Sheffield Joint Pain

NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

# Polymyalgia Rheumatica

Polmyalgia Rheumatica is a relatively common illness which in most cases can be managed in primary care. The key features on history taking are:

- Age > 50
- Symmetrical upper and or lower limb proximal muscle pain and stiffness
- Stiffness worst first thing in the morning (at least 1 hour) and in bed at night
- Evidence of raised CRP
- Absence of clinical evidence of significant visible joint swelling, symptoms suggestive of Temporal Arteritis, or other metabolic illness that would explain their symptoms

Baseline investigation should be performed in accordance with BSR criteria, with results available for the following investigations:

- ✓ Full blood count
- ✓ CRP and ESR
- ✓ U+E, LFT and bone profile
- ✓ Protein electrophoresis (& urinary Bence Jones if positive)
- ✓ TSH
- ✓ CK (particularly if statin use)
- ✓ Antibodies including RF and ANA if joint swelling or CTD symptoms (rash, Raynauds, fatigue, oral ulcers, hair loss etc)
- ✓ CXR
- ✓ Urine Dip

**If above criteria met:**

**Step 1** **Prednisolone should be commenced at a dose of 15mg,** together with appropriate bone protection if appropriate - see separate guidance

**Step 2 -** Review appointment 1-2 weeks after starting steroid, to ensure that:

- Symptoms have responded appropriately.
- Baseline investigations reviewed.
- Decision taken whether to continue or stop steroids
- If steroids continued, then patients provided with appropriate information and follow up
- Ensure that appropriate bone protection / investigation in place.

**Step 3 -** Follow steroid withdrawal protocol as below

# Primary Care PMR Follow up Protocol

**Prednisolone Dosage:**

The following regime for prednisolone dose reduction is advised:

15mg for 1 month
12.5mg for 1 month
10mg for 1 month
Then reduction of 1mg per calendar month, until either:

- Steroids are stopped at the end of treatment period
- Symptoms recur
- Significantly raised CRP in the absence of infection

**Blood test Monitoring:**

Blood tests advised every 3 months, including FBC, U+E, LFT, CRP glucose.
The aim is to keep CRP within normal limits.
CRP check before each prednisolone dose change is not necessary in the absence of a return of symptoms.

**If Symptoms recur:**

CRP should be checked before steroid dose escalated.

If CRP remains normal, then alternative causes for patients symptoms should be considered – osteoarthritis of shoulders or hips, thyroid disease, subclinical fracture etc.

If CRP elevated, then steroid dose should be escalated to last dose where patient was symptom free and then maintained for 3 months & CRP normalised before attempting further reduction according to advice above.

**If Blood tests abnormal 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 Temporal 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 2 weeks later, if remain abnormal, refer back to Rheumatology Department

**Unable to Get Patients Off Steroids:**

It should be possible to get around 80% of patients completely off steroids by around 18 months after treatment started. For the 20% that are unable to stop steroids, the lowest possible long term maintenance dose should be used with careful monitoring for known complications such as osteoporosis, type 2 diabetes, cataracts, glaucoma etc. As above if symptoms of PMR return when steroids are reduced, the dose should only be increased if

evidence of raised inflammatory markers, as steroids can mask other symptoms such as osteoarthritis, which then returns as the dose is lowered. In the absence of raised CRP, alternative measures should be considered to control patients symptoms – physio, analgesia etc.

**Referral back to Rheumatology Department:**

Patients should be referred back to the Rheumatology Department if:

- Patients symptoms / blood tests can not be adequately controlled by following the pathway above
- New symptoms not expected in the context of PMR – new onset inflammatory arthritis, or Temporal Arteritis (follow temporal arteritis pathway)
- Not possible to get prednisolone treatment down to 5mg or below 1 year after treatment started