Diagnostic and Treatment Dilemmas in Polymyalgia Rheumatica (PMR)

PMR is a diagnosis made by observing typical symptoms, excluding other diagnoses, and confirming a response to glucocorticoid (GC) therapy[1-3]

1. Presence of acute, intense pain and stiffness
2. Exclusion of mimicking disorders
3. Observation of rapid improvement with GC therapy

1 PMR symptoms are nonspecific and can present in a variety of other conditions

Demographics[4,5]
- ≥50 years
- Female

Pain and stiffness[4,5]
- Bilateral shoulder pain and tenderness
- Pelvic girdle pain
- Restricted range of motion in affected muscles

Physical and mental[5,6]
- Fever
- Fatigue, malaise
- Loss of appetite
- Weight loss
- Depression

2 Mimicking disorders typically have one or more key differentiation features, which allow them to be distinguished from PMR[1,7,8]

*Headache, temporal tenderness, jaw claudication, visual disturbances**

Multisystem involvement, antinuclear factor and DNA binding; autoantibodies

Inadequate response to GC therapy

Elevation of muscle enzymes (CPK, aldolase), muscle weakness

Slow-onset, large-joint pain, or pain in joints of hands and feet, or knees; autoantibody positive

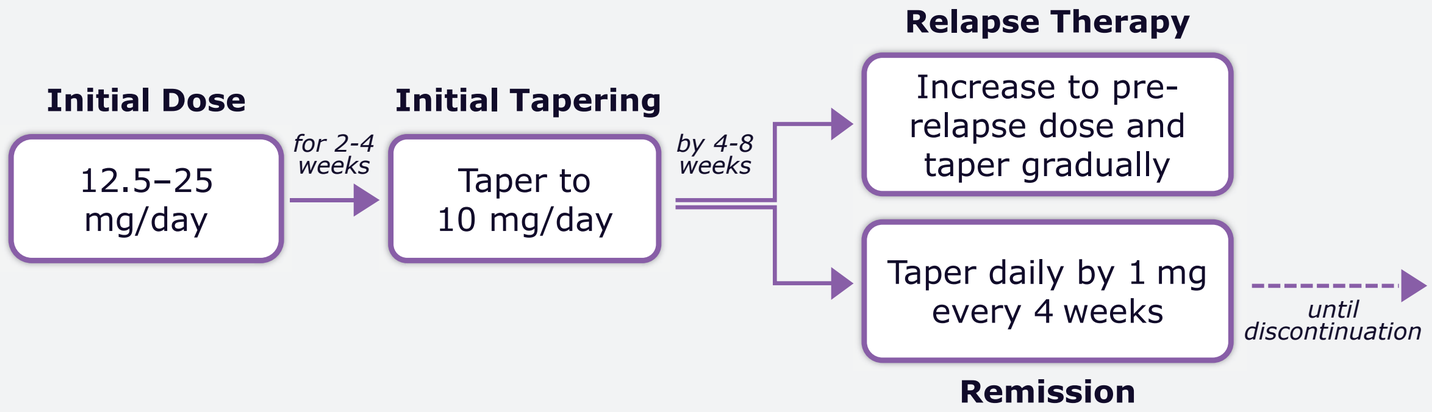
Altered thyroid function tests

Acute-phase reactant laboratory tests within normal range

Asymmetrical joint pain or swelling

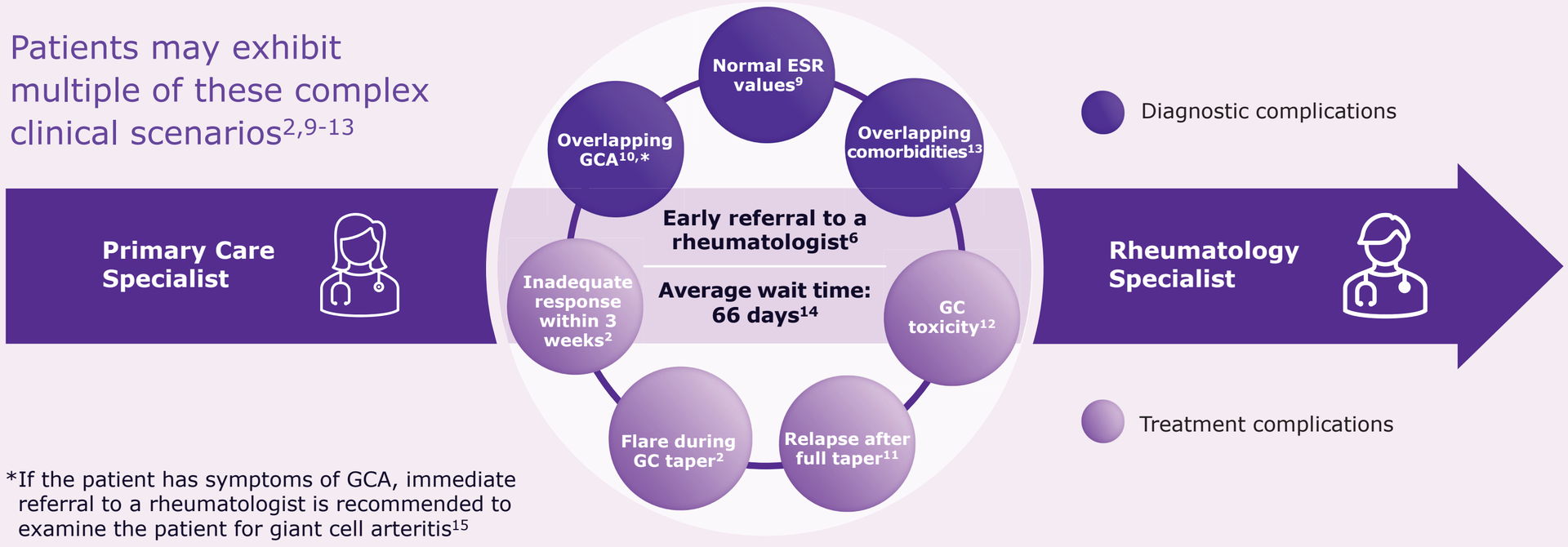
3 Patients with PMR typically show marked response to GC treatment, sometimes as soon as 1 day after initiation[2]

EULAR/ACR recommend low-dose GC therapy with gradually tailored tapering[3]



Complex clinical scenarios are common and early referral to a rheumatologist is recommended[3,7]

Patients may exhibit multiple of these complex clinical scenarios[2,9-13]



*If the patient has symptoms of GCA, immediate referral to a rheumatologist is recommended to examine the patient for giant cell arteritis[15]

Once referred, rheumatologists may recommend the use of alternative treatment options for PMR[2,16]

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