Polymyalgia rheumatica: Not well understood, but important to consider

The disease first described by Bruce[1] in 1888 as "senile rheumatic gout" and known since 1957 as "polymyalgia rheumatica"[2] is a great example of a nosological entity that we recognize as a syndrome, but about which our knowledge has, for practical purposes, evolved very little in the past 100 years.

As Dr. Brian Mandell elegantly describes on page 489 of this issue,[3] polymyalgia rheumatica, or PMR for short, is recognized by its symptoms and setting, not by any specific test or marker of disease. The name has changed several times through the years—rhizomelic pseudoarthrosis, humeroscapular periarthrosis, and anarthritic rheumatoid syndrome are just a few—depending on the current theory about its cause, and based more on what we think it *isn't* (ie, gout, rheumatoid disease) than on what we think it is.

Research into the nature of PMR and its relationship to giant cell arteritis and to other conditions continues.[4] Its genetics have been explored and immunological and infectious mechanisms have been investigated, but not much useful information has emerged. The cause and pathogenesis remain unknown (as with fibromyalgia, another musculoskeletal syndrome about which we know little of substance), and the treatment (prednisone) remains symptomatic.

So why is this disease important? First, it is relatively common in older people, and so is likely to become more common as the population ages. Second, it responds quickly (and usually completely) to treatment, although there are exceptions. Third, as Dr. Mandell points out, it may be accompanied by a much more onerous condition, giant cell arteritis, which must be recognized and treated as a medical emergency to avoid some nasty and often permanent sequelae such as blindness. Prednisone works for that, too, although the required dosage is higher (though how much higher is still controversial), but no dose of prednisone is sufficient to reverse blindness, once it occurs.

It is therefore important for the internist, particularly one who deals with elderly patients, to be aware of PMR and to ascertain the likelihood that any patient suspected of having it might also have giant cell arteritis. Failure to make this diagnosis and start treatment in a timely manner can have serious long-term implications—medically for the patient and medicolegally for the physician.

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REFERENCES

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