



What is polymyalgia rheumatica?



Polymyalgia rheumatica (PMR) is a condition that causes severe stiffness and pain, mainly in the muscles of the shoulders and thighs. In this booklet we'll explain the main symptoms of PMR and how it can be treated. We'll also suggest some sources of further information and support.

At the back of this booklet you'll find a brief glossary of medical words - we've underlined these when they're first used in the booklet.

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Polymyalgia rheumatica (PMR) most commonly starts after the age of 60, though it can start as early as 50, and affects women more often than men.

At a glance

Polymyalgia rheumatica (PMR)

How is PMR diagnosed?

PMR is usually diagnosed by your GP, based on your symptoms, the history of your condition and blood tests which will show inflammation. Your doctor may refer you to a specialist if the diagnosis isn't clear because several other conditions (including rheumatoid arthritis) may have similar symptoms in the early stages.

Your doctor will want to check up on you regularly after treatment is started and do further tests to monitor your condition and treatment.

What treatments are there?

PMR is usually treated with steroid tablets. These often start to work very quickly but will need to be continued for some time to keep the inflammation under control and prevent the symptoms coming back. Your doctor will keep the dose of steroids as low as possible.

How can I help myself?

While you're taking steroids, it's important to make sure you get enough calcium and vitamin D, and your GP may prescribe treatment that will help to maintain bone strength. Weight-bearing exercise such as walking will also help to keep your bones strong and healthy.

PMR is an inflammatory condition that causes very painful muscles.

What related problems might occur?

PMR is sometimes associated with inflammation of the arteries in the head, a condition called giant cell arteritis or temporal arteritis. This needs prompt medical treatment to protect your vision. **You should see your doctor straight away if you have any of the following symptoms:**

- severe headaches
- tenderness or swelling at the temples
- blurred or double vision
- jaw, tongue or facial pain – especially when chewing.

If your doctor suspects giant cell arteritis, you may be referred to a specialist and will be asked to have a biopsy of the temporal artery. However, your doctor may start you on a high dose of steroids even before you see the specialist as a precaution against possible loss of vision.

What is polymyalgia rheumatica (PMR)?

Polymyalgia rheumatica (usually shortened to PMR) is an inflammatory condition that causes many (*poly*) painful muscles (*myalgia*). It tends to mainly affect the muscles of the shoulders and thighs.

PMR can start at any age from 50 but mainly affects people over the age of 60. Women are affected 2–3 times as often as men and it affects about 1 in 2,000 people.

What are the symptoms of PMR?

If you have PMR you'll have severe and painful stiffness in the morning, especially in your shoulders and thighs. PMR often strikes suddenly, appearing over a week or two and sometimes just after a flu-like illness. The stiffness may be so severe that dressing, reaching, climbing stairs or even getting out of bed may be difficult.

The symptoms are quite different from the ache you may feel after exercise that your body isn't used to. The pain and stiffness is often widespread and is made worse by movement, but it may also wake you at night.

It's also common to feel unwell or to have a slight fever, and you may lose weight.

At times, tiredness can be overwhelming. The condition can also make you feel low and become depressed.

Related condition

Giant cell arteritis

PMR is sometimes associated with painful inflammation of the arteries of the skull. This is called giant cell arteritis (GCA) or temporal arteritis and needs prompt treatment as there's a risk of damage to the arteries of the eye. About 20% of PMR patients also develop GCA, while 40–60% of patients with GCA have symptoms of PMR.

The symptoms of GCA are:

- severe headaches and pain in the muscles of the head
- tenderness at the temples
- pain in the jaw, tongue or side of the face when chewing
- pain or swelling in the scalp
- blurred or double vision.

i See **Arthritis Research UK booklet** *Giant cell arteritis*.



Effective treatments for PMR are available, and in most cases they'll bring a complete recovery over time.



There's no specific test to diagnose PMR, so your doctor may try a number of different tests.

How is PMR diagnosed?

Normally PMR will be diagnosed and treated by your GP. However, you may be referred to a rheumatologist if there's any doubt about the diagnosis or if there are complicating factors – for example, if the symptoms don't improve with steroid treatment or if you have side-effects from it.

There's no specific test to diagnose PMR. Your doctor will make the diagnosis based on the history of your illness, a physical examination and blood tests for inflammation. There are three tests that may be used:

- erythrocyte sedimentation rate (ESR)
- plasma viscosity (PV)
- C-reactive protein (CRP).

The presence of inflammation alone won't confirm the diagnosis of PMR. Inflammation is a feature of many other conditions, including rheumatoid arthritis, so your doctor will need to do some tests to rule these out. You may need to have tests such as x-rays or ultrasound scans of the shoulders and hips.

Anaemia (a lack of red blood cells) is quite common in PMR so your doctor may test for this, although anaemia can also be a symptom of other conditions.

If your doctor suspects giant cell arteritis, they may suggest a temporal artery biopsy, when a small piece of the artery is taken from the scalp and examined under a microscope (See Figure 1).

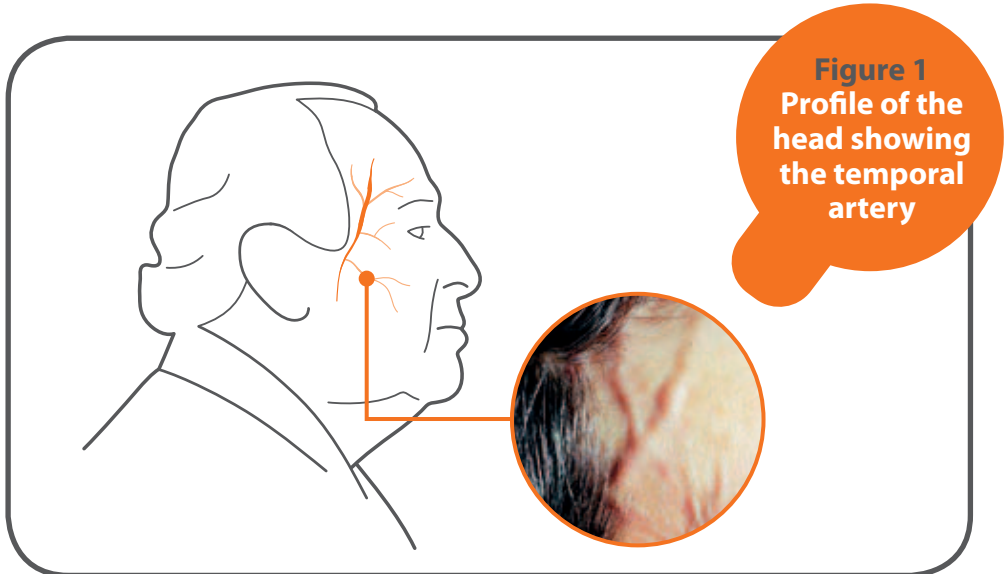


Figure 1
Profile of the head showing the temporal artery



What treatments are there for PMR?

Steroid tablets

Standard painkillers or anti-inflammatory drugs alone aren't enough to ease the symptoms. However, steroid (corticosteroid) treatment is usually very effective.

The body makes several of its own steroids (including one called cortisol) in the adrenal glands, which sit on top of the kidneys, and they play an important part in keeping you healthy – for example, by maintaining blood pressure and balancing salt and water levels in the body. When corticosteroid drugs are given in doses larger than the amount we already have in our bodies, they can have a powerful effect in reducing inflammation.

Steroids won't cure PMR but the symptoms often improve significantly within a day or two once steroid treatment is started. However, treatment usually needs to continue for 2 years or more to stop symptoms returning.

The steroid tablet most often prescribed is prednisolone. In most cases an initial dose of 15 mg of prednisolone a day makes the symptoms disappear completely. However, if you have giant cell arteritis you'll need higher doses than this to begin with in order to protect your vision.

i See **Arthritis Research UK drug leaflet** *Steroid tablets*.

After a time your doctor will try to gradually reduce the dose of steroids to avoid potential side-effects such as osteoporosis. The reduction will be made in stages depending mainly on your symptoms but helped by repeat ESR or CRP test results. If symptoms return when the dose is reduced, your doctor may have to increase the dose for a short time and then, after several weeks, try to reduce it again. Raised ESR or CRP test results alone don't necessarily mean your steroid dose needs to be increased.

! You shouldn't stop taking your steroid tablets or alter the dose unless advised by your doctor, even if your symptoms have completely cleared up. This is because your body stops producing its own steroids while you're taking steroid tablets and needs a period of time to resume normal production of natural steroids before the drug is stopped.

Even when you feel well, your doctor may wish to see you regularly so that you can be assessed for signs of a relapse or side-effects from the drugs. Your doctor may want to check your general health and you may also be asked to have a bone density (DEXA) scan to assess the strength of your bones.

! We recommend you carry a steroid card that shows what dose of steroid you're on and how long you've been taking them. If you need to see

another doctor, for example while you're away from home, show them the card – depending on what treatment you need, the steroid dose may need to be adjusted.

i See Arthritis Research UK booklet *Meet the rheumatology team.*

Other treatments

Steroid treatments can increase the risk of developing osteoporosis, making your bones more likely to fracture or break in a fall. Your doctor will therefore advise on drugs to help guard against osteoporosis, such as bisphosphonates, including risedronate or alendronate.

If your symptoms are mild, you may be advised to take painkillers, also known as analgesics (e.g. paracetamol), or non-steroidal anti-inflammatory drugs (NSAIDs) to help ease the pain and stiffness, along with small doses of steroid tablets.

Symptoms often improve significantly within a day or two of starting steroid treatment.

If your symptoms don't improve with steroids, or if it's difficult to reduce the dose of steroids over a period of time, your doctor may want to get a specialist opinion to confirm the diagnosis and treatment. The specialist may decide to prescribe methotrexate tablets alongside the steroid tablets for better disease control. Methotrexate works by reducing the activity of the immune system and therefore reduces inflammation. If you do need methotrexate it's important to have regular check-ups and blood tests to monitor the side-effects of the drug. Methotrexate can cause adverse effects such as feeling sick and mouth ulcers. More rarely it can cause more serious side-effects in the blood, liver or lungs. Most of these are picked up by the regular blood tests and get better if the drug is stopped.

Methotrexate is usually only given to people who've had repeated relapses. As the methotrexate takes effect it's usually possible to reduce the steroid dose.

i See Arthritis Research UK drug leaflets *Drugs for osteoporosis; Methotrexate; Non-steroidal anti-inflammatory drugs.*

Self-help and daily living

Because steroid treatment can increase the risk of osteoporosis, it's important to think about the other risk factors associated with this condition. Smoking or drinking a lot of alcohol will both increase your risk of developing osteoporosis, while a diet that contains plenty of calcium and vitamin D, combined with some weight-bearing exercise, will help to reduce your overall risk.

Sitting for any length of time may cause stiffness, making activities such as driving more difficult. Stop from time to time on a long journey to stretch your legs, arms and shoulders. Simple measures like a hot bath or shower can help to ease pain and stiffness, either first thing in the morning or after exercise.

i See Arthritis Research UK booklets *Diet and arthritis; Osteoporosis.*

Exercise

You'll need to find the right balance between rest and activity. Too much exercise is likely to make your symptoms worse, but activity usually helps to ease morning stiffness. Physiotherapy, including range of movement exercises for the shoulders, can be helpful in reducing pain and maintaining mobility.

Weight-bearing exercise (any exercise that involves walking or running) is best for maintaining bone strength and guarding against osteoporosis, but walking is usually more suitable for people with PMR.

Figure 2 Approximate calcium content of some common foods

Food	Calcium content
115 g (4 oz) whitebait (fried in flour)	980 mg
60 g (2 oz) sardines (including bones)	260 mg
0.2 litre (½ pint) semi-skimmed milk	230 mg
0.2 litre (½ pint) whole milk	220 mg
3 large slices brown or white bread	215 mg
125 g (4 ½ oz) low-fat yogurt	205 mg
30 g (1 oz) hard cheese	190 mg
0.2 litre (½ pint) calcium-enriched soya milk	180 mg
125 g (4 ½ oz) calcium-enriched soya yogurt	150 mg
115 g (4 oz) cottage cheese	145 mg
3 large slices wholemeal bread	125 mg
115 g (4 oz) baked beans	60 mg
115 g (4 oz) boiled cabbage	40 mg

Note: measures shown in ounces or pints are approximate conversions only.

Diet and nutrition

Steroid treatments reduce the amount of calcium absorbed from the gut and increase calcium loss through the kidneys. To counteract this we recommend a daily intake of calcium of 1,000 milligrams (mg) or 1,500 mg if you're over 60. A pint of milk a day, together with a reasonable amount of other foods that contain calcium, should be enough (see Figure 2).

Vitamin D is sometimes called the sunshine vitamin because it's produced by the body when the skin is exposed to sunlight. It's also obtained from some foods, especially oily fish, and is added to some soya milks and vegetable margarines. It's sometimes necessary to take a daily supplement containing 10–20 micrograms (µg) (this is the same as 400 to 800 international units (IU)) of vitamin D, especially for people over 60.



Glossary

Anaemia – a shortage of haemoglobin (oxygen-carrying pigment) in the blood which makes it more difficult for the blood to carry oxygen around the body. Anaemia can be caused by some rheumatic diseases such as rheumatoid arthritis or lupus, or by a shortage of iron in the diet. It can also be a side-effect of some drugs used to treat arthritis.

Analgesics – painkillers. As well as dulling pain they lower raised body temperature, and most of them reduce inflammation.

Biopsy – the removal of a small amount of living tissue from the body. The sample can help diagnose illness when examined under a microscope.

Bisphosphonates – drugs used to prevent the loss of bone mass and treat bone disorders such as osteoporosis. They work by reducing high levels of calcium in the blood and by slowing down bone metabolism.

C-reactive protein (CRP) – a protein found in the blood. The level of C-reactive protein in the blood rises in response to inflammation and a blood test for the protein can therefore be used as a measure of inflammation or disease activity.

DEXA (dual-energy x-ray absorptiometry) – a scan to test the strength or density of the bones. It involves lying on a couch, fully clothed, for about 15 minutes while your bones are x-rayed. The dose of x-rays is tiny – about the same as spending a day out in the sun. The results will tell how much risk there is of the bones fracturing.

Erythrocyte sedimentation rate (ESR) – a test that shows the level of inflammation in the body and can help in the diagnosis of a number of inflammatory conditions. Blood is separated in a machine with a rapidly rotating container (a centrifuge), then left to stand in a test tube. The ESR test measures the speed at which the red blood cells (erythrocytes) settle.

Immune system – the tissues that enable the body to resist infection. They include the thymus (the gland that lies behind the breastbone), the bone marrow and the lymph nodes.

Inflammation – a normal reaction to injury or infection of living tissues. The flow of blood increases, resulting in heat and redness in the affected tissues, and fluid and cells leak into the tissue, causing swelling.

Non-steroidal anti-inflammatory drugs (NSAIDs) – a large family of drugs prescribed for different kinds of arthritis that reduce inflammation and control pain, swelling and stiffness. Common examples include ibuprofen, naproxen and diclofenac.

Osteoporosis – a condition where bones become less dense and more fragile, which means they break, fracture or crumble more easily. Steroid treatment can increase the risk of developing osteoporosis.

Plasma viscosity (PV) – a screening test that measures the thickness or stickiness of the fluid in which blood cells are suspended. It's used as an indicator of disease activity in a number of conditions

Arthritis Research UK

Polymyalgia rheumatica

including rheumatoid arthritis, psoriatic arthritis and lupus.

Rheumatoid arthritis – an inflammatory disease affecting the joints, particularly the lining of the joint. It most commonly starts in the smaller joints in a symmetrical pattern – that is, for example, in both hands or both wrists at once.

Ultrasound scan – a type of scan that uses high-frequency sound waves to examine and build up pictures of the inside of the body.

Where can I find out more?

If you've found this information useful you might be interested in these other titles from our range:

Conditions

- *Giant cell arteritis*
- *Osteoporosis*

Therapies

- *Meet the rheumatology team*

Self-help and daily living

- *Diet and arthritis*

Drug leaflets

- *Drugs for osteoporosis*
- *Methotrexate*
- *Non-steroidal anti-inflammatory drugs*
- *Steroid tablets*

You can download all of our booklets and leaflets from our website or order them by contacting:

Arthritis Research UK

PO Box 177
Chesterfield,
Derbyshire S41 7TQ
Phone: 0300 790 0400
www.arthritisresearchuk.org

Related organisations

The following organisations may be able to provide additional advice and information:

Arthritis Care

18 Stephenson Way
London NW1 2HD
Phone: 020 7380 6500
Helpline: 0808 800 4050
www.arthritiscare.org.uk

PMR-GCA UK

Centre for Disability Studies
Adult Community College
Rocheway, Rochford
Essex SS4 1DQ
Phone: 0300 111 5090
www.pmr-gcauk.com

Arthritis Research UK

Providing answers today and tomorrow



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ΙΩΑΝΝΗΣ Γ. ΡΟΥΤΣΙΑΣ

ΜΙΚΡΟΒΙΟΛΟΓΙΚΟ
ΔΙΑΓΝΩΣΤΙΚΟ
& ΕΡΕΥΝΗΤΙΚΟ
ΕΡΓΑΣΤΗΡΙΟ



ΜΙΚΡΟΒΙΟΛΟΓΙΚΟ
ΔΙΑΓΝΩΣΤΙΚΟ
ΙΑΤΡΕΙΟ



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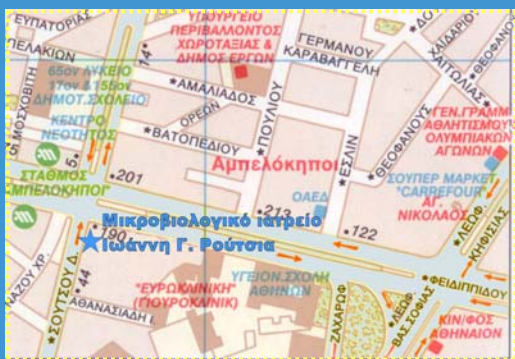


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