PMR Polymyalgia Rheumatica Pathway

-PMR is the most common inflammatory disease of the elderly, but accurate diagnosis can be difficult

-Typical presentation of PMR should be treated in primary care

- Refer difficult / resistant cases to Rheumatology to exclude other causes eg RA, malignancy, CTD, Ank-spondylitis

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

URGENT bloods

- CRP, ESR, FBC, U&E, LFT, Glucose
- Start PREDNISOLONE 15 mg
- **PATIENTS UNDER THE AGE OF 50 NEED TO BE ASSESSED BY THE RHEUMATOLOGIST BEFORE STARTING ANY STEROIDS**

Assess clinical and inflammatory response to prednisolone in 2 weeks

(If the clinical presentation is highly suggestive of PMR then steroid should be continued even if the ESR and CRP are on the low side. However, try to reduce the steroids faster and refer if response is not as expected)

- **GP to reduce prednisolone as symptoms and inflammatory markers improve :-**
  - Mild cases- reduce prednisolone by 2.5 mg every month aiming to stop steroids in 6 months
  - Moderate cases – reduce prednisolone by 1mg every month
  - Resistant cases – reduce prednisolone by 1 mg every 2month

Regular check for

Steroid induced Diabetes Mellitus.

Gastric protection:

a PPI is needed if there are any other risk factors

Bone protection:

ALL patients require calcium and vitamin D supplements

AND

- 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).

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