The authors stated that at the time of the second US examination after starting prednisone (about a mean of \(~24\) weeks), \(59\%\) of patients in remission or with low disease activity still had US evidence of persistent inflammatory lesions. This observation contrasts with the results of previous works from the same group, in which MRI findings dramatically improve in only 1 week after starting therapy \[2\].

Moreover, the dramatic response to corticosteroids of PMR lesions was used to justify the significant lower subacromial–subdeltoid (SA–SD) bursitis frequency (ranging from 16 to 70\%) reported in previous US studies \[3–6\], with respect to their observations (frequency ranging from 96 to 100\%) \[2, 7\]. In fact, the authors proposed to explain the lower frequencies of SA–SD bursitis in these previous PMR series with the probable use of corticosteroids before US examination.

The US persistence of SA–SD bursitis despite corticosteroid treatment gives a new validity to the results of these previous series and this could reopen the debate on the real frequency of SA–SD bursitis in PMR at onset and, consequently, on the real accuracy of this finding for the diagnosis of PMR.

In a recent work of our group (data not published) we confirm a 79\% frequency of SA–SD bursitis in PMR at onset, lower than was observed by Salvarani’s group \[2, 7\]. Our result supports that SA–SD bursitis is a cardinal feature of PMR, but with moderate accuracy to differentiate at-onset PMR patients from patients with chronic arthritides of other nature. We also proposed to use US and PDUS to make a multi-district screening in order to obtain more findings, possibly indicating other diagnosis than PMR (active synovitis of wrist, MCP and MTP joints for elderly onset RA, enthesitis for elderly onset SpA, menisci and tendon calcifications for crystal-related arthritides).

The surprising persistence of inflammatory findings in PMR shoulders (59\% of patients in remission or with low disease activity) also with positive PD signals, after a mean of 24 weeks with prednisone therapy seems a strong indicator for chronic synovitis, and a diagnosis of chronic arthritis should be considered. An analysis of SF would be useful in these situations, to also exclude crystal-related arthritis, which is reported as a condition frequently mimicking PMR \[8\].

Moreover, protracted active shoulder synovitis (with PD signals) unresponsive to corticosteroids, could induce secondary joint changes such as juxta-articular osteoporosis, capsular and ligamentous degeneration with joint instability, regardless of diagnosis. In our opinion, this situation should induce clinicians to introduce DMARDs to prevent disease progression and joint damage.

Disclosure statement: The authors have declared no conflicts of interest.

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References


Letters to the Editor

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Comment on: Longitudinal examination with shoulder ultrasound in patients with polymyalgia rheumatica: reply

Sir, We have read with interest the comments of Falsetti et al. \[1\] on our article on the longitudinal ultrasound (US) evaluation of PMR patients during corticosteroid treatment \[2\]. Their observations are relevant and some explanation is needed in response.

Our previous longitudinal study \[3\] on PMR patients cited by Falsetti et al. is an MRI study conducted in a small group of patients after repeated shoulder bilateral injection of CSs, so its results are not directly comparable with those obtained in this study on patients treated with continuous oral CS and studied with ultrasonography (US).
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