!
4. Who gets it:
    - F > M (by 2-3:1)
    - Highest in northern Europeans, lowest in Asian, black, and Hispanic patients
    - Peak age 70-80
    - Prevalence 0.7% in Caucasians
5. Symptoms:
    - Painful symmetric **stiffness** of the proximal arms and legs (*sine qua non*)
    - Usually rapid onset (often overnight)
    - Prolonged morning stiffness and gelling (difficulty moving after rest)
    - Restriction in movement due to pain and stiffness
    - Constitutional symptoms: malaise, fever, loss of appetite, weight loss
    - NOT: swollen joints, rash (implies something else)
6. Exam:
    - Non-specific
    - Restriction of movement in proximal limbs due to pain
    - Cannot detect synovitis in shoulders or hips easily enough to be helpful
    - Should NOT see synovitis of distal joints
7. Labs:
    - I recommend testing CRP over ESR (more responsive to change, much less false negatives/positives)
    - Expect CRP ~10-50 (not over 100, not normal)
    - Can see anemia & mild thrombocytopenia (inflammation)
    - Serology usually negative (RF/anti-CCP, ANA), **BUT** note that prevalence of positive results of all serologic tests rises with age – does not mean pt has inflammatory arthritis/connective tissue disease
8. Imaging: typically not helpful unless other symptoms present
9. Giant cell arteritis:
    - Occurs in ~10% of patients with PMR (can present at **any** time, even after Rx completed)
    - Watch for new temporal headache (worst ever), scalp tenderness (glasses/hairbrush), visual changes (diplopia), jaw/tongue claudication, prominent non-pulsatile temporal arteries
    - Clue to GCA: failure to resolve constitutional symptoms on prednisone 20mg daily

Call me!

10. Differential:
    - **RA**: seronegative RA affecting larger joints often seen in patients over 60 – can be very hard to tell the difference; careful joint exam useful, refer if concerned

- **RS3PE** (Remitting Symmetric Seronegative Synovitis with Pitting Edema): variant of PMR often seen in men, presents with "boxing glove" pitting edema in the hands, with PMR symptoms, exquisitely sensitive to prednisone
- **Bursitis:** subacromial/trochanteric bursitis often mimics PMR **but** expect CRP to be (nearly) normal, symptoms often gradual onset
- **Myalgias/myositis:** drug-related myalgias should have normal CRP and CK (much less stiffness and more pain); dermatomyositis causes pain**less** weakness with (usually) elevated CK
- **Other arthritis:** look for systemic clues on exam, can often cause stiffness and pain
- **Endocrinologic:** hypothyroidism can present with significant stiffness and muscle weakness, but CRP should be normal (TSH abnormal)
- **Fibromyalgia:** often in younger patients, normal CRP and serology, should have other features of chronic diffuse pain

11. Treatment – Prednisone!
    - No substitute
    - Start 15-20mg daily (based on patient features) – no higher or lower
    - Stay at starting dose >=1 month, ensure symptoms and CRP normal (usually dramatic rapid response)
    - Taper **SLOWLY!** By 5mg per month until 10mg, then by 1mg per month (too fast -> flare!)
    - Steroid sequelae must be managed as best possible (sugar, infection, skin, bones, mood, sleep, weight gain)
    - Steroid-sparing agents (methotrexate) can be used if unsuccessful in tapering by normal schedule – consider referral to Rheum
    - Average duration of treatment: 18-24 months (don't rush to taper!)
    - Often need to slow taper at lowest doses (alternate daily dosing)
    - Patients often get transient arthralgias when lowering dose – don't raise prednisone unless certain PMR flaring
    - If flare occurs (with elevation in CRP) then raise prednisone to last working dose, wait 4 weeks, then start tapering again
12. Prognosis: excellent!
    - No apparent increase in mortality (even without treatment!) provided Dx is correct
    - Thus: do not err on the side of over-diagnosis (consequences of prednisone **worse** than of disease)
13. When to refer:
    - Anytime!
    - Diagnostic confusion, failure to respond appropriately to treatment
    - Difficult taper or ++ sequelae from prednisone

1. Dejaco C *et al*. 2015 Recommendations for the Management of Polymyalgia Rheumatica. *Arthritis Rheum* 2015; **67**: 2569.
2. Weyand CM and Goronzy JJ. Giant cell arteritis and polymyalgia rheumatica. *N Eng J Med* 2014; **37**: 50.
3. Ameer F and McNeil J. Polymyalgia rheumatica: clinical update. *Aust Fam Physician* 2014; **43**: 373.
4. Gonzalez-Gay MA *et al*. Polymyalgia rheumatica. *Lancet* 2017; **390**: 1700