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PMR Management: Challenges & Opportunities

ReachMD Announcer:
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Dr. Stone:
I’m Dr. John Stone. I’m a rheumatologist and a Professor of Medicine in Boston, Massachusetts.

ReachMD Announcer:
What options are currently available to manage PMR symptoms?

Dr. Stone:
So really, we have a very limited, very few management approaches. For the past 70 years or so, the only therapy truly regarded universally as being effective is glucocorticoids.

One can also use nonsteroidal anti-inflammatory drugs for some of the other musculoskeletal symptoms. In my experience, those drugs don’t work nearly as well as prednisone, and in the elderly population non-steroidals have lots of adverse effects: gastric ulceration, renal insufficiency, hypertension, et cetera, so I tend to avoid those.

But, because of the desperation to reduce glucocorticoid toxicity, rheumatologists often use methotrexate, often use leflunomides, sometimes use Plaquenil and a whole host of other things have been tried for polymyalgia rheumatica but suffice it to say that for seven decades now, nothing except for glucocorticoids have been widely regarded to be effective.

ReachMD Announcer:
What types of patients that present with PMR symptoms are not appropriate for glucocorticoids?

Dr. Stone:
So, remember, these patients are typically elderly, so they have many comorbidities. This may include obesity, glucose intolerance, many of them may be on insulin, they may be brittle diabetics, they may have hypertension, they may have cataracts or glaucoma and be at risk for serious eye complications from steroids. Patients who are osteoporotic, the disease affects women three times more often than it affects men, and women are at a greater risk of osteoporosis, not that men can’t get osteoporosis as well. So, bone health and poor bone health is a major relative contraindication to the use of steroids. And any patient who has had difficulty with infectious issues, infections of one type or another, then glucocorticoids lower the threshold for infection and it’s been shown that doses even lower than 5 milligrams a day significantly increase the risk of serious infections leading to hospitalization so there’s a long list of relative contraindications to prolonged steroid use.

ReachMD Announcer:
How do you approach treating PMR patients who are unable to take corticosteroids or who relapse while tapering off steroids?

Dr. Stone:
Well, this is the battle that we continually fight because we really have to treat these patients with glucocorticoids. So even if they have comorbidities that put them at substantial risk for glucocorticoid toxicity and make steroids relatively contraindicated, we have to use them because patients are utterly miserable without them in the early going, so we try to minimize the dose. If I have an elderly

osteoporotic woman or a man with a history of neuropsychiatric issues that might make them tolerate glucocorticoids poorly, then I might bite the bullet and start at a lower-than-usual dose. The same is true if a patient is a brittle diabetic. I would perhaps start at a lower dose. And I would try to reduce the prednisone very quickly to attenuate - mitigate some of the very predictable glucocorticoid side effects.

ReachMD Announcer:
What are the current challenges clinicians face when managing PMR today?

Dr. Stone:
I think the biggest challenge that physicians still face really, is managing the glucocorticoid toxicity. Remember, this is a disease that tends to affect middle-aged and elderly individuals with, really, the emphasis on "the elderly". So, they very often have multiple comorbidities at the time of their diagnosis. So, this means big challenges when it comes to obesity, diabetes, hypertension, osteoporosis, risk of infection, et cetera.

ReachMD Announcer:
What opportunities exist to improve the management of PMR?

Dr. Stone:
Well, it begins with early diagnosis. And so, teaching our providers, physicians of other healthcare providers to be more attuned to the symptoms of PMR. That's very, very important.

And then being wiser about how we use glucocorticoids, paying careful attention to glucocorticoid toxicities and avoiding them, prophylaxing against these toxicities to the extent that they can be prevented will all help outcomes.

Ultimately, the management of PMR is going to be improved when we have better medications and one can look around the rheumatic disease space, the inflammatory disease space, and see so many examples where treatment has been improved by the development of better therapies.

PMR remains a striking exception for a disease that is so common in the United States and in the world. So ultimately, it's really going to be a better understanding of the pathophysiology of the disease.

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