INTRODUCTION

There was a need identified by the rheumatology department at OUH to develop a sensible primary care focused guideline for the diagnosis and management of Polymyalgia Rheumatica. Although generic guidelines exist, we were unable to find a useful one for primary care, taking into account the realities of how the condition presents in general practice. The group audited the current practice in Oxfordshire, compared to existing guidance and developed the following suggested guideline for primary care.
Diagnosis and Early Management of Polymyalgia Rheumatica in Primary Care

1. Suspect PMR

**Does the patient have these key features?**
- Bilateral shoulder &/or pelvic girdle aching
- Morning stiffness > 45 minutes
- Duration > 2 weeks
- Age > 50 years

Check for red flags & examine the patient

**Consider differential diagnosis:**
- Infection
- Malignancy (e.g. myeloma, metastasis)
- Inflammatory disease (e.g. RA, GCA)
- Drug induced myalgia
- Endocrine disease (e.g. hypothyroid)
- Neurological conditions (e.g. Parkinson’s)
- Osteoarthritis shoulders / hips
- Chronic pain syndromes

*Consider referral if key features not present*

Further investigation

CRP
If normal CRP, reconsider diagnosis
Full blood count
U&E
Liver function tests
Bone profile
Serum electrophoresis
Thyroid stimulating hormone
Creatine kinase
Dipstick urinalysis
Chest XR e.g. if previous smoker

2. Confirm PMR

**Trial of therapy**
Prednisolone 15mg daily for 3 days
Assess clinical and inflammatory marker response

**Good clinical response**

3. Treat PMR

**Use a planned steroid reduction**
AND

**Bone protection**
- Bisphosphonate
- Calcium & Vitamin D

*Consider referral to Bone Metabolism Team if intolerant of bone protection*

**No clinical improvement**
Stop prednisolone and review diagnosis
Consider referral

Review patient

*At 1 month; Check bloods and clinical response to treatment*

*Every 3 months; assess symptoms, review steroid reduction, bone protection and steroid related side effects. (gastro / diabetes).*
Long term Management of Polymyalgia Rheumatica in Primary Care

Steroid reduction – following on from ‘15mg trial doses’ referred to in step 2 above

- Reduce by 1mg a month
- A slower steroid reduction may help especially at the lower doses e.g. 5mg a month, then 5mg / 4mg / 5 mg for 1 month, then 4 mg for a month...and so on
- This can be made even slower if need e.g. 5mg a month, then 5mg, 5mg, 4mg for a month, then 5mg/4mg for a month, then 5mg/4mg/4mg for a month then 4 mg...and so on

Management of a PMR flare on reducing steroids

- Check inflammatory markers
- Consider alternative diagnosis e.g. intercurrent infection
- Increase prednisolone to the dose which previously controlled flare. This may be by 1mg.
- Continue for 1 month and reduce along same pathway
- Consider a slower reduction regimen (see above)
- If unable to reduce prednisolone below 10mg despite these modifications, refer for consideration of steroid sparing agent such as methotrexate

Glossary:

- CRP – C-reactive protein
- GCA – Giant Cell Arteritis
- PMR – Polymyalgia Rheumatica
- RA – Rheumatoid Arthritis
- U&E – Urea and electrolytes
- XR – X-ray

Guidelines written by Drs Anne Miller, William Cooke, Merlin Dunlop and Vicky Stansfield

http://www.rheumatology.org.uk/resources/guidelines/archive_guidelines/default.aspx

These guidelines have been reviewed by the Oxford Rheumatology Consultants

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