

Summary of the BSR guideline for the treatment of polymyalgia rheumatica

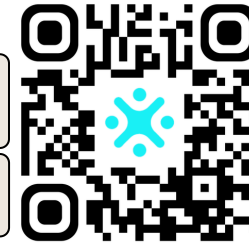


Continuous Education & Support

 Diagnosis of typical PMR (clinical features, inflammatory markers $\pm$ imaging)

 Start GCs: Prednisolone 12.5–15mg daily
+ initiate bone protection unless contraindicated

For all people with newly diagnosed PMR, discuss the option of referral to rheumatology to consider adding methotrexate (MTX).



[Refer to rheumatology for diagnostic review](#)

If diagnosis uncertain, atypical features* (see below), age ≤ 55 years, features of GCA $\ddagger$ (see below)

 Assess clinical response at 1–2 weeks

 Good clinical response

Partial clinical response

No response or partial response to high-dose GCs/Contraindication to GCs

[Refer to rheumatology to consider GC-sparing therapy](#)

Rheumatology can consider starting MTX/IL-6R antagonist in those who have relapsed, are at higher risk of GC toxicity, or have had an inadequate response to or are unable to taper GCs.

 Increase prednisolone dose up to 25mg/day

 Start prednisolone taper
2.5mg every 2–4 weeks until 10mg then, 1mg every 4–8 weeks
OR
To consider a faster taper at 1mg/2–3 weeks in some individuals

 Continued clinical remission

One relapse

Two relapses
Prolonged GC therapy (≥ 18 months)

 Aim to discontinue GC therapy

Consider discussion with rheumatology to re-evaluate diagnosis or consider GC-sparing therapies

PMR, polymyalgia rheumatica; GCA, giant cell arteritis; GCs, glucocorticoids; MTX, methotrexate; IL-6R, interleukin-6 receptor; CRP, C-reactive protein.

Atypical features*:

- Joint swelling
- Fever
- Night sweats
- Significant weight loss
- Unilateral symptoms
- CRP ≥ 100 mg/L

GCA symptom $\ddagger$:

Headache, scalp tenderness, thickening or pain in temporal arteries, jaw claudication, visual loss or double vision

$\ddagger$ Requires immediate specialist review