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 symptoms of PMR return when steroids are reduced, then **check CRP**

- **If CRP elevated**, then increase steroid dose to the last dose where patient was symptom free
  AND THEN maintain for 3 months & CRP normalised before attempting any further reduction using the regime above.

- **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

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

- 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

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 symptoms not expected in the context of PMR – suspicious of new onset inflammatory arthritis or Giant Cell Arteritis. Patients who need an urgent rheumatology assessment for suspected inflammatory arthritis, giant cell arteritis or suspected vasculitis can now be referred directly to the Rheumatology RAS (Referral Assessment Service) at Barnsley Hospital, outside of the MSK pathway. Patients will be triaged into an urgent clinic appointment. This will support a quicker patient journey as well as facilitating direct conversation between Rheumatology and GP that is not possible if routed via MSK. Treatment from other local providers will continue to be accessed via ERs.

Rheumatology Advice

Please contact us via the Rheumatology Advice and Guidance Service **(RAS)** on **ERS**, if you have any concerns or questions about patient management.

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-rhematica

Patient information leaflets

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

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