Perspective

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Polymyalgia Rheumatic: Treatment

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Abstract

Polymyalgia Rheumatic (PMR) is one of the most common inflammatory rheumatologic diseases in the elderly and is characterized by a specific clinical picture. Recently, a core set of provisional classification criteria was designed by the European league against Rheumatism and the American college of rheumatology to provide a validated tool to differentiate PMR from nonpolymyalgic chronic inflammatory disorders. The high inflammatory burden characterizing this disease at onset accounts, at least in part, for the increased incidence of subclinical atherosclerosis detected in these patients. Moreover, although an increased mortality for Cardiovascular (CV) causes has not been clearly demonstrated, patients with PMR display a significantly higher risk of overt CV events with respect to age and sex matched control subjects, independent of traditional CV risk factors. Low dose Glucocorticoids (GC) is the mainstay of treatment of PMR. Introduction of GC sparing immunosuppressive drugs may be indicated for patients displaying frequent disease relapses or for that experiencing disease recurrence following GC discontinuation.

Keywords: Glucocorticoids (GC); Cardiovascular (CV); Polymyalgia Rheumatic (PMR); Immune suppressive agents; Giant Cell Arteritis (GCA); Nonsteroidal Antiinflammatory Drugs (NSAIDs)

Introduction

Severe muscle pain characterizes polymyalgia rheumatica. This diagnosis should not be given without full investigation because of two major implications: The high frequency of temporal arteritis and the effectiveness of corticosteroid therapy. The diagnosis should be limited to those with the typical picture, including increased erythrocyte sedimentation rate, and not used as an explanation for various aches, cramps, and pains. Women are affected more commonly than men, and the disorder is rare in individuals younger than age 55. The patient develops muscle stiffness, pain, and a feeling that the muscles have set. The arms are involved more commonly than the legs. Manipulation of the limb exacerbates the pain. The symptoms are particularly prominent in the morning when the patient arises and improve as the patient loosens up. These symptoms may be associated with chronic malaise, pyrexia, night sweats, and weight loss. On examination, the only specific muscle complaint is soreness. Tenderness over the temples, suggesting temporal arteritis, is an associated condition in 20% to 30% of affected individuals.

Description

Polymyalgia rheumatica

The erythrocyte sedimentation rate is elevated (often >70 mm/h), and this should be considered an essential part of the diagnosis of polymyalgia rheumatica. A mild hypochromic anemia may be associated. Otherwise, laboratory studies are generally normal. The serum CK concentration is not elevated, EMG may be normal, and muscle biopsy may show type 2 fiber atrophy, a nonspecific finding unhelpful in the diagnosis.

Polymyalgia rheumatica may be self-limiting but may take years to fade. For this reason, the recommended treatment is with prednisone and Nonsteroidal Anti-inflammatory Drugs (NSAIDs). The response to prednisone may be quite dramatic, with resolution of symptoms in hours to days. For the most part, the doses can be lower than used in other inflammatory autoimmune disorders. Maintenance on a low level of corticosteroids is often necessary for 2 years, and even then, only 24% of patients were able to stop treatment in one prospective study.

Treatment

Patients with polymyalgia rheumatica without clinical evidence of arteritis usually feel relief of symptoms after a few days of taking 10 mg–20 mg daily of prednisone. Patients should be followed closely and informed of serious arteritic complications, such blindness or stroke that could develop if giant cell arteritis is associated.

Polymyalgia rheumatic is usually self-limited within 1–4 years, but it may relapse if steroid therapy is discontinued before 2 years of therapy have been completed; low dose steroid treatment may be needed for up to 4 years. In patients with giant cell arteritis, 60 mg of prednisone is recommended. After symptoms are controlled and the ESR is normalized, the dose of

prednisone may be gradually reduced over 12 months–18 months, unless clinical relapse occurs. Salicylates and nonsteroidal anti-inflammatory drugs are less effective than corticosteroid treatment. Intramuscular injections of 120 mg of methylprednisolone every 3 weeks for 12 weeks followed by monthly injections of methylprednisolone for a total of 1 year in patients with polymyalgia rheumatic was reported to have excellent results and showed no suppression of the hypothalamus–pituitary–adrenal axis. Immune suppressive agents, such as azathioprine or methotrexate, may be used to treat steroid dependent or resistant patients.

The first description of Polymyalgia Rheumatica (PMR) is believed to have been made in Scotland by Dr. William Bruce in 1884. In 1957, Barber suggested the present name. In 1960, Paulley and Hughes reported on 67 patients, emphasizing the occurrence of arthritic rheumatism" in Giant Cell Arteritis (GCA), providing more solid clinical evidence for the relation between PMR and GCA. Histologic support came from the work of alerting and confirming the coexistence of the two conditions. Both disorders almost always affect patients age 50 years or over. A systemic inflammatory response and a marked response to glucocorticoid therapy are common to both.

Conclusion

Polymyalgia Rheumatica (PMR) is a systemic inflammatory disease that occurs in patients older than 50 years of age and is characterized by an elevated ESR, proximal extremity pain, morning stiffness, and rapid relief with the administration of corticosteroids. Giant Cell Arteritis (GCA), also known as temporal arteritis, is an inflammatory vasculitis of large and medium vessels primarily arising from the aortic arch. It occurs in adults older than 50 years of age and is characterized by headache, jaw claudication, and visual loss.

Many experts consider these two diseases to be points along a continuum of a specific systemic inflammatory disease syndrome, with PMR being the expression of a milder form of disease and GCA suggesting more severe disease. Both conditions are diseases of the elderly population, occurring exclusively in persons older than 50 years of age and peaking in incidence between 70 and 80 years of age. Women are affected twice as often as men, and whites of Northern European descent are most often predisposed to having these diseases. Various mechanisms have been postulated as causes of PMR, but the exact cause is unclear.

The disorder can generally be distinguished from other diseases on the basis of clinical presentation, laboratory evaluation, response to steroid therapy, or diagnostic imaging. Stiffness, pain, and weakness are common complaints in many older patients, but polymyalgia rheumatic may respond dramatically to treatment. Rheumatoid arthritis produces morning stiffness but is usually present in more peripheral joints and without muscle tenderness. Polymyositis is usually characterized by increased serum muscle enzymes with a normal ESR and may include a skin rash (dermatomyositis). Often, a therapeutic trial of prednisone helps make the diagnosis. Giant cell arteritis can be a serious and, occasionally, fatal illness, with sudden irreversible visual loss, permanent hearing loss, or aortic dissection. Permanent visual loss occurs in approximately 15% of patients with GCA. Larger doses of corticosteroids are required than for polymyalgia rheumatic.