Polymyalgia Rheumatica
&
Temporal Arteritis

Introduction

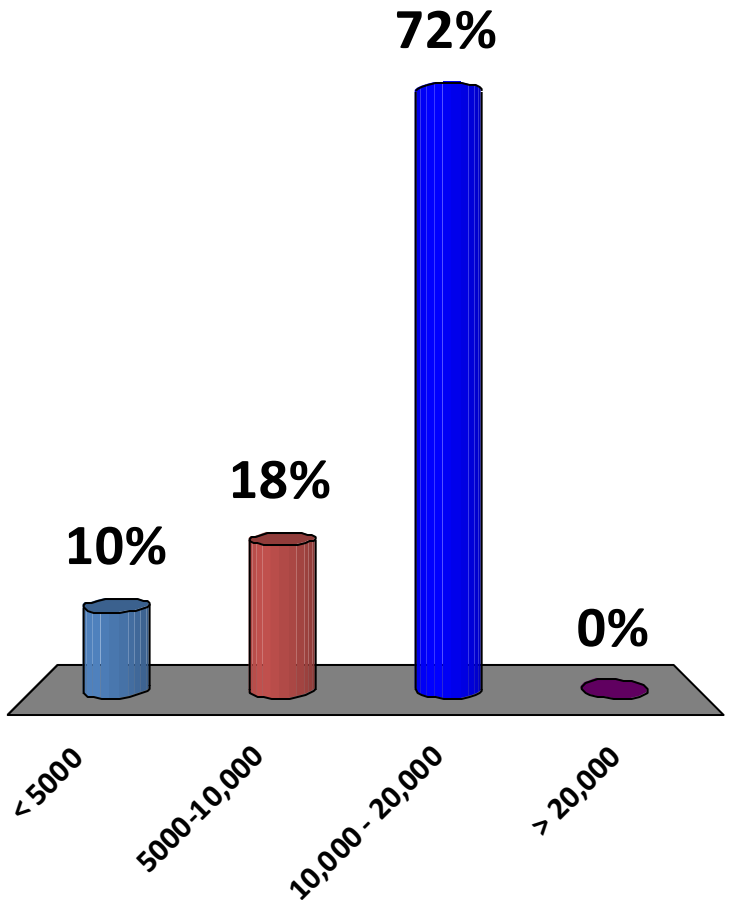
- PMR is the most common inflammatory disease of the elderly
- Accurate diagnosis is difficult

Differential Diagnosis

- Rheumatoid arthritis and other inflammatory conditions (connective tissue disease, vasculitis, myositis)
- RS3PE (relapsing symmetrical sero negative synovitis with pitting oedema)
- Osteoarthritis, septic arthritis, concomitant sepsis
- Adhesive capsulitis and fibromyalgia
- Neoplastic disease
- Metabolic bone disease
- Parkinsonism

What is the patient population of your surgery?

A. < 5000
B. 5000-10,000
C. 10,000 - 20,000
D. > 20,000



Eular Criteria for PMR Patients > 50 year old with Bilateral Shoulder Pains and Abnormal ESR/CRP

	Points
Morning stiffness > 45 minutes	2
Hip pain or limited range of movement	1
Normal RF or ACPA	2
Absence of other joint pains	1

* A score of 4 had 72% sensitivity and 62% specificity

± Ultrasound evidence of subacromial bursitis or hip synovitis improves the sensitivity and specificity

ACR criteria for the classification of TA

- 1. Age over 50 years.
- 2. New onset localised headache.
- 3. TA tenderness or decreased pulse.
- 4. ESR more than 50.
- 5. Abnormal TA biopsy showing inflammatory changes with granulomatous infiltration.
- A score of 3 has a sensitivity of 93% and a specificity of 91%

Epidemiology of PMR

(Cimmino et al, clin exp 2000 July 18)

Incidence of 12 — 112/100,00

Italy — Norway

USA 50/100,00

(1 in 2000 patients practice/year)

UK Primary Care

(Yates et al BMC MSC July 2016 Norfolk) (15-17) 285

Prevalence in patients aged >55

GCA 0.25%

PMR 1.5%

Women > Men, more in older groups

UK Annual Incidence

0.01% - 0.08% (11 in 10,000 Practices per year)

Lifetime risk of PMR - 2.4% Female
- 1.7% Male

Prednisolone for up to 2 years
(PMR is the most common indication for long-term use of steroids)

Exclude Alternative Diagnosis

- Rheumatoid arthritis
- Malignancy
- Connective tissue disease *
- Ankylosing spondylitis *

Case Scenario 1

Patient – Mrs SL 75 year old female

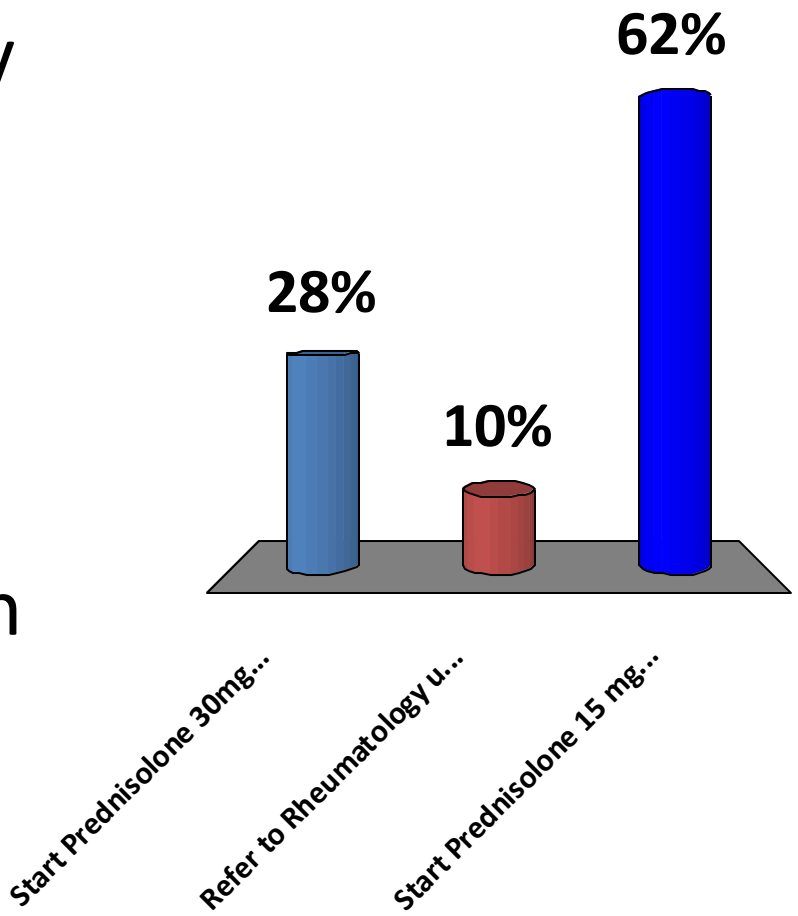
February 2012

- Acute onset pain and stiffness in both shoulders and hips (2 weeks)
- Early morning stiffness > 2 hours
- No pain in hands or feet
- No skin rash, no localising signs

At Practice urgent FBC Hb 11.8, ESR 47, CRP 54

Impression - PMR

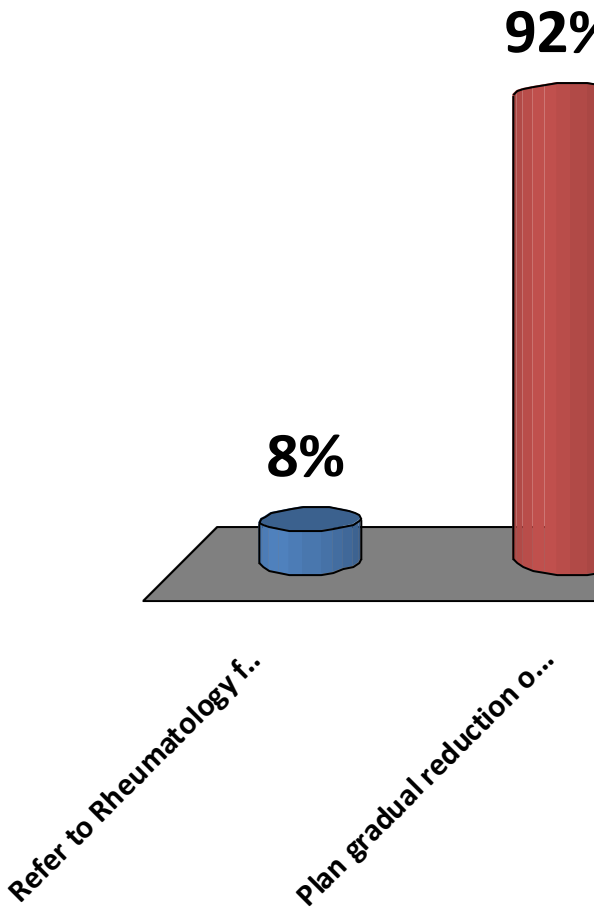
A. Start Prednisolone 30mg od and refer to Rheumatology
B. Refer to Rheumatology urgently without starting steroids
C. Start Prednisolone 15 mg and assess in Surgery again in 2 weeks



- Reasonable to start Prednisolone 15mg od, assess clinically and repeat inflammatory markers in 2 weeks

Patient Responded well. What next?

A. Refer to Rheumatology for advice
B. Plan gradual reduction of steroids and monitor



GP to reduce Prednisolone by 2.5mg every month aiming to stop steroids in 6 months. (mild cases)

Reduce by 1mg/ month (Moderate cases)

Reduce by 1mg every 2 months (resistant cases)

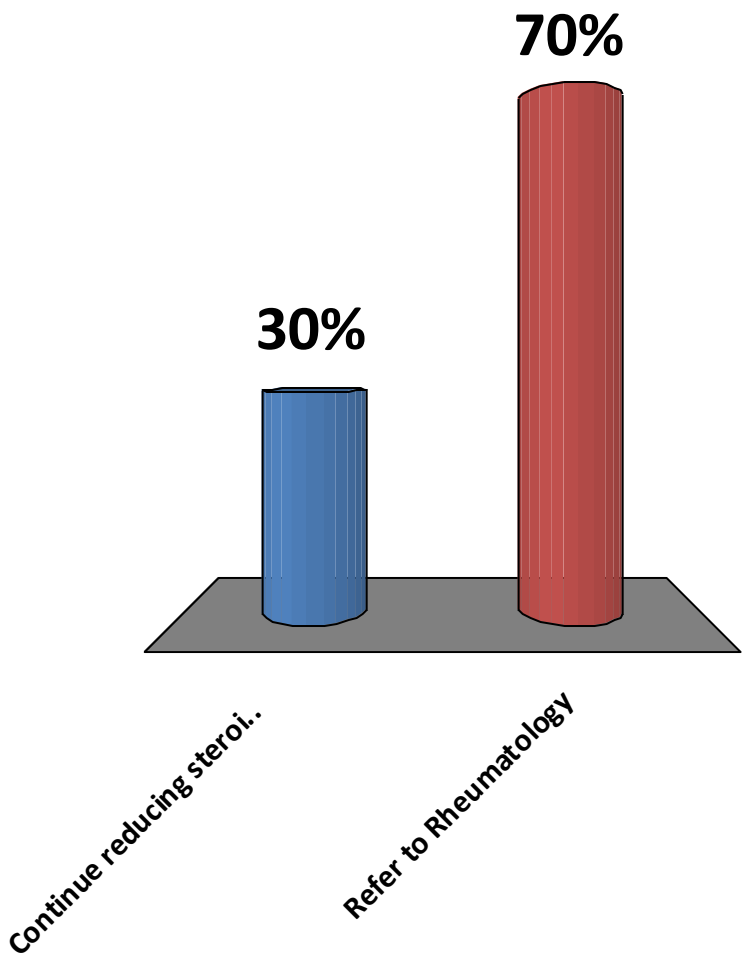
Patient Reviewed on 2 or 3 occasions.

Every time steroids reduced < 10mg,

PMR symptoms recur and increased ESR.

What will you do next?

A. Continue reducing steroids down according to symptoms (good response)
B. Refer to Rheumatology



Case Scenario 2

Patient – Mrs MG 78 year old female

Acute onset headache

Tender right side scalp and temple regions, Intermittent pain in the jaw

Felt unwell and off her food

Achy shoulders

No visual symptoms

On Examination

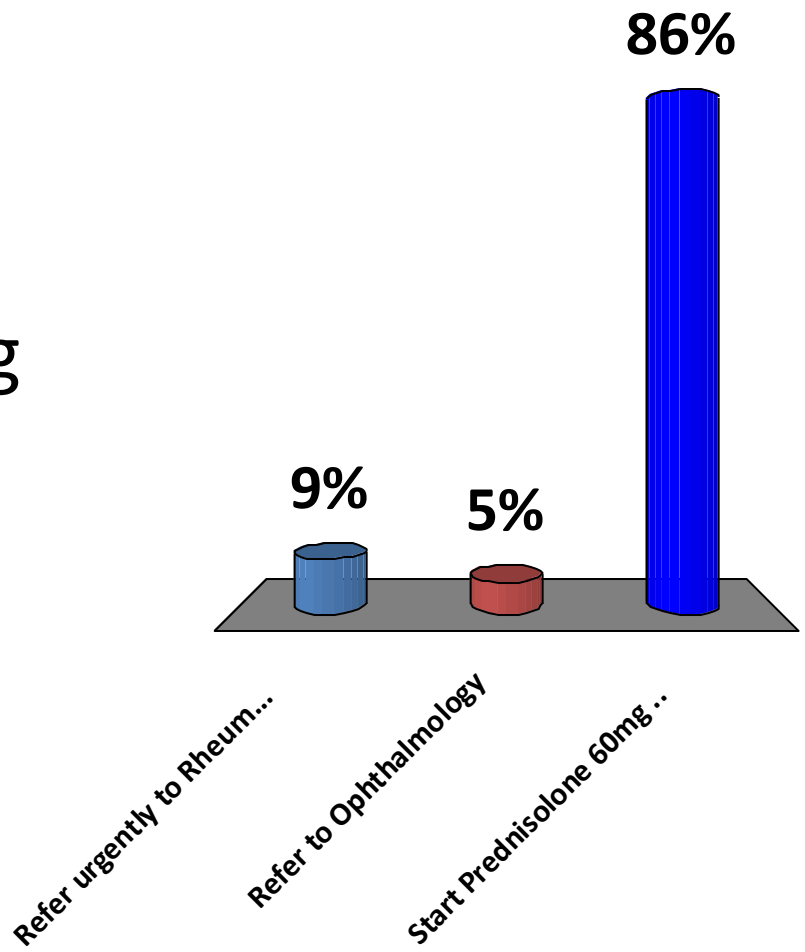
- Tenderness right temple
- Temporal artery is tender but pulsatile
- Painful and stiff shoulders
- No other significant abnormalities on physical examination

Urgent Bloods

ESR 72, CRP 54, Hb 12.1

Impression – Possible Temporal Arteritis

A. Refer urgently to Rheumatology
B. Refer to Ophthalmology
C. Start Prednisolone 60mg od and refer urgently to Rheumatology



I suggest 3rd option

Fax urgent letter to Rheumatologist and patient will be seen urgently

- Assess clinically, inflammatory markers for the response to steroids
- Organise urgent temporal artery biopsy or possibly PET scan
- Will also be seen by Ophthalmologist

- 2 weeks later improved and ESR normalised
- Reduced steroids by 10mg every 2 weeks, slower after 20mg, will probably need the steroids for up to 2 years.
- Started on Aspirin and on bone protection
- Regular check for possible steroid induced diabetes mellitus

Bone protection

- All patients require Ca and Vit D supplements.
- Patients > 65 yr and <65yr with a h/o fracture, start Alendronic acid 70mg/wk.
- Patients <65yr with no h/o fracture, need a dexa scan. Treat if already have osteoporosis or osteopenia.

Case Scenario 3

Patient – Mr PT 80 year old gentleman

Presents with acute onset headache, scalp tenderness, jaw pain, tongue paraesthesia, blurring of vision and double vision

No PMR symptoms

On Examination

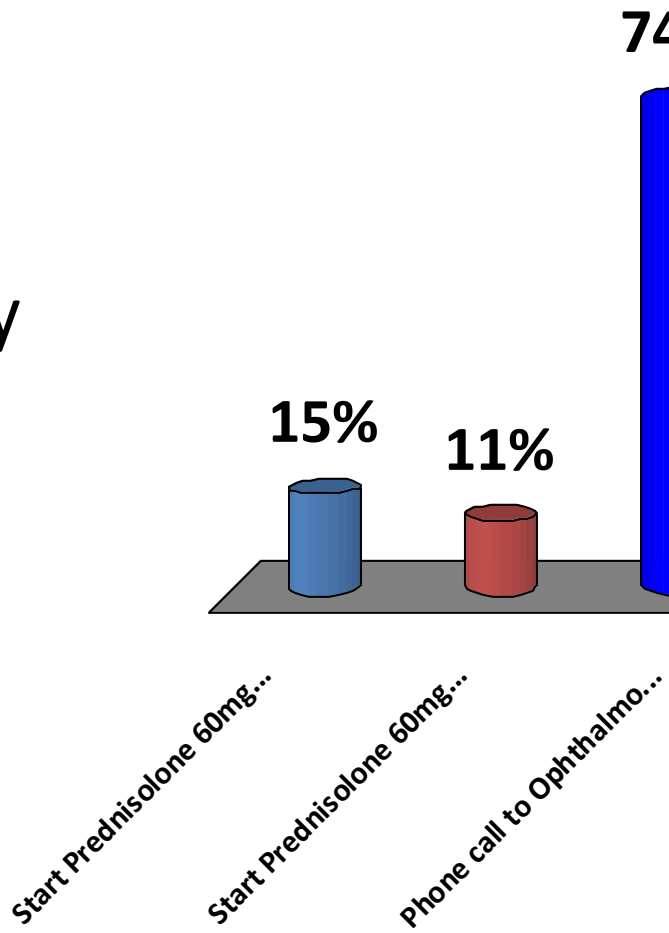
- Severe tenderness scalp left side
- Left temporal artery tender and non-pulsatile

Urgent Bloods

ESR 104, CRP 84 Hb 11.1

Impression – Temporal Arteritis

A. Start Prednisolone 60mg and refer urgently to Rheumatology
B. Start Prednisolone 60mg and refer urgently to Ophthalmology
C. Phone call to Ophthalmologist and fax a referral letter to Rheumatology and start Prednisolone 60mg



Case Scenario 4

Patient – Mrs KM 48 year old lady

Presents with acute onset pain and stiffness in shoulder, pelvic girdle, knees and back

No swollen joints

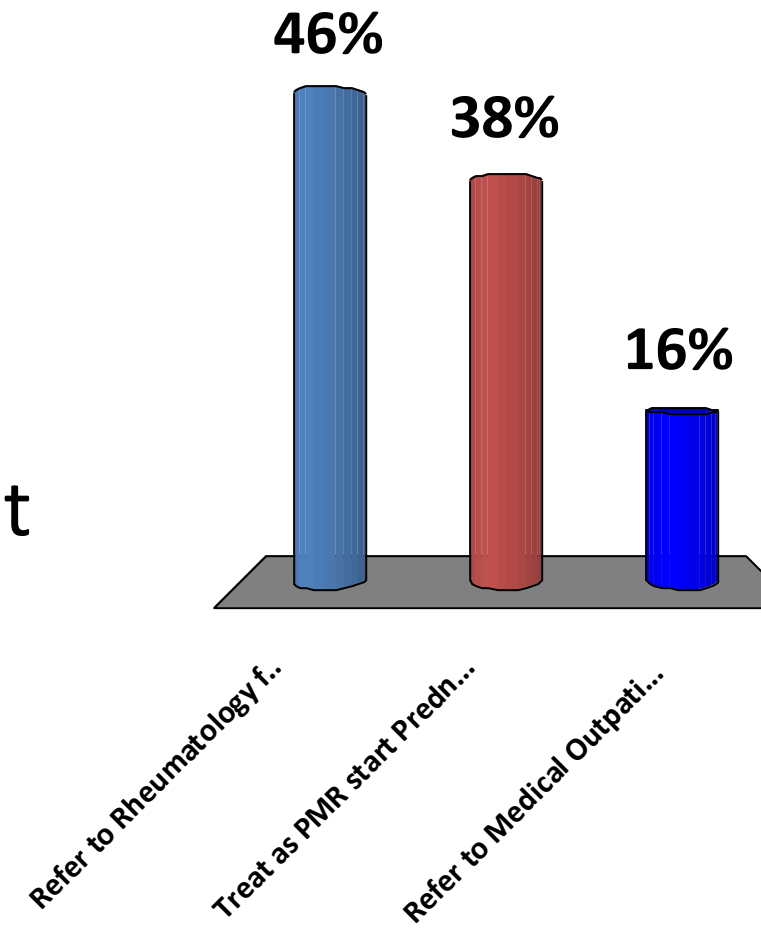
No other localising signs

Urgent Bloods

ESR 75,CRP 54, Hb 12.0, RF negative, ACPA negative

Enter Question Text

A. Refer to Rheumatology for soon assessment
B. Treat as PMR start Prednisolone 15mg od
C. Refer to Medical Outpatient Department



What Happened

Started on Prednisolone 20mg od

After 2 weeks:

ESR reduced to 55

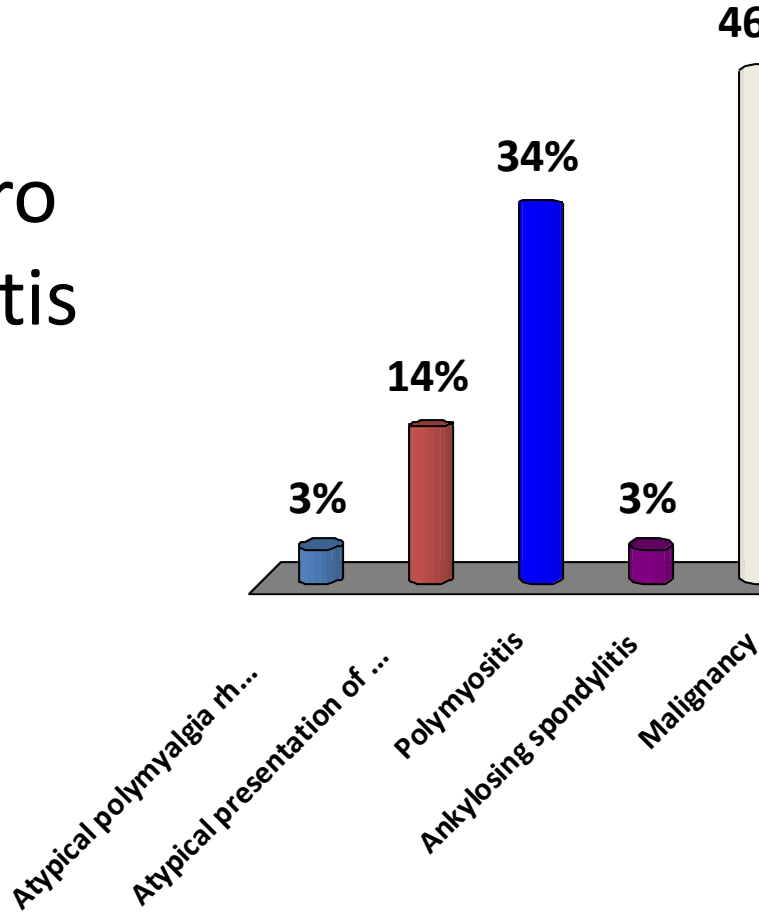
CRP reduced to 35

Hb improved to 12.4

- Steroids reduced, symptoms recurred, inflammatory markers increased, felt weak, difficulty with stairs and shortness of breath
- Referred to Rheumatology for further assessment

Possibilities

A. Atypical polymyalgia rheumatica
B. Atypical presentation of sero negative rheumatoid arthritis
C. Polymyositis
D. Ankylosing spondylitis
E. Malignancy



Further Assessment

- No peripheral or large joint synovitis
- Proximal muscle weakness
- Chest – fine bilateral basal crackles
- Bloods – ANF (ANA) positive
- Raised CK and LDH
- Chest x-ray – mild fibrotic lung disease

Impression – Polymyositis

Plan

- ENA (extractable nuclear antigen)
- PFT (pulmonary function test)
- HRCT (high resolution CT scan)
- EMG and muscle biopsy
- Increase dose of Prednisolone to 40mg and add Azathioprine and assess response

Conclusion

- Treat typical presentation of PMR locally
- Atypical presentation and associated TA symptoms need to be referred to Secondary Care as soon as possible
- TA presenting with visual involvement needs assessment by the ophthalmologist asap.
- Patients under the age of 50yr need to be assessed by the rheumatologist before starting any steroids.

Thank you

Temporal Arteritis Pathway