Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/medical-industry-feature/reading-the-rheum-lets-talk-about-pmr-management/14175/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Reading the Rheum: Let's Talk About PMR Management

ReachMD Announcer:
You're listening to ReachMD. This medical industry feature, titled "Reading the Rheum: Let's Talk About PMR Management," is brought to you by Sanofi and Regeneron. This program is intended for healthcare professionals. Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:
What clinical approaches and considerations are needed to determine the diagnosis for patients who present with polymyalgia rheumatica, or PMR for short? That question will be the focus of our discussion today.

This is ReachMD and I'm your host, Dr. Jennifer Caudle, and joining me to discuss the pain and presentation of PMR are Dr. Anisha Dua and Ms. Amanda Mixon. Dr. Dua is an Associate Professor of Medicine in the Division of Rheumatology. Dr. Dua, thank you so much for being here today.

Dr. Dua:
It's a pleasure to be here.

Dr. Caudle:
And Ms. Mixon is a physician assistant specializing in rheumatology. Ms. Mixon, it's great to have you with us.

Ms. Mixon:
Thank you for inviting us.

Dr. Caudle:
Of course. Well, we're happy that you're here. So, you know, let's begin with some background. Dr. Dua, how prevalent is PMR, and what types of patients are most commonly affected?

Dr. Dua:
PMR is a very common inflammatory rheumatic disease, much more common than people think. Just to give you an idea, it's even more common than colorectal cancer. And the patients who suffer most often from PMR are typically 50 years or older. And it's something we see much more commonly in women.

Dr. Caudle:
And now turning to you, Ms. Mixon, what symptoms do PMR patients most commonly experience, and how do they compare to other rheumatic conditions?

Ms. Mixon:
PMR is characterized by pain and stiffness in the neck, shoulders, and pelvic girdles. About half of PMR patients experience weight loss, fatigue, and/or low-grade fever that can last for months. PMR is often described as a flu that doesn't go away. Patients often struggle to sleep because it hurts when they move in bed, and sometimes they have a hard time getting out of bed because the pain is usually more intense in the morning.

There is also an aspect of losing independence, like not being able to comb their hair. The pain that patients experience is quick to onset and can be debilitating, negatively affecting their quality of life.

Dr. Caudle:
Thank you for that. Now let's switch gears and talk about making a diagnosis. Dr. Dua, how is PMR typically diagnosed, and are there

any barriers that may prevent diagnosis?

Dr. Dua:
Diagnosis can be tricky, since there is no test or biomarker that's specific for PMR. It can also mimic other diseases. So diagnosis is based on clinical history with some lab tests to exclude other illnesses. But I always say that getting a sense of the clinical history is the most important diagnostic test for PMR. Some blood tests can be helpful, like the sed rate and the C-reactive protein. And you can also exclude some mimics of PMR by checking things like rheumatoid factor, or anti-CCP antibodies. But typically when you're diagnosing PMR, clinicians are really working to rule out rheumatoid arthritis, inflammatory myopathy, infections, or cancers, and some forms of metabolic disease can all mimic PMR. So in many cases, we need to see a patient's response to treatment in order to confirm a diagnosis.

Dr. Caudle:
You know, that seems like a very different method compared to diagnosing other diseases. Can you explain further about how a patient's response to initial treatment may help confirm the presence of PMR?

Ms. Mixon:
Yeah. Patients are typically treated first with moderate doses of steroids, and a rapid response, usually within days, supports a diagnosis of PMR. In general, if you think a patient has PMR, we recommend referring them to a rheumatologist, and if a patient's symptoms don't resolve within days of steroid treatment, then the patient needs to be seen immediately by a specialist for further diagnostic workup.

Also, if PMR is suspected, it's important to check for symptoms of giant cell arteritis, or GCA for short, which is a systemic vasculitis affecting the large arteries. PMR and GCA can appear either simultaneously or consecutively, but 40-50% of GCA patients have PMR manifestations. GCA is a medical emergency, and if left untreated it can cause serious consequences, such as blindness, stroke and aortic aneurism. So it's important to screen all patients with suspected PMR for GCA as well.

I'd also like to note that if a patient has GCA symptoms, it is recommended that they be referred to a rheumatologist immediately.

Dr. Caudle:
For those of you who are just tuning in, you're listening to ReachMD. I'm Dr. Jennifer Caudle, and today I'm speaking with Dr. Anisha Dua and Ms. Amanda Mixon about polymyalgia rheumatica.

Now, Ms. Mixon, you mentioned steroids are usually first-line treatment. Dr. Dua, can you tell us why and how they're typically used to treat PMR?

Dr. Dua:
Yeah, so steroids are typically used because of the inflammatory nature of PMR. But the regimen and then the schedule can really vary between the patients. So usually, patients are started on glucocorticoids with a dose of around 12.5 to 25 milligrams per day. And we use that for about 4 weeks. Usually patients feel dramatically better within the first few days of treatment. And then once we have stable symptoms, then we'll start the tapering process to try to get them off of steroids. However, it needs to be individualized to the patient. And it's recommended that the dose be reduced gradually, because if it's done too fast, then the patient's symptoms can come back.

Dr. Caudle:
And as a quick follow-up to that, Ms. Mixon, how important is tapering off steroids?

Ms. Mixon:
It's very important. Glucocorticoids are useful in the initial stages post-diagnosis, but it's important not to use them for too long. About a quarter of PMR patients are still on steroids at various dosages, five years after treatment initiation, which is not ideal.

The main reason we want to avoid long-term use of steroids is because of their side effects, even if continued at relatively low doses. Our goal is to make sure that the symptoms are controlled while also monitoring steroid toxicity. For example, we recommend monitoring patients' blood pressure, vision changes and weight gain, and do regular osteoporosis screening and bone density measurements, just to name a few.

Dr. Caudle:
And Dr. Dua, are there any patients with PMR who shouldn't receive steroids?

Dr. Dua:
We worry about conditions like hyperglycemia diabetes, glaucoma, people who have joint infections are prone to multiple infections, uncontrolled hypertension, all of those are things that make us worry a little bit about the use of glucocorticoids. We still may need to use them, but we do so with caution. And so of course, if a patient has one of these conditions, or we're unable to fully taper them off of

the steroids, then they might benefit from using a different steroid-sparing agent. So sometimes we'll use things like methotrexate or other immunosuppressives.

But methotrexate can also be associated with other adverse events that require regular blood monitoring. I mean, as rheumatologists, we've used methotrexate to reduce glucocorticoid toxicity. And we've used other drugs such as leflunomide, hydroxychloroquine, and a variety of other treatments. But really, for seven decades now, nothing except glucocorticoids has been widely regarded as effective.

Dr. Caudle:
As we come to a close, I'd like to thank our guests, Dr. Anisha Dua and Ms. Amanda Mixon, for joining us to explore diagnostic and therapeutic considerations for polymyalgia rheumatica. Dr. Dua and Ms. Mixon, it was great speaking with you both today.

Dr. Dua:
Thank you very much. I really enjoyed our conversation.

Ms. Mixon:
Thank you for having me. It was my pleasure.

Dr. Caudle:
Im your host, Dr. Jennifer Caudle.

ReachMD Announcer:
This program was brought to you by Sanofi and Regeneron. If you missed any part of this discussion, visit ReachMD.com/IndustryFeature. This is ReachMD. Be Part of the Knowledge.

References

1. Algeria G, Boukhlal S, Cornec D, Devauchelle-Pensec V. The pathophysiology of polymyalgia rheumatica, small pieces of a big puzzle. *Autoimmun Rev.* 2020; 19(11):6. doi:10.1016/j.autrev.2020.102670
2. Bartoloni E, Pucci G, Alunno A, Gerli R, Shchillaci G. Chapter 9: Polymyalgia Rheumatica. In: Nussinovitch U, ed. *The Heart in Rheumatic, Autoimmune and Inflammatory Diseases.* 1st edition. Elsevier; 2017:213-231.
3. Bin-Mahmoud S, Nelson E, Padniewski J, Nasr R. Polymyalgia rheumatica: an updated review. *Cleve Clin J Med*. 2020; 87(9):553. doi:10.3949/ccjm.87a.20008
4. Camellino D, Duftner C, Dejaco C. New insights into the role of imaging in polymyalgia rheumatica. *Rheumatology.* 2021;60(3):1016-1033. doi:10.1093/rheumatology/keaa646
5. Dejaco C, Singh YP, Perel P. 2015 Recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. *Ann Rheum Dis*. 2015;74:1799-1807. doi:10.1136/annrheumdis-2015-207492
6. Dejaco C, Brouwer E, Mason JC, Buttgereit F, Matteson EL, Dasgupta B. Giant cell arteritis and polymyalgia rheumatica: current challenges and opportunities. *Nature Reviews Rheumatology*. 2017;13(10):578-592. doi:10.1038/nrrheum.2017.142
7. Floris A, Piga M, Cauli A, Salvarani C, Mathieu A. Polymyalgia rheumatica: an autoinflammatory disorder? *RMD Open.* 2018;4(1):e000694. doi:10.1136/rmdopen-2018-000694
8. Floris A, Piga M, Chessa E, et al. Long-term glucocorticoid treatment and high relapse rate remain unresolved issues in the real-life management of polymyalgia rheumatica: a systematic literature review and meta-analysis. *Clinical Rheumatology*. 2022;41(1):19-31. doi:10.1007/s10067-021-05819-z
9. Gonzalez-Gay MA, Matteson EL, Castañeda S. Polymyalgia rheumatica. *Lancet.* 2017;390(10103):1700-1712. doi:10.1016/S0140-6736(17)31825-1
10. Hodgens A, Sharman T. Corticosteroids. StatPearls. Updated July 26, 2022. Accessed October 11, 2022 https://www.ncbi.nlm.nih.gov/books/NBK554612/
11. Korkmaz C, Yıldız P. Giant cell arteritis, polymyalgia rheumatica, and late-onset rheumatoid arthritis: Can they be components of a single disease process in elderly patients? *European Journal of Rheumatology*. 2017;4(2):157-160. doi:10.5152/eurjrheum.2016.039
12. Lopez-Hoyos M. Clinical utility of anti-CCP antibodies in the differential diagnosis of elderly-onset rheumatoid arthritis and polymyalgia rheumatica. *Rheumatology*. 2004;43(5):655-657. doi:10.1093/rheumatology/keh143
13. Matteson EL, Dejaco C. Polymyalgia rheumatica. *Ann Intern Med*. 2017;166(9):ITC65-ITC80. doi:10.7326/AITC201705020
14. Milchert M, Brzosko M. Diagnosis of polymyalgia rheumatica usually means a favourable outcome for your patient. *Indian J Med Res.* 2017;145(5):593-600. doi:10.4103/ijmr.IJMR_298_17
15. National Cancer Institute. Cancer of the Colon and Rectum - Cancer Stat Facts. SEER. Published 2018. https://seer.cancer.gov/statfacts/html/colorect.html
16. Prior JA, Ranjbar H, Belcher J, et al. Diagnostic delay for giant cell arteritis – a systematic review and meta-analysis. *BMC Medicine*.

2017;15(1). doi:10.1186/s12916-017-0871-z
17. Raheel S, Shbeeb I, Crowson CS, Matteson EL. Epidemiology of Polymyalgia Rheumatica 2000–2014 and Examination of Incidence and Survival Trends Over 45 Years: A Population-Based Study. *Arthritis Care & Research*. 2017;69(8):1282-1285. doi:10.1002/acr.23132

MAT-US-2209555-V1.0-03/2023