Polymyalgia rheumatica

- Unknown aetiology.
- Autoimmune inflammatory disease.
- Tenderness is due to synovial inflammation of the tendons and bursitis.
- NOT a muscle inflammation/disease.

differentials

Rheumatoid arthritis
Osteoarthritis
Shoulder synovitis
Rotator cuff tendonitis
Sub-deltoid bursitis
Capsulitis
Polymyositis
Hypothyroidism
Chronic pain syndrome
Endocarditis
Malignancy
Parkinson disease
RS3PE
Depression

Relapsing symmetrical seronegative synovitis with pitting edema (RS3PE)

- Wrists commonly affected.
- Pitting oedema.

- Low dose steroid and NSAIDs.
- Excellent prognosis.

References:
1. Pulsetoday.co.uk
2. RCGP e-Learning
3. Dr Sanjev Patel rheumatologist consultant, webinar Feb 2021.

Symptoms

WARNING
- It's a purely clinical Dx.
- Hence, depends on clinicians ability to interpret Hx from pt.
- Very easy to throw some pred, see some improvement and misdiagnose as PMR and condemn pt to s/e of pred for yrs.

- >50y.
- Abrupt onset (within 1/52) bilateral myalgia of shoulder/hip girdles, and can radiate to elbows/knees.
- Ongoing for ≥ 2/52.
- Limited movement of neck, shoulder and hips
- Inability to actively abduct shoulders beyond 90o.
- Can be worse at night.
- Severe stiffness after periods of inactivity is frequently seen e.g. severe morning stiffness (typically >45 mins).
- Synovitis of the wrists and MCPS-not uncommon.
- Mild knee effusions
- Feet/ankle not affected
- Patients frequently complain that they cannot get up on their own.
- Constitutional symptoms.

- Do not Dx in anyone < 50 without careful thought i.e. basically refer to rheum.

- Low-grade fever.
- Weight loss.
- Anorexia.
- Malaise.
- Depression.

WARNING
- Rule out symptoms of GCA.

18-26% of PMR can develop GCA

Investigations

- ↑ ESR & ↑ CRP.
- Mild to moderate anaemia.
- ↑ WCC.
- ↑Platelets.
- ↑ alkaline phosphatase.
- Imaging does not diagnose.

- Frequently ESR >40 and occasionally >100.
- Mildly elevated in 7-20%.
- Rarely normal in limited disease activity.

- X-ray shoulders / hands: erosions in RA.
- US: shoulder effusion, SAB bursitis.
- MRI: tendon hypertrophy, tenosynovitis and effusion, bursitis, rarely focal muscle edema.
- CXR

Management

Ensure referral not required

- Age <50 yrs.
- Chronic onset (>2 months).
- Lack of shoulder involvement.
- Lack of inflammatory stiffness.
- Wt loss, night pain, neurological signs.
- Features of other rheumatic diseases.
- Normal or very high inflammatory markers.

Look for Ca.

- Higher risk of cancer in first 6/12 of diagnosis of PMR compared to controls.
- So have a high suspicion for it if any new symptoms.

WARNING
- Hence, don't get Dx wrong.

Steroid

- Just because steroid help doesn't mean it's PMR.
- Steroids help lot's of conditions.
- Basically make sure you are clinically confident it's PMR.
- Majority of them show a marked clinical response within 1/52, and normalisation of the inflammatory markers within 4/52.
- 29% to 45% may not reach full clinical remission by 3-4/52.
- Consider alternative diagnosis/adjust steroids.
- Around 50% of patients have one relapse during the course .

Steroid s/e

- Weight.
- Fractures.
- BP.
- HbA1c.
- Cataracts.
- Glaucoma.
- Lipids.
- Skin.
- Bone protection.
- GI protection.

- It is a steroid sensitive condition so only need 10-15mg of prednisolone.
- One consultant starts 10mg in EVENING so some steroid exposure overnight and mornings are better. If they become stiff later in the day he ADDS 5mg at lunchtime.
- Should get significant improvement after a week or two.
- Taper and reduce over 1-2 yrs as able.
- 50-75% pt's weaned off by 3 yrs.

GCA	PMR
Prednisolone 40–60mg (not <0.75 mg/kg) continued for 4 weeks (until resolution of symptoms and laboratory abnormalities)	Prednisolone 15 mg for 3 weeks
Reduction by 10 mg every 2 weeks to 20 mg	12.5 mg for 3 weeks
Reduction by 2.5 mg every 2–4 weeks to 10 mg	10 mg for 4–6 weeks
Reduction by 1 mg every 1–2 months provided there is no relapse	Reduction by 1 mg every 4–8 weeks or alternate day reductions (eg. 10/7.5 mg alternate days)

Relapse

- Increase to the pre relapse dose.
- Consider referral for alternative immunosuppressive (e.g. methotrexate).

- With frequent relapse (> 2).
- Poor response to steroids.
- Steroids related adverse events.
- Unfavourable prognosis e.g. female, high ESR and peripheral arthritis.

Giant cell arthritis (GCA)

- Headache.
- Scalp tenderness.
- Temporal artery abnormalities.
- Jaw claudication.
- Visual symptoms.
- Constitutional symptoms.

REAL CLINICAL CASE:
He described jaw pain but it is not typical of claudication as it can last between 1 and 2 hours at rest and does not worsen when he eats. He does not describe tongue or limbs claudication.

- Irreversible in 25%.
- Visual loss 6%.
- Sudden, painless and permanent.
- Mistiness, field loss, complete loss.
- Second eye involvement can occur in 24 hrs.

Investigations

Careful head and neck examination
Erythema, tenderness, nodularity, thickening of temporal artery, decreased pulse (vs. unaffected temporal artery)
Eye examination
Visual acuity, pupillary light reflex, visual field testing with finger confrontation and fundoscopy
Neurological examination
1/3 of patients can have cranial n palsies, peripheral neuropathy and Stroke in the carotid or VB artery territory
Raynaud's phenomenon
Assess pulse and blood pressure in upper extremities
Listen for bruits over carotid, brachial, axillary and subclavian arteries
Listen for aortic regurgitation/other murmurs

Management

- Don t delay treating suspected GCA while waiting for a biopsy /Temporal artery US
- Uncomplicated GCA (no jaw claudication or visual disturbance) = 40 mg Prednisolone daily
- Evolving visual loss or amaurosis fugax (complicated GCA) = 60mg Prednisolone ???500mg to 1 gm IV methylprednisolone for 3 days before oral prednisolone???
- Established visual loss = 60mg Prednisolone to protect the contralateral eye

??? IV methylpred???

Tapering

GCA	PMR
Prednisolone 40–60mg (not <0.75 mg/kg) continued for 4 weeks (until resolution of symptoms and laboratory abnormalities)	Prednisolone 15 mg for 3 weeks
Reduction by 10 mg every 2 weeks to 20 mg	12.5 mg for 3 weeks
Reduction by 2.5 mg every 2–4 weeks to 10 mg	10 mg for 4–6 weeks
Reduction by 1 mg every 1–2 months provided there is no relapse	Reduction by 1 mg every 4–8 weeks or alternate day reductions (eg. 10/7.5 mg alternate days)

REAL CASE: GCA
60mg OD for 4/52 by GP
Rheum then wrote:
40mg OD for 1/52
30mg OD for 1/52
25mg OD for 2/52
20mg OD for 2/52
To stay on 15mg OD until rheum r/v

- A transient (< 1/52) ↑ in PMR-like symptoms after a ↓ dose is common and usually manageable if patients are forewarned.

Relapse

- Headache only- treat with previous dose of steroid dose
- Headache and jaw claudication- 40-60mg Prednisolone
- Eye symptoms- 60mg Prednisolone or IV methylprednisolone
- Large vessel GCA- Investigate (PET/ MRI), use systemic vasculitis protocols