UR MEDICINE

GER-E-NEWS

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Polymyalgia Rheumatica (PMR)

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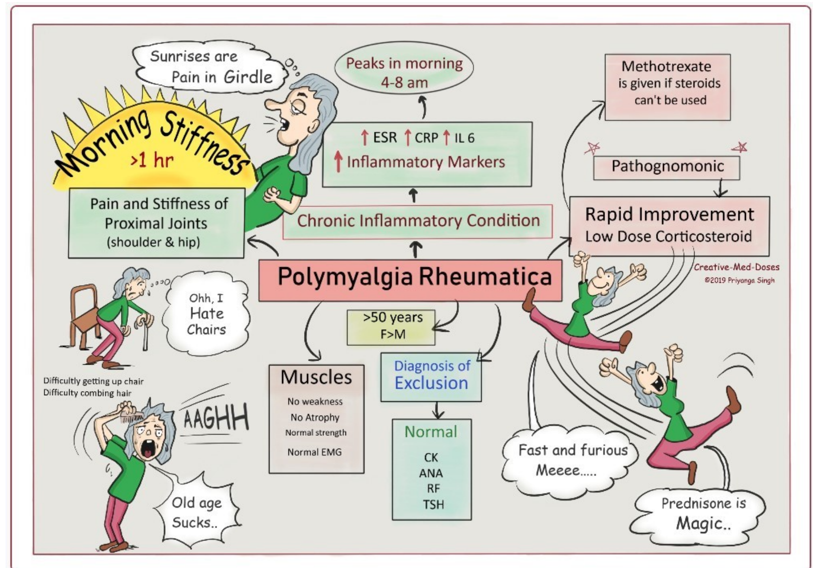
BACKGROUND



Polymyalgia Rheumatica (PMR) is an inflammatory rheumatic disorder with emphasis on chronic pain, typically achy and morning stiffness of the truncal aspect of the body such as the shoulder, hip girdle and neck. PMR is most commonly seen in Caucasian people aged over 50 and its incidence increases with advancing age, it typically peaks around age of 70 - 80 years. Etiology of PMR is idiopathic. PMR is also commonly associated with Giant Cell Arteritis/GCA (Temporal), large vessel vasculitis that affects the aorta and its branches.

SYMPTOMS

- Onset is typically gradual, however can occur abruptly warranting promptly medical evaluation.
- Morning stiffness of the shoulder (seen approx. 70 to 95%), hip girdle, neck and torso, customarily lasting approximately 45 minutes with a symmetrical presentation. Sleep disturbance is self-reported.
- Systemic symptoms: malaise, fatigue, depression, anorexia, weight loss, and low-grade fever.
- Typically affects activities of daily living such as dressing (put on and taking off shirts and bras) and transferring due to weakness and pain in proximal muscle groups.

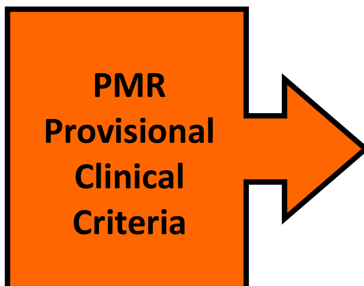


Table II - European League Against Rheumatism and American College of Rheumatology provisional criteria for classification of polymyalgia rheumatica.

Required criteria: age 50 years or older, bilateral shoulder aching and abnormal C-reactive protein and/or erythrocyte sedimentation rate	
Clinical criteria for scoring algorithm:*	
1. Morning stiffness lasting more than 45 min	2 points
2. Hip pain or restricted range of motion	1 point
3. Absence of rheumatoid factor and antibody to cyclic citrullinated peptide	2 points
4. Absence of other joint involvement	1 point
Ultrasound criteria for scoring algorithm:*	
5a. At least one shoulder with subdeltoid bursitis, biceps tenosynovitis, or glenohumeral synovitis; and at least one hip with synovitis or trochanteric bursitis	1 point
5b. Both shoulders with subdeltoid bursitis, biceps tenosynovitis, or glenohumeral synovitis	1 point

*With only clinical criteria, a score of ≥4 had a sensitivity of 68% and specificity of 78% for discriminating polymyalgia rheumatica from comparison patients. With a combination of clinical criteria and ultrasound criteria, a score of ≥5 had a sensitivity of 66% and specificity of 81% for discriminating patients with the disorder from comparison patients.

Diagnostic/Work-Up

History

- Thorough Review of System to rule out other causes of pain.
- Review of chronic medical conditions to ensure they are medically controlled appropriately.

Physical Exam

- Assesses each joint and range of motion of shoulder, cervical spine and hip.
- Typically patients are unable to actively abduct the arms above 90 degrees. Neurological exams are benign.

Labs/ Testing

- CBC with differential, erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP), also consider these labs prior to initiation of treatment: glucose, creatinine, liver function tests, and calcium.
- Other labs for consideration: serum thyroid-stimulating hormone (TSH), creatine kinase (CK), vitamin D, rheumatoid factor (RF), and anti-cyclic citrullinated peptide (anti-CCP) antibodies.

Imaging/ Other

- Imaging is not indicated, however can be considered on a case to case basics.
- If GCA is also considered, which can be seen with PMR patients, be vigilant for the following: New onset headaches, visual disturbances abruptly, transient monocular visual loss and jaw claudication.

Differential Diagnosis

Inflammatory: Giant Cell arteritis, Late onset Rheumatoid Arthritis, Myositis, Calcium pyrophosphate deposition disease

Non-inflammatory: Fibromyalgia, Hypothyroidism, Parkinson Disease, Osteoarthritis of the Cervical Spine and Shoulder

Management/Treatment

- Low dose Prednisone 10-20mg daily. Some improvement noted within 3 days to a week of treatment. No improvement of symptoms should consider alternative diagnosis.
- Follow up of inflammatory markers after 4 weeks of corticosteroids therapy.
- Taper can be considered after prolonged corticosteroids use however relapse can occur on tapering, thus resulting in extended corticosteroids therapy.

The Bottom Line

- Polymyalgia Rheumatica is a diagnosis of exclusion. however other rheumatological disorders need to be excluded. Typically overlooked in geriatric population with chronic pain.
- Consider use of European League Against Rheumatism and American College of Rheumatology, PMR provisional clinical Criteria as a tool.
- Corticosteroid is your drug of choice.

References

1. 1.Muratore, F., Salvarani, C., & Macchioni, P. (2018). Contribution of the new 2012 EULAR/ACR classification criteria for the diagnosis of polymyalgia rheumatica. Reumatismo, 70(1), 18-22. https://doi.org/10.4081/reumatismo.2018.1107
2. 2.Polymyalgia rheumatica : Mournful mornings. (2019, November 20). Creative Med Doses. https://creativemeddoses.com/topics-list/polymyalgia-rheumatica-mournful-mornings/ (ILLUSTRATION)
3. 3. Muratore F., & Salvarani C,: Clinical manifestations and diagnosis of polymyalgia rheumatica. Jan 13, 2021 Available from: uptodate.com