Polymyalgia rheumatica

We last covered polymyalgia rheumatica (PMR) based on a review published in the BMJ in 2008. A seminar from the Lancet brings us right up to date with PMR: a chronic disorder of unknown aetiology which affects the over 50s (Lancet 2013;381:63).

The lifetime risk of somebody developing PMR is 2.4% for women and 1.7% for men. The incidence is higher in those of Northern European descent, with Norway leading the way with 113:100 000/y, the UK 80:100 000/y and Italy 15:100 000/y. Theories abound as to the underlying cause with infections (mycoplasma, ParvoB19 and chlamydia) or hypothalamic–pituitary–gonadal axis dysfunction being raised as possible reasons for this disease.

The diagnosis and management of PMR can be straightforward but there are three traps we must avoid:

- Misdiagnosing another condition as PMR.
- Missing Giant Cell Arteritis (GCA – previously temporal arteritis).
- Not protecting our patient from the dangers of long-term oral steroids.

Trap 1: Diagnosis and differential diagnosis of PMR

Reviews of PMR have noted that between 2 and 30% of patients given a diagnosis of PMR are subsequently found to have a different diagnosis, typically late onset rheumatoid arthritis or GCA, and so we are advised to keep an open mind and be ready to review our diagnosis at any stage.

There have been a number of diagnostic criteria proposed for PMR, the latest being published in April 2012 by the European League against Rheumatism and the American College of Rheumatology. However, their criteria are not useful for GPs because they can include ultrasound scan findings and antibodies to cyclic citrullinated peptide, neither being available routinely in primary care.

Ultrasound scanning of shoulder and hip girdle is being used more frequently now because it can pick up bursitis and tenosynovitis in certain muscle groups and may be helpful in diagnosis. This is currently still being evaluated and is probably best left to those difficult cases that are referred to the rheumatologists.

The diagnostic criteria given in the box below is an older one which has been well evaluated and has good sensitivity and specificity – useful in primary care.

### Diagnostic criteria for polymyalgia rheumatica

Seven most valuable pointers for PMR are:

- ≥65y old
- Onset of illness <2w
- Bilateral shoulder pain, stiffness or both
- Bilateral upper arm tenderness
- ESR ≥40mm/h
- Depression, weight loss, or both

A diagnosis of PMR is made if 3 or more of these criteria are met: sensitivity 92%, specificity 80%

Ann Rheum Dis 1979;38:434

In all cases, however, ask yourself: could it be any of the following?

### Differential diagnosis

- Inflammatory arthritis: small joint swelling (particularly of the feet)? tenosynovitis?
- Malignancy: abdominal mass
- Polymyositis: muscle weakness alone?
- Thyroid diseases
- Parkinsonism
- Hypovitaminosis D: knee and thigh pain alone?
- Drug-induced myopathy – statins

As a consequence most guidelines suggest a full physical examination and the following blood tests:
- FBC
- ESR/CRP
- U&E
- LFT
- Calcium
- TFT
- CK
- Vitamin D if considered at risk
- Urinalysis
- (Protein electrophoresis)*

*In the “Easily Missed” series in the BMJ (BMJ 2012;344:d7953) there was some suggestion we should also consider testing protein electrophoresis in every patient we consider might have PMR to rule out multiple myeloma. This is not something that has been advised elsewhere.

**Trap 2: Missing Giant cell arteritis (GCA – temporal arteritis)**

Evidence is growing that GCA is a subtype of PMR. There is considerable overlap, with about 50% of patients with GCA exhibiting PMR symptoms and one-fifth of PMR patients having GCA. Indeed, studies of patients with PMR have shown many to have inflammation in their temporal arteries.

So it is suggested with every patient with PMR you ask yourself: has this patient also got GCA?

**Clinical features of GCA**
- Headache
- Jaw claudication
- Scalp tenderness
- Visual disorders
- Carotidynia (unilateral tenderness of the carotid artery at the bifurcation)
- Limb claudication

If any of the above are positive then GCA must be ruled out, usually requiring a biopsy. Local management for this is very variable and even knowing which registrar (surgical or rheumatological) to phone can be difficult. GPs should liaise with secondary care at this stage and establish how further investigation will be arranged and whether high dose steroids should be started immediately (usually) or not.

**Trap 3: Ensuring adequate bone protection**

BUT equally: not everybody taking oral steroids needs to take a bisphosphonate.

Bone fracture risk rises immediately a patient is started on prednisolone so it is important you assess bone risk using NICE guidelines CG146 (as set out in our Older people chapter). If your assessment requires a DEXA scan to be undertaken, and this is likely to take some time, it may be better to start a bisphosphonate in the meantime, stopping it if the patient is subsequently not considered at risk.

All patients (regardless if they require treatment or not with a bisphosphonate) should be offered calcium (if they have an inadequate dietary intake) and vitamin D supplements.

**Treatment of PMR**

Treatment is with corticosteroids and every one seems to have a different regimen.

**The Lancet proposed treatment regimen for PMR**
- Start with 15–20mg prednisolone daily
- Maintain for 2–4w
- Taper gradually by 2.5mg every 4w until 10mg
- After 1m of 10mg reduce thereafter by 1mg each month

**Starting dose in PMR**

In a small study of 60 consecutive patients treated for PMR (BMC Musculoskelet Disord 2011;12:94) researchers found that body weight was an important parameter in predicting which patients would respond best to their starting dose of prednisolone. Mean dose in those that responded to their starting dose was 0.19mg (+/− 0.03) prednisolone/kg/day. This might be a pragmatic way of
deciding whether to start with 15 or 20mg/day. For the mathematically challenged amongst us it means we should only use 20mg as a starting dose in those patients who weigh more than 100kg (about 15½ stone).

About 50% of patients will relapse during treatment requiring steroids to be stepped up again for a brief period before tapering more slowly. Most patients remain on steroids for 2y. Patients with persistent symptoms, or multiple relapses should have the diagnosis reviewed. DMARDs and biologicals are sometimes used in this group, though the evidence is patchy for their effectiveness.

**PMR and heart disease**


The study compared 3249 patients who developed PMR between 1987 and 2000 with 12 735 controls. Over a median of 7.8y:

- The PMR group had 36.1 vascular events/1000 person years.
- The control group had 12.2/1000 person years (hazard ratio 2.6; CI 2.4–2.9).
- The risk difference was highest in the younger (<60y) group.

So it seems that having PMR is associated with a higher risk of cardiovascular disease. We see similar associations with other inflammatory conditions such as inflammatory arthritis, vasculitis and SLE. What this study does not tell us (and I have not found a study that does) is whether controlling variable risk factors such as smoking habit, BP, cholesterol, etc. can modify this. However, it would seem sensible to be aware of this association when reviewing these patients.

### Polymyalgia rheumatica

- Diagnosis of PMR is usually straightforward but avoid the traps.
- Beware GCA.
- Be ready to review diagnosis.
- Protect patient’s bones.
- PMR is associated with 3x risk of cardiovascular disease.

---

*We make every effort to ensure the information in these pages is accurate and correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular check drug doses, side effects and interactions with the British National Formulary. Save insofar as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in these pages.*

GP Update Limited
March 2016
ALL OUR 2016 COURSES

Our comprehensive one-day update courses for GPs, GP STs, and General Practice Nurses.

We do all the legwork to bring you up to speed on the latest issues and guidance.

All our courses are:

Relevant
Developed and presented by practicing GPs and immediately relevant to clinical practice.

Challenging
Stimulating and thought-provoking.

Unbiased
Completely free from any Pharmaceutical company sponsorship.

Fun!
Humorous and entertaining – without compromising the content!

Are they for me?
Our courses are designed for:

• GPs, trainers and appraisers preparing for appraisal and revalidation or wanting to keep up to date across the whole field of general practice.
• GP ST1, 2 & 3, looking for the perfect launch pad into general practice and help with AKT and CSA revision.
• GPs who want to be brought up to speed following maternity leave or a career break.
• General Practice Nurses, especially those seeing patients with chronic diseases.

What’s included?

• 6 CPD credits in a lecture based format, with plenty of time for interaction, humour and video clips, to keep you focused and awake.
• A printed copy of the relevant Handbook including the results of the most important research in primary care over the last 5 years and covering the subjects more extensively than possible in the course.
• 12 months subscription to www.gpcpd.com. With three times the content of the handbook, it allows you to capture CPD credits as you read on the site and use it in consultations! It also comes with focussed learning activities to double your CPD credits...at the end of the year you simply upload everything ready for your appraiser!
• Buffet lunch and refreshments throughout the day!

What’s not included? Our courses contain NO theorists, NO gurus, NO sponsors, NO reps on the day! Just real life GPs who will be back at the coal face as soon as the course has finished.

www.gp-update.co.uk
The GP Update Course – our flagship course!

With the amount of evidence and literature inundating us, it can be hard to know which bits should change our practice, and how. The GP presenters summarise and discuss the results of the most important new evidence and guidance, concentrating on what it means to you and your patients in the consulting room tomorrow.

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol</td>
<td>Wed 11 May</td>
</tr>
<tr>
<td>Exeter</td>
<td>Thur 12 May</td>
</tr>
<tr>
<td>London</td>
<td>Fri 13 May</td>
</tr>
<tr>
<td>London</td>
<td>Sat 14 May</td>
</tr>
<tr>
<td>Newcastle</td>
<td>Wed 18 May</td>
</tr>
<tr>
<td>Sheffield</td>
<td>Thur 19 May</td>
</tr>
<tr>
<td>Manchester</td>
<td>Fri 20 May</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Sat 21 May</td>
</tr>
<tr>
<td>Norwich</td>
<td>Tue 24 May</td>
</tr>
<tr>
<td>Chelmsford</td>
<td>Wed 25 May</td>
</tr>
<tr>
<td>London</td>
<td>Thur 26 May</td>
</tr>
<tr>
<td>Belfast</td>
<td>Wed 8 June</td>
</tr>
<tr>
<td>Oxford</td>
<td>Fri 30 Sep</td>
</tr>
<tr>
<td>Southampton</td>
<td>Sat 1 Oct</td>
</tr>
<tr>
<td>Cardiff</td>
<td>Wed 5 Oct</td>
</tr>
<tr>
<td>Exeter</td>
<td>Thur 6 Oct</td>
</tr>
<tr>
<td>London</td>
<td>Fri 7 Oct</td>
</tr>
<tr>
<td>London</td>
<td>Sat 8 Oct</td>
</tr>
<tr>
<td>Leeds</td>
<td>Wed 12 Oct</td>
</tr>
<tr>
<td>Liverpool</td>
<td>Thur 13 Oct</td>
</tr>
<tr>
<td>Manchester</td>
<td>Fri 14 Oct</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Sat 15 Oct</td>
</tr>
<tr>
<td>Cambridge</td>
<td>Tue 18 Oct</td>
</tr>
<tr>
<td>London</td>
<td>Wed 19 Oct</td>
</tr>
<tr>
<td>Nottingham</td>
<td>Thur 20 Oct</td>
</tr>
<tr>
<td>Inverness</td>
<td>Wed 2 Nov</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>Thur 3 Nov</td>
</tr>
<tr>
<td>Glasgow</td>
<td>Fri 4 Nov</td>
</tr>
</tbody>
</table>

The Women’s Health Update Course

From the pill to pelvic pain, periods and prolapses, this one day women’s health update is a comprehensive guide to understanding and managing common gynaecological problems in general practice. The subjects are covered in a much greater depth than is possible on the GP Update course and includes simple ideas which we as GPs have found helpful in our consultations.

The day is designed for all GPs and GP STs – not just those with a special interest!

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh</td>
<td>Thu 23 Jun</td>
</tr>
<tr>
<td>Newcastle</td>
<td>Fri 24 Jun</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Thur 30 Jun</td>
</tr>
<tr>
<td>London</td>
<td>Fri 1 Jul</td>
</tr>
<tr>
<td>Exeter</td>
<td>Thur 3 Nov</td>
</tr>
<tr>
<td>London</td>
<td>Fri 4 Nov</td>
</tr>
<tr>
<td>Leeds</td>
<td>Thur 10 Nov</td>
</tr>
<tr>
<td>Manchester</td>
<td>Fri 11 Nov</td>
</tr>
</tbody>
</table>

The Cancer Update Course

Since 2012, Red Whale | GP Update has joined forces with Macmillan Cancer Support to provide a course that gives all GPs the knowledge and inspiration they need when dealing with cancer. From cancer prevention, screening, diagnosis and treatment to palliative care.

2015 has seen the biggest shake up in cancer in the last 10 years with the publication of the updated NICE guidelines on suspected cancer. If, like many of us in England & Wales, you are still finding your way around them, then this course will definitely help!

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds</td>
<td>Thu 16 June</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Fri 17 June</td>
</tr>
<tr>
<td>Bristol</td>
<td>Thur 23 June</td>
</tr>
<tr>
<td>London</td>
<td>Fri 24 June</td>
</tr>
<tr>
<td>Manchester</td>
<td>Thur 10 Nov</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Fri 11 Nov</td>
</tr>
<tr>
<td>Cambridge</td>
<td>Thur 17 Nov</td>
</tr>
<tr>
<td>London</td>
<td>Fri 18 Nov</td>
</tr>
</tbody>
</table>
Lead. Manage. Thrive! – The NEW management skills course for GPs.

Sometimes it feels like the thriving GP is an endangered species – demands on limited time and resources have never been higher. Our practices run in ever more complex ways and our teams extend beyond the practice walls. Often we get that instinctive feeling that there must be a better way to do things but creating the space to make it happen can be difficult.

As usual Red Whale has done all the legwork to bring you a concise, practical and actionable one day course and handbook. Not only have we trawled through lots of relevant management, leadership and development literature, but we have also distilled its content through the lens of real GPs, enabling you to apply it to the reality of your practice.

Our Consultation Skills Courses

One day small group courses designed for GPs, GP STs and General Practice Nurses.

The courses have a practical focus and lots of engaging exercises allowing delegates to rehearse the most effective consultation behaviours.

But don’t worry, there won’t be any role playing in front of everybody!

The Telephone Consultation Course

With the increased importance of telephone consultations this course aims to deliver practical skills which can be put to use immediately. The telephone is being used more and more by nurses as well as doctors in primary care, for triage, consultation and follow-up; in the daytime as well as out of hours. Our goal is to help you overcome difficulties and leave you with concrete ideas to enhance your own telephone contacts with patients.

The Effective Consultation Course

The Course focuses on behaviours which enhance effective use of time in the consultation. Efficient consultations reduce clinical risk and lower the risk of complaints and lawsuits. The course uses the rich evidence base on which consultation behaviours enhance effectiveness and how to go about learning them. We focus on actions and you will leave with many practical tips to use in your consulting room the following day.

The Medically Unexplained Symptoms Course

A significant proportion of patients who present to us will turn out to have symptoms that are medically inexplicable. We all know that there is no magic solution with these patients and sometimes they leave us feeling defeated and not sure what to do. However, there is evidence which can help address the issue.

Prices:

GP Update Course:
GP £195 | GP Registrar £150 | Nurse £150

All other courses:
£225 or £210 for members of www.gpcpd.com

(GPCPD members, please log in and then click on the relevant button within the 'Member information' box on the right of the home screen to get your discount code)
I would like to come on the following course(s) (please write legibly!):

- The GP Update Course (location).............................................................   (date).........................
- The Women’s Health Update Course (location).............................................................   (date).........................
- The Cancer Update Course (location).............................................................   (date).........................
- Lead. Manage. Thrive! The management skills course (location).............................................................   (date).........................
- The Telephone Consultation Course (location).............................................................   (date).........................
- The Effective Consultation Course (location).............................................................   (date).........................
- The Medically Unexplained Symptoms Course (location).............................................................   (date).........................

I can’t attend a course but would like to order your Handbook or DVD

- GP Update Handbook and 12 months access to GPCPD £150
- GP Update Handbook, DVD and 12 months access to GPCPD (pre-order for shipment mid May 2016) £225
- Women’s Health Update Handbook £70
- Cancer Update Handbook £70

For downloadable information on becoming a presenter with us please visit: www.gp-update.co.uk/team Or email team@gp-update.co.uk

To book: Online at www.gp-update.co.uk or call us on 0118 9607077 or use the form below

---

Can you prescribe GPs, Nurses and Registrars a lively course of evidence based updates and good humour?

Are you as passionate as we are that pharma sponsorship has no place in medical education?

Do you want to add presenting courses to your GP portfolio?

We are looking for practising GPs to start making big, bold waves in primary care education as Red Whale presenters.

You will be trained in presenting one-day, lecture-based courses to audiences of 50-300 delegates.

GP Update – Red Whale is a market leading educator for GPs, Nurses and Pharmacists. We are looking to expand our team of enthusiastic presenters and continue making our courses relevant, challenging and fun.

For downloadable information on becoming a presenter with us please visit: www.gp-update.co.uk/team Or email team@gp-update.co.uk

To book: Online at www.gp-update.co.uk or call us on 0118 9607077 or use the form below