SIR, It is time to take a fresh look at polymyalgia rheumatica (PMR). PMR is a clinical syndrome of unknown aetiology, and is characterized by aching, pain and stiffness in the proximal muscle groups, namely the shoulder and pelvic girdles and the neck. PMR usually occurs in the over fifties and often presents a ‘challenge’ because of the lack of definitive diagnostic criteria, the large number of differential diagnoses, atypical clinical features and lack of conformity in therapeutic regimes.

Epidemiological studies have shown that the incidence of PMR varies, and that this increases with age. The incidence per 100 000 of the population aged above 50 yr has been reported between 12.7 and 68.3, and would appear to be more common in Scandinavia and North America [1]. The estimated prevalence of PMR is 0.5% in people over 50 in North America [2] and as much as 2% in people over 60 in the UK [3].

As PMR can mimic a number of different clinical conditions it is essential that any effective strategy directed at this condition should have clear criteria, which enable the diagnosis to be made. Currently there are a number of different criteria sets, all of which differ slightly. The main sets of criteria used are shown in Table 1. The Hunder [2], Healey [4], and Jones/Hazleman [5] criteria require the presence of all the listed features for the diagnosis of PMR. The Healey criteria broadly include the features of the Hunder criteria, but also the presence of morning stiffness, and a rapid therapeutic response to steroids. The attraction of the Bird [6] criteria lies in its practical application in clinical practice, as the presence of just three features confers a sensitivity of 92% and specificity of 80% in the diagnosis of PMR.

At the European Congress of Rheumatology held in Prague in June 2001, experts met in an attempt to develop a consensus opinion on the diagnosis and management of PMR. Data from over 200 patients, judged by a consensus opinion of experts to have PMR, were compared against the commonly used diagnostic criteria sets. Using the Bird criteria, along with the additional criterion of a brisk response to oral steroids, provided a sensitivity of 99% in the diagnosis of PMR [7].

There is likewise a lack of clear agreement regarding which criteria to use in assessing remission. A range of clinical and serological features which might indicate remission were examined and these included visual analogue scale (VAS) pain score, VAS physician assessment, morning stiffness, elevation of upper limbs, myalgia, tenderness on pressure of upper or lower limbs, response time after initiation of steroids, headache and masseter muscle claudication. Serological markers analysed were erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), haemoglobin, serum iron and $\alpha_2$-globulin. The best indicators for remission of PMR were improvements in three or more of the following five criteria: VAS pain score, CRP or ESR, early morning stiffness, elevation of upper limbs and physician’s global assessment [8].

A further issue of clinical importance might lie in determining the severity of the disease at an early stage. Subjects with more severe disease may require steroids for longer periods, and it may be more difficult to ‘wean off’ steroids in this group. In a preliminary study...
involved 30 patients, the severity of PMR could be determined by using a combination of ESR and interleukin-6 (IL-6) levels [9]. Patients with mild disease had an ESR < 50 mm/h and normal IL-6 levels; those with moderate or severe disease had an ESR > 50 mm/h with either a moderately or strongly elevated IL-6 level. Thus, IL-6 levels in combination with the ESR may be of value in determining disease severity and in predicting the outcome in subgroups of patients with PMR.

Studies undertaken to evaluate the management of PMR have shown that there is considerable variation in the approach to the diagnosis and management of this condition [10]. In a practical sense, patients may, therefore, end up with a widely fluctuating steroid dosage, and may ‘yo-yo’ between high and low doses of steroids. As a result, there is a higher chance that they may incur side-effects or become steroid-dependent in the long term.

The overarching objective of any clinical management strategy is to improve patient care. We believe that the management of PMR lends itself ideally to a ‘building bridges’ approach, by developing a partnership between health care providers across the primary and secondary care divide. The ethos of such an approach is based on the implementation of the principles of clinical governance in primary and secondary care, and aims to facilitate best practice. However, such an approach needs to be underpinned by a consensus opinion on the diagnostic and remission criteria of PMR, and also needs to be followed by appropriately structured interface audits to demonstrate continuous improvement.

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Table 1. The main sets of diagnostic criteria for PMR

<table>
<thead>
<tr>
<th>North American diagnostic criteria</th>
<th>UK diagnostic criteria</th>
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<tbody>
<tr>
<td>All of the below required for the diagnosis of PMR</td>
<td>All of the below required for diagnosis of PMR</td>
</tr>
<tr>
<td>Age &gt; 50 yr</td>
<td>Age &gt; 50 yr</td>
</tr>
<tr>
<td>ESR &gt; 40 mm/h</td>
<td>ESR &gt; 30 mm/h or CRP &gt; 6 mg/l</td>
</tr>
<tr>
<td>Bilateral aching and stiffness &gt; 1 month involving at least two of the following areas: neck, torso, shoulders or proximal regions of hips or proximal regions of thighs</td>
<td>Shoulder and pelvic girdle pain</td>
</tr>
<tr>
<td>Exclusion of other diagnoses causing ‘secondary’ PMR</td>
<td>Bilateral upper arm tenderness</td>
</tr>
<tr>
<td>Morning stiffness &gt; 1 h</td>
<td>Morning stiffness &gt; 1 h</td>
</tr>
<tr>
<td>Rapid response to prednisolone (&lt; 20 mg/day)</td>
<td>Rapid response to steroids</td>
</tr>
<tr>
<td>Depression and/or weight loss</td>
<td></td>
</tr>
</tbody>
</table>

*Time of onset to maximal stiffness less than 2 weeks.