

# PMR Polymyalgia Rheumatica Pathway

PMR is relatively common and in most cases can be dealt with in Primary care

## The key features:

- Age > 50 (if < 50 then refer to rheumatology)
- Bilateral shoulder AND/OR pelvic girdle aching
- Stiffness lasting at least 45 minutes after waking or periods of rest, that may cause difficulty turning over in bed
- High CRP

No significant inflammatory joint swelling, symptoms suggesting Giant Cell Arteritis or other metabolic illness that would explain their symptoms

## Urgent bloods:

- FBC, CRP, ESR,
- U+E, LFT, HbA1C

## Other necessary investigations:

- Bone profile, TSH, CPK
- Protein electrophoresis (& urinary Bence Jones if positive)
- Urine dipstick
- Antibodies RF, anti CCP and ANA if joint swelling /CTD symptoms (rash, Raynauds, fatigue, oral ulcers, hair loss etc)
- Consider Chest Xray

## Primary Care Initial Management

1. Prescribe Prednisolone 15mg daily
2. Assess response **in** 1-2 weeks after starting prednisolone to ensure that symptoms have improved by 70%.
  - If partial response inc. prednisolone dose to 20mg daily
  - If no response consider alternative diagnoses and referral
3. Organise appropriate bone protection / investigation
4. Follow steroid reduction protocol as below

## Bone protection:

**ALL** patients require vitamin D supplements and calcium if low dietary intake

AND use FRAX (see below)

- in **patients over 65 years** (or under 65 but with fractures), an oral bisphosphonate should be prescribed.
- In **patients under 65 years** without fractures, DXA scan can guide the need for bisphosphonates (required if osteopenia or osteoporosis).

## Primary Care PMR Follow up

Reduce the steroid dosage when symptoms are fully controlled (usually after 4 weeks), using the regime below

### Prednisolone Dosage:

- 15mg for 1 month
- 12.5mg for 1 month
- 10mg for 1 month

Then reduce by 1mg per calendar month

An alternative slower reduction is to reduce the dose every 4-8 weeks.

- approx 80% of patients are completely off steroids by around 18 months after treatment is started
- the 20% that are unable to stop steroids, the lowest possible long term maintenance dose should be used with careful monitoring for known complications (osteoporosis, type 2 diabetes, cataracts, glaucoma)

## Gastric protection:

a PPI is needed if there are any other risk factors

**Review** 3 monthly for the first 12 months to check

BP

glucose (to exclude steroid induced diabetes)

FBC and U+Es

**CRP** as the aim of treatment is to keep CRP within normal limits

If CRP abnormal during treatment but **without** return of PMR symptoms

## Patient information leaflet

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<https://www.versusarthritis.org/media/1322/polymyalgia-rheumatica-information-booklet.pdf>

- Screen for evidence of infection, and treat if present, repeating blood tests 1 week after antibiotics stopped
- If no infection, consider other causes including giant cell arteritis or new onset inflammatory arthritis

?recent onset headache with temporal tenderness

?recent onset jaw pain which worsens with chewing

?recent visual symptoms – blurring, loss of vision, double vision

?recent onset joint pain, swelling or stiffness

- If no cause apparent repeat CRP 2 weeks later, and if CRP remains abnormal, refer to Rheumatology

### CRP elevated

When increase steroid dose to the last dose where patient has symptoms. AND THEN maintain for 3 months & CRP normalised before attempting any further reduction using the regimen above.

### If CRP remains normal

- If CRP remains normal, then alternative causes for patients' symptoms should be considered – eg. osteoarthritis of shoulders or hips, thyroid disease, subclinical fracture etc. as steroids can mask other symptoms which return as steroid dose lowered
- alternative measures should be considered to control patients' symptoms – physio, analgesia etc

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<https://www.nhs.uk/conditions/Polymyalgia-rheumatica/>

### Referral to Rheumatology

1. GP is unsure of the diagnosis
2. Patients symptoms / blood tests cannot be adequately controlled by following the pathway above
3. Unable to reduce prednisolone to 5mg or below 1 year after treatment started
4. New PMR diagnosis

### References / further information

This advice document is based on <https://cks.nice.org.uk/polymyalgia-rheumatica> and is in line with other local guidelines <https://sheffieldhandandelbowpain.com/joint-professional-resources/duplicate-of-polymyalgia-rheumatica>