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 algorithms that transcend the barriers of speciality and arena of practice. The skill set is more important than the speciality of the clinician. We have recently published quality standards for the care of people with giant cell arteritis and used this principle of ensuring the skill set rather than a particular speciality (4). However, I agree with Manzo *et al*. that in a particular region, if the best clinician happens to be a rheumatologist than we should not be afraid of creating pathways to refer all suitable patients without worrying about rationing of healthcare. We must not be afraid of doing the right thing because of capacity issues. It was not very long ago that the diagnosis of rheumatoid arthritis was routinely delayed for several months. Chan *et al*. even concluded that the goal of initiating 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 tele-medicine. We have recently published guidance on the use of telemedicine 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.

C.B. Mukhtyar, *MD, PhD*

Vasculitis Service, Rheumatology Department, Norfolk and Norwich University Hospital NHS Foundation Trust, Norwich, UK.

Please address correspondence to:
Chetan B. Mukhtyar
Rheumatology Department,
Norfolk and Norwich University Hospital,
Colney Lane,
Norwich NR4 7UY, United Kingdom.
E-mail: chetan.mukhtyar@nnuh.nhs.uk

Competing interests: none declared.

Clin Exp Rheumatol 2023; 41 (Suppl. 135): S23.

References

1. GRAN JT, MYKLEBUST G: The incidence of polymyalgia rheumatica and temporal arteritis in the county of Aust Agder, south Norway: a prospective study 1987-94. *J Rheumatol* 1997; 24(9): 1739-43.
2. MUKHTYAR CB, TWOHIG H, HODGSON H: Getting it right for polymyalgia rheumatica. *Rheumatology* (Oxford) 2022; 61(11): 4221-2. https://doi.org/10.1093/rheumatology/keac187
3. MANZO C, NATALE M, NUNE A, CASTAGNA A: The management of patients with Polymyalgia Rheumatica: limitations to get it right. *Clin Exp Rheumatol* 2023; 41 (Suppl. 135): S22. https://doi.org/10.55563/clinexprheumatol/dxmvl1
4. COATH F, BUKHARI M, DUCKER G *et al*.: Quality standards for the care of people with giant cell arteritis in secondary care. *Rheumatology* (Oxford) 2023; 62(9): 3075-83. https://doi.org/10.1093/rheumatology/kead025
5. CHAN KW, FELSON DT, YOOD RA, WALKER AM: The lag time between onset of symptoms and diagnosis of rheumatoid arthritis. *Arthritis Rheum* 1994; 37(6): 814-20. https://doi.org/10.1002/art.1780370606
6. KORN JH: Diagnosis of arthritis by primary care providers versus rheumatologists: comment on the article by Chan et al. *Arthritis Rheum* 1995; 38(3): 448-9. https://doi.org/10.1002/art.1780380330
7. DE THURAH A, BOSCH P, MARQUES A *et al*.: 2022 EULAR points to consider for remote care in rheumatic and musculoskeletal diseases. *Ann Rheum Dis* 2022; 81(8): 1065-71. https://doi.org/10.1136/annrheumdis-2022-222341
8. MARQUES A, BOSCH P, DE THURAH A *et al*.: Effectiveness of remote care interventions: a systematic review informing the 2022 EULAR Points to Consider for remote care in rheumatic and musculoskeletal diseases. *RMD Open* 2022; 8(1): e002290. https://doi.org/10.1136/rmdopen-2022-002290