Polymyalgia Rheumatica

Incidence 50-10 per 10 000. 30% of these will have temporal arteritis
Mainly disease of caucasians
Rare in people <50. Average age 70
75% are in women

Characteristic features

- Bilateral shoulder/upper arm pain and stiffness
- Acute or sub-acute onset
- Symmetrical
- Often accompanied by hip girdle pain and stiffness
- May have pain/stiffness in back of the neck
- Stiffness classically worse after rest in the morning, can last more than 1 hour
- System features are common: fatigue, loss of appetite, weight loss, low grade fever and sometimes depression

Rule out temporal arteritis [note will require higher steroid dose than with PMR]:

- New headache?
- Jaw claudication
- Visual disturbance
- Pain on palpating temporal artery.
- If any of the above present consider temporal artery biopsy. Do not delay starting steroid [histological changes will be detectable up to 1w after starting steroid]

Differential diagnosis includes:
Rheumatoid arthritis (maybe seronegative), systemic vasculitis, inflammatory myopathy, SLE, SBE, undifferentiated spondyloarthropathy
Rarer: thyroid/parathyroid disorders, parkinsonism, osteomalacia, TB, malignancy

Investigations
CRP is more sensitive than ESR. [ESR will often, but not always be raised >40]
Other tests: FBC,UE,glucose,Alp,TSH,CK,calcium,urinanalysis

Confirm diagnosis:

- Trial of treatment confirms the diagnosis:

Prednisolone 15mg daily. Some need 20mg but higher doses should not be needed
Most are better within 24-48hrs: if not, consider other diagnoses
By 3-4w there should be a 70% improvement and ESR/CRP should be normal.

- USS shows classical features BUT use only if diagnosis is in doubt

Shoulders:sub-deltoid bursitis and less commonly a synovitis of glenohumeral joint
Hips:synovitis and trochanteric bursitis
Both of these USS changes are present even if ESR is normal

Treatment

- Treatment is with prednisolone starting at 15mg. Occas increasing 20mg daily if complete symptom resolution is not achieved in the first week or two
- Taper doses by 1mg every 1-3months. Aim for lowest dose that holds in remission
- Titrate downwards according to:
    - Symptoms (stiffness, pain in shoulders and hips)
    - Disability
    - Lab markers (mainly CRP). Don't reply on these alone. Some have persistent raised markers but are asymptomatic
- May need treatment for 2-3 years. 10% will relapse within 10 years of first diagnosis
- Consider bone protection if on long term steroid with DEXA scanning/prophylaxis
- Don't used NSAIDs: don't seem to help
- ?physio if mobility a problem

Managing relapses
For first and second relapses consider increase back to starting dose of prednisolone [15/20mg]
For further relapses increase prednisolone dose to 1-2mg above the previously effective dose.

Temporal arteritis (giant cell arteritis)

Visual loss occurs in 20%. Most occur before treatment starts. Higher risk the older they are
Recovery of sight is rare but progression including loss of vision in the other eye is common. 5% will suffer some form of visual loss on treatment. Can be associated with large vessel disease such as CVD/aneurysms

Treatment

- If visual disturbance:
  Prednisolone 60mg od. Same day admission to opthalmologist
- Without visual disturbance:
  - 40mg od prednisolone
  - Continued for 4-6w
  - Then reduce by 5mg every 2-4w until dose of 10mg daily reached
  - Then reduce by 1mg every 4-6w until maintenance dose of 5-7mg reached
  - Continue this maintenance dose for 12 months then start to reduce again by 1mg every 6-8 weeks until 3mg is reached
  - Then reduce by 1mg but at 3 monthly intervals

If symptoms flare whilst stepping down, increase dose by 5mg and leave for 4-6w then start tailing off again as per the above protocol
If any visual symptoms occur on treatment reinstate full dose (60mg) and refer.