

The management of patients with polymyalgia rheumatica: limitations to get it right

Sirs,

We read with interest the editorial article recently published by Mukhtyar *et al.* (1). We thank the authors for their considerations and suggestions about “getting it right for polymyalgia rheumatica (PMR)”. The authors suggested integrating pathways to improve the diagnostic accuracy of patients suspected to have PMR to reduce reliance on trials of glucocorticoids (GCs). According to their viewpoint, PMR might be relatively straightforward to manage, providing the diagnosis is correct.

The general practitioner (GP) is usually the first clinician to care for patients with PMR and most patients are not referred to rheumatologists. In a study from the UK, only 17% of the suspected PMR patients underwent specialist consultant evaluation (2). On the other hand, the level of the GP’s diagnostic accuracy is usually low. In a cohort-study from Italy, the percentage of misdiagnosis of PMR was reported to be as high as up to > 85 % (3). Possible explanations are that PMR is scarcely present in the GP’s routine clinical practice, with only 1-2 cases of PMR presenting to the GP per year, and that the GPs are not always satisfactorily trained (3, 4).

Misdiagnosis leads to serious consequences. For instance, several PMR patients may not receive a correct diagnosis and several no-PMR patients may undergo an inappropriate treatment with GCs (5). In addition, even if the patient is correctly diagnosed, GPs may face several clinical challenges because the response to GC treatment is not always linear (6, 7).

We understand that secondary healthcare is rationed in some countries due to different healthcare structures and workloads. However, bearing these challenges to the GPs and the other considerations highlighted by Mukhtyar *et al.* in mind, a different approach should be discussed in which the patients with PMR should be referred to rheumatologists during the initial management of PMR. Not just when atypical findings and/or lack of response to GCs are present, as in the case in most cases.

Rapid access to rheumatologists for patients suspected of PMR has been proposed as a solution. Its feasibility depends on the resources of the national health systems,

which are heterogeneous. The availability of well-experienced rheumatology outpatient clinics with clinical and ultrasound (US) examination expertise is mandatory because if it is true that diagnosis of PMR is primarily based on clinical observation, it is equally true that US examination can provide useful information (8-10).

GPs engagement and training should be prioritised to improve PMR diagnosis at the primary healthcare level. While fixed algorithms are useful, they cannot replace shared learning. Meetings between GPs and rheumatologists should be planned more frequently because learning-based collaboration is critical to reducing the overburdening of rheumatology clinics and ensuring the delivery of economically unsustainable care to PMR patients. The organisation of these meetings is possible even when there are limited funds available.

Telemedicine may be a viable aid for rheumatologists to fast track and provide accurate patient management and timely decisions where there is diagnostic or treatment uncertainty. Telemedicine may also aid in the provision of assistance to GPs who care for PMR patients, at their request.

In conclusion, we agree with Mukhtyar *et al.*’s primary concerns about PMR diagnosis. Our overall opinion is that it is time to change how we deliver PMR management because the current PMR care is inadequate and unsatisfactory. We are concerned that if PMR is not primarily managed by the rheumatologists, it will continue to be misdiagnosed, jeopardising patient outcome and satisfaction and resulting in long-term morbidity.

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