

**DIAGNOSTIC RECOMMENDATIONS****History**

If polymyalgia rheumatica (PMR) is suspected, ask about the following:

- ★ pain in the neck, shoulder and/or pelvic girdle, morning stiffness, severity, impact on daily life;
- ★ duration of the symptoms.

Ask about symptoms that could indicate giant cell arteritis (GCA):

- ★ newly developed headache, unilateral or bilateral;
- ★ pain while chewing, pain when combing hair;
- ★ vision problems: partial or total vision loss, fast-originating decreased visual acuity, unilateral or bilateral, temporary or permanent, double vision.

For presence of disorders that may resemble PMR of GCA pay attention to:

- ★ presence of swollen joints or synovial sheath (rheumatoid arthritis);
- ★ temperature (infection);
- ★ malaise, loss of appetite, weight loss, back pain, coughing (malignancy, hypothyroidism);
- ★ the course of the symptoms (infection, malignancy, non-specific symptoms of the locomotor apparatus);
- ★ use of statins, muscle weakness (myopathy).

**Physical examination**

- ★ Active range of motion examination of the neck, shoulders and hips: pay attention to pain and limitations. Consider myopathy in the presence of loss of strength.
  - ★ Tenderness of the joint capsules of the knee, wrist and finger and hand joints, localised swelling of the finger/hand joints: consider RA.
  - ★ Pain or swelling on palpation of the temporal artery, presence of temporal artery pulsations.
- Depending on the findings of the history and the physical examination, a more comprehensive physical examination aimed at other causes may be required.

**Investigations**

Determine the ESR and perform additional blood tests in the presence of an elevated ESR:

- ★ Complete Blood Count (infectious diseases, malignancy);
- ★ TSH;
- ★ Serum Total protein and protein spectrum (multiple myeloma);
- ★ CK (myopathy due to statins, polymyositis/dermatomyositis).

Anamnesis and physical examination can provide an indication for additional examinations.

**Evaluation**

Exclude frequently occurring disorders that may resemble PMR:

- ★ rheumatoid arthritis (for diagnostic characteristics, see the NHG Guideline on Arthritis);
- ★ hypothyroidism.

In addition, consider whether other illnesses could explain the clinical picture: infectious disease, malignancy, tendino-arthrogenic neck and shoulder or hip problems, myopathy, non-specific problems with the locomotor apparatus (see guideline text).

When the symptoms cannot be reasonably explained by another cause, establish the diagnosis of PMR in patients older than 50 with:

- ★ bilateral pain in the neck and shoulder and/or the pelvic girdle that causes limited range of motion; and
- ★ symptoms that persist for longer than four weeks from the moment of onset; and
- ★ morning stiffness > 60 min; and
- ★ ESR > 40 mm/hour.

## THERAPEUTIC RECOMMENDATIONS

### Education

Inform the patients about the following:

- ★ In case of disease with unknown origin, treatment consists of glucocorticoids for one to two years.
- ★ Regular check-ups are necessary; glucocorticoids should not be discontinued abruptly.
- ★ Contact a physician in case of fever or symptoms of GCA: unfamiliar headache, sudden loss of visual acuity, blindness (unilateral and sometimes short-term) or double vision.

### Drug treatment

Treat PMR with prednis(ol)one, dosing according to the table.

Table Dosing of prednis(ol)one

Moment from start of treatment	Dosing of prednis(ol)one
Week 0-4	1 times daily 15 mg
Week 4-8	1 times daily 12.5 mg
Week 8-12	1 times daily 10 mg
As of week 12	Decrease the dose very gradually based on the symptoms. See the <i>example dose reduction schedule for prednis(ol)one</i> at <a href="http://www.nhg.org">www.nhg.org</a> .
Relapse	If symptoms recur or if the ESR increases, increase the daily dose to the lowest level at which the symptoms were still absent or acceptable and try to decrease the dose again in four weeks.

### Follow-up

Schedule a follow-up appointment after one week and after four weeks, and one to four weeks after each dose change.

- ★ Assess the following compared to the previous check-up:
  - the symptoms: pain, stiffness and limited range of motion;
  - new complaints or symptoms that fit with an alternative diagnosis.
  - use of medication; side effects, in-take adequate.
- ★ Determine the ESR four weeks after the start of treatment and always check this one to four weeks after every dose change. Reconsider the diagnosis and revise the dose reduction schedule if the ESR is elevated.
- ★ Determine the fasting glucose prior to the start of treatment and after three to seven days.
- ★ Check the blood pressure regularly at the start of the treatment.

## REFERRAL OR CONSULTATION

Referral:

- ★ acute decreased visual acuity, (partial or complete) vision loss or double vision, the patient must go to the ophthalmologist *immediately*;
- ★ suspicion of GCA, the patient must see a rheumatologist/internist *within 24 hours*;
- ★ serious side effects of or contraindications for long-term use of glucocorticoids, the patient must be referred to a rheumatologist/internist for possible treatment with methotrexate.

Refer to or consult a rheumatologist/internist:

- ★ if clinical improvement does not occur one week of treatment;
- ★ if after four weeks there is no clear clinical improvement and the ESR does not decrease;
- ★ in the event of regular relapse (more than 2 times per year);
- ★ if it is not possible to decrease the glucocorticoid dose;
- ★ if there is doubt about the diagnosis.