Polymyalgia rheumatica

Hans Rosenberg MD, Samantha Halman MD MMED, Krishan Yadav MD MSc

■ Cite as: *CMAJ* 2021 November 22;193:E1770. doi: 10.1503/cmaj.210541

1 Polymyalgia rheumatica is a common inflammatory disorder that affects older patients

Polymyalgia rheumatica is the second most prevalent systemic rheumatological disease in adults. Lifetime risk is 2.4% for women and 1.7% for men, with incidence rising from age 50 to 80 years.[1]

2 Taking a thorough patient history is critically important, as physical manifestations can be subtle

Polymyalgia rheumatica is characterized by acute-onset bilateral shoulder pain with morning stiffness. Less commonly, the neck, pelvic girdle and proximal thighs are involved. Constitutional symptoms are common; however, any fever is typically low grade. Active joint range of motion may be restricted, without observable joint inflammation or weakness.[2]

3 The European League Against Rheumatism (EULAR) and American College of Rheumatology (ACR) criteria can distinguish polymyalgia rheumatica from mimicking conditions

The condition is likely in patients with the aforementioned symptoms with elevated erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) or both, and response to glucocorticoids. The EULAR and ACR classification criteria are the most sensitive and specific and can help differentiate polymyalgia rheumatica from conditions such as rheumatoid arthritis, shoulder osteoarthritis and myopathies.[3]

4 The treatment is long-term prednisone started at 12.5–25 mg orally daily

Improvement is typically seen within 24–72 hours, but fewer than half of patients completely recover by 3 weeks.[2] The minimum effective prednisone dose should be used, typically over at least 12 months. Tapering below 10 mg/d should be started once clinical and biochemical remission (normalization of ESR or CRP or both) is achieved.[4] Specialist referral is warranted for atypical symptoms, therapy-related adverse effects, refractory symptoms, relapses and suspected giant cell arteritis.[5]

5 All patients with polymyalgia rheumatica should be checked for symptoms and signs of giant cell arteritis

Giant cell arteritis is associated with 10%–21% of cases of polymyalgia rheumatica.[1] Its features include headache, vision changes, jaw claudication and temporal artery tenderness. Complications include permanent vision loss. Patients with these symptoms should start prednisone at the higher dose of 40–60 mg/d and be referred urgently for temporal artery biopsy.

References

1. Buttgereit F, Dejaco C, Matteson EL, et al. polymyalgia rheumatica and giant cell arteritis: a systematic review. *JAMA* 2016;315:2442-58.
2. González-Gay MA, Matteson EL, Castañeda S. Polymyalgia rheumatica. *Lancet* 2017;390:1700-12.
3. Macchioni P, Boiardi L, Catanoso M, et al. Performance of the new 2012 EULAR/ACR classification criteria for polymyalgia rheumatica: comparison with the previous criteria in a single-centre study. *Ann Rheum Dis* 2014;73:1190-3.
4. Dejaco C, Duftner C, Cimmino MA, et al.; International Work Group for PMR and GCA. Definition of remission and relapse in polymyalgia rheumatica: data from a literature search compared with a Delphi-based expert consensus. *Ann Rheum Dis* 2011;70:447-53.
5. Dejaco C, Singh YP, Perel P, et al. 2015 Recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. *Ann Rheum Dis* 2015;74:1799-807.

Competing interests: Samantha Halman reports receiving grants from the Medical Council of Canada, Royal College of Physicians and Surgeons of Canada, the Department of Medicine at the Ottawa Hospital, the Department of Innovation in Medical Education at the University of Ottawa, and the Canadian Society for Internal Medicine, all outside the submitted work. Hans Rosenberg reports receiving honoraria from Podcast CAMP. No other competing interests were declared.

This article has been peer reviewed.

Affiliations: Departments of Emergency Medicine (Rosenberg, Yadav) and of Medicine (Halman), University of Ottawa and the Ottawa Hospital, Ottawa, Ont.

Correspondence to: Hans Rosenberg, hrosenberg@toh.ca

