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

Dr KJ Donaldson  PMR guidelines Nov 2016  Review date Nov 2018

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:
  o Incomplete or non-response to corticosteroids
  o Ill-sustained response to corticosteroids
  o Unable to reduce corticosteroids
  o Contraindications to corticosteroid therapy
  o 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.