PMR- Polymyalgia Rheumatica Local 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).

Gastric protection:

a PPI is needed if there are any other risk factors

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)

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. These are indications for **URGENT** referral, which can be done straight to the rheumatology referral advice service **(RAS)**, without prior referral to MSK.

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.nhs.uk/conditions/Polymyalgia-rheumatica/

see **Versus Arthritis** website for further patient information leaflet https://www.versusarthritis.org/