

A Difficult Case of Polymyalgia Rheumatica

To the Editor:

We read with great interest the article by Mazzantini, *et al*¹ that assessed the occurrence of adverse events in patients with polymyalgia rheumatica (PMR) treated with low-dose glucocorticoids (GC). They found that longterm, low-dose GC treatment of PMR is associated with serious adverse events. PMR is an inflammatory rheumatic disease of elderly people that is characterized by aching and stiffness in shoulder and pelvic girdle. The incidence of PMR increases with age, peaking in the 70 to 80-year age group². The response to systemic GC therapy is usually rapid but longterm GC treatment may be necessary to maintain clinical improvement. Patients with PMR frequently experience relapses that make management of the disease more difficult. Prolonged GC use can be associated with various adverse events. Methotrexate (MTX) has been proposed as a steroid-sparing drug in treatment of PMR^{3,4}.

We would like to share our experience with an elderly patient with PMR who suffered gastrointestinal (GI) bleeding and used oral anticoagulant therapy because of atrial fibrillation. A man aged 78 years experienced upper GI bleeding after nonsteroidal antiinflammatory drug use for shoulder pain. He had a history of peptic ulcer disease and medication with warfarin for atrial fibrillation. He had stomach ulcer without dysplasia on endoscopic examination. After stabilization for bleeding he was evaluated for shoulder pain. He reported increasing pain and stiffness in his shoulder and pelvic girdle over 1 month. Blood tests showed erythrocyte sedimentation rate (ESR) 69 mm/h, C-reactive protein (CRP) 51 mg/l, white blood cell count 8000/mm³ (reference range 5.2–11.4/mm³), hemoglobin 9.7 g/dl (reference range 13–17 g/dl), and platelet count 285,000/mm³ (reference range 130,000–400,000/mm³). He was diagnosed as having PMR because he fulfilled the standard criteria⁵. Then he was treated with oral prednisolone 15 mg daily, pantoprazol (PPI) 2 × 40 mg intravenous/day, MTX 15 mg subcutaneous/week, and folic acid 5 mg/week. Symptoms improved within 48 hours with no evidence for re-bleeding. ESR and CRP values decreased in 7 days and the steroid dose was reduced to 7.5 mg; 3 weeks later steroid dose was reduced to 5 mg. He was followed with subcutaneous

MTX 15 mg, oral PPI, and daltacortril 5 mg treatment for 4.5 months. After that his steroid therapy was stopped completely and he has been followed without relapse for 6 months.

PMR is seen in older age groups who may have many comorbid diseases. This situation makes patients' treatment and followup difficult. We suggest that MTX can be effective in treatment of PMR when the drug is started at disease onset, to avoid side effects of steroid therapy.

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J Rheumatol 2012;39:8; doi:10.3899/jrheum.120146