



Polymyalgia Rheumatica

Polymyalgia rheumatica (PMR) is a relatively common cause of widespread aching and stiffness in older adults. It can be difficult to diagnose because it rarely causes swollen joints or other abnormalities on physical exam. It may occur with another condition, [giant cell arteritis](#).

Fast facts

- PMR affects adults over the age of 50.
- The symptoms of PMR are aching and stiffness, worse on arising in the morning, affecting the upper arms, neck, buttocks, and thighs.
- Symptoms usually respond promptly and completely to low doses of corticosteroids.

What is polymyalgia rheumatica?

The typical symptoms of polymyalgia rheumatica (PMR) are aching and stiffness around the upper arms, neck, lower back and thighs. Symptoms tend to develop quickly, over a period of several days or weeks, and occasionally even overnight. Both sides of the body are affected. Involvement of the upper arms, with difficulty raising them above the shoulders, is especially common.

Aching and stiffness are much worse in the morning, and tend to improve gradually as the day goes by, but periods of inactivity, such as a long car ride or sitting too long in one position, will cause stiffness to return. Stiffness may be so severe that there is pain at night, problems getting dressed in the morning (for example, putting on a jacket or bending over to pull on socks and shoes), or difficulty getting up from a low chair. Occasionally, aching occurs in distal joints such as those of the hands and wrists.

What causes polymyalgia rheumatica?

The cause of PMR is unknown. PMR does not arise from side effects of medications. The tendency for symptoms to begin abruptly suggests the possibility of an infection but, so far, no specific infection has been found. “Myalgia” comes from the Greek word for “muscle pain,” but specific tests of the muscles, such as an enzyme test (a type of blood test) or actual biopsy, are all normal.

PMR has a particular tendency to involve the shoulder and hip joints, and the bursae (or sacs) around these joints. Pains at the upper arms and thighs thus come from the nearby shoulder and hip joints, and



represent what rheumatologists call “referred pain.” PMR should not be confused with [fibromyalgia](#), a poorly understood condition that affects mainly younger adults and is not a form of arthritis.

Who gets polymyalgia rheumatica?

PMR occurs only in older adults and very rarely in people younger than 50. The average age of onset of symptoms is 70, so people who have PMR may be in their 80s or even older. Women are affected somewhat more often than men, and the disease is more frequent in whites than nonwhites, but all races are susceptible. PMR is not unusual; in fact, as a new diagnosis it is more common in older adults than rheumatoid arthritis.

How is polymyalgia rheumatica diagnosed?

In PMR, results of blood tests to detect inflammation are usually abnormally high. One such test is the erythrocyte sedimentation rate, or “sed rate.” Another is the C-reactive protein, or CRP. Both of these tests are typically significantly elevated in PMR but, in a small proportion of patients, these tests may be normal or only slightly increased.

How is polymyalgia rheumatica treated?

If the diagnosis of PMR is strongly suspected, a trial of low-dose corticosteroids is given, usually in the form of 10 to 15 mg of prednisone (*Deltasone*, *Orasone*, etc.) per day. If PMR is present, stiffness is quickly relieved. The response to corticosteroids can be dramatic – sometimes patients are better after only one dose – but improvement can be slower. However, if symptoms have not been completely relieved after 2-3 weeks of treatment, the diagnosis of PMR must be called into question and other diagnoses considered. Unfortunately, non-steroidal anti-inflammatory drugs (commonly called “NSAIDs”), such as ibuprofen (*Advil*, *Motrin*, etc.) and naproxen (*Naprosyn*, *Aleve*), are ineffective in the initial treatment of PMR.

When symptoms have been controlled, the dose of corticosteroid medication is decreased gradually. The goal is to find the lowest dose that keeps an individual comfortable. Some people can stop corticosteroids within a year, but many will need a small amount of this medication for 2-3 years, to keep aching and stiffness under control. Recurring symptoms are not unusual. Because the symptoms of PMR are so sensitive to even small changes in the dose of corticosteroids, the gradual decrease of this medication should be directed by the physician.

Living with polymyalgia rheumatica

Once stiffness has subsided, normal activities can be resumed, including exercise as tolerated. Even low doses of corticosteroids can cause side effects, including higher blood sugars, weight gain, sleeplessness,



In PMR, the aching is located primarily around the shoulders and hips.



[osteoporosis](#) (bone loss), cataracts, thinning of the skin and bruising. Monitoring for these problems, including bone density testing, is an important part of regular follow-up visits with the physician. Medication may be needed to prevent osteoporosis in older patients.

Because PMR can be associated with a more serious condition, [giant cell arteritis](#), a patient who has PMR should immediately contact the physician if there are symptoms of headache, changes in vision, or fever.

Points to remember

- Aching and stiffness tend to come on quickly in PMR, and are especially common about the shoulders and upper arms.
- Symptoms are worse at night and on rising in the morning.
- Symptoms respond briskly to low doses of corticosteroids, but may recur as the dose is lowered.

The rheumatologist's role in the treatment of polymyalgia rheumatica

PMR may be difficult to diagnose. Rheumatologists are specialists in musculoskeletal disorders and, therefore, are more likely to make a proper diagnosis as well as expertly manage medications to minimize side effects.



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To find a rheumatologist

For more information about rheumatologists, [click here](#).

Learn more about [rheumatologists](#) and [rheumatology health professionals](#).

For more information

The American College of Rheumatology has compiled this list to give you a starting point for your own additional research. The ACR does not endorse or maintain these Web sites, and is not responsible for any information or claims provided on them. It is always best to talk with your rheumatologist for more information and before making any decisions about your care.

The Arthritis Foundation

<http://www.arthritis.org>

National Library of Medicine

<http://www.nlm.nih.gov/medlineplus/polymyalgiarheumatica.html>

National Institute of Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse

http://www.niams.nih.gov/Health_Info/Polymyalgia/default.asp



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Written by William P. Docken, MD, and reviewed by the American College of Rheumatology Patient Education Task Force.

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