Reply:
Who can get it right for polymyalgia rheumatica?

Sirs,
Polymyalgia rheumatica is a unique disease. It is thought to be one of the most common autoinflammatory musculoskeletal disease with an annual incidence as high as 112.6/100,000 population above the age of 50 (1). Despite that, it is a poorly researched and commonly misdiagnosed condition. We have recently called for a paradigm shift in how this condition is managed (2). I thank Manzo et al. for their interest and engagement with our thoughts in their letter to this journal (3).

There is broad agreement between us that there is low security of diagnosis in the way that polymyalgia rheumatica is currently managed. We agree that misdiagnosis has serious consequences. However, we disagree slightly about blanket referral to rheumatology for all individuals with suspected polymyalgia rheumatica. Polymyalgia rheumatica is a difficult diagnosis to make but may be managed very satisfactorily by any individual who has an interest and expertise in the condition. This may be a rheumatologist in most instances, but equally may be an internist, a geriatrician, or a primary care physician. Equally, a rheumatologist without a special interest in polymyalgia rheumatica may use empirical glucocorticoid therapy without diligent investigations. The stress should be laid on designing treatment early was unrealistic for most patients (5). Proposed strategies to facilitate early diagnosis in primary care were challenged (6). But over time, capacities were built and now a referral within 3 days of suspicion of inflammatory arthritis has become a national standard in the UK (https://www.nice.org.uk/guidance/qs33/chapter/Quality-statement-1-Referral).

Manzo et al. advocate the use of telemedicine. We have recently published guidance on the use of teledmedicine in rheumatology (7). During the systemic literature review for that topic, we did not find any polymyalgia rheumatica specific study (8). Telemedicine would certainly facilitate pre-diagnostic processes and in some instances ruling out a diagnosis of polymyalgia rheumatica, but a diagnosis should always be established in a face-to-face visit after clinical examination (7).

We have subtle differences in our thoughts, but I am of one mind with Manzo et al. that the current status quo must change. It will require collaboration with our partners in primary care to facilitate early recognition, a work-up for differential diagnosis and a tailored plan for the use of glucocorticoid use.

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References