Q&A: What has changed in the new BSR guideline for PMR?

Introduction

The British Society for Rheumatology (BSR) has published updated guidance on treating polymyalgia rheumatica (PMR), the first major update since 2009. We've put together this Q&A to explain what the guidance covers, what is different from the 2009 version, and what it may mean in practice for people living with PMR.

This Q&A is a general summary for patients and carers. It isn't medical advice, and the guideline is written for healthcare professionals. Please don't change or stop any medication without speaking to your GP or specialist team.

1. What is the BSR guideline and who is it for?

It is guidance for healthcare professionals in the UK on how to treat PMR in adults. It was developed by a group of rheumatologists, GPs, nurses, physiotherapists, pharmacists and people with lived experience of the condition, and it is endorsed by the Primary Care Rheumatology & Musculoskeletal Medicine Society (PCRMM) and the Royal College of General Practitioners (RCGP). It gives doctors and nurses an evidence-based framework, but treatment should always be tailored to you.

2. Why was the guideline updated?

The previous BSR guideline was published in 2009. A lot of research has been done since then. We now know more about how often PMR relapses when steroids are reduced, how common steroid side effects are, and whether other medicines can help. Steroids work well for most people, but evidence suggests many people relapse while reducing their dose, and a large proportion experience side effects.

3. Does the guideline change how PMR is diagnosed?

No. The update covers **treatment and management** of people with confirmed PMR. It does not replace the diagnostic advice in the 2009 guideline.

4. Are steroids still the main treatment?

Yes. Steroid tablets (prednisolone) remain the main treatment, as they were in 2009. What has changed is the emphasis on using them carefully: starting and reducing doses in a planned way, watching for side effects, and thinking earlier about other options if steroids are causing problems or you keep relapsing.

5. How has the advice on starting and reducing steroids changed?

2009: The guideline recommended a starting dose of 15 mg prednisolone a day, reducing to 12.5 mg after three weeks and 10 mg after a further three weeks, then 10 mg for 4 to 6 weeks, and after that reducing by 1 mg every 4 to 8 weeks. Treatment was expected to last 1 to 2 years.

Now: The new guideline includes recommendations on how steroids should be started and reduced, and recognises that many people relapse during tapering. It also looks at options for a faster taper which start with 12.5–15 mg daily, increasing to a maximum of 25 mg daily if needed; once symptoms have been controlled for 2–4 weeks, reduce by 2.5 mg every 2–4 weeks to 10 mg; then reduce by 1 mg every 4–8 weeks; for people at high risk of steroid toxicity, a faster taper may be considered—for example, 1 mg every 2–3 weeks, aiming to stop within six months of initial disease control.

Please don't change your own dose. Your team will tell you what is right for you.

6. What does the guideline say about relapses?

2009: If PMR symptoms returned, the advice was to go back up to the previous higher dose of prednisolone (or give a single steroid injection). A steroid-sparing medicine (a DMARD) was suggested for consideration after **two** relapses.

Now: The new guideline encourages healthcare professionals to **consider rheumatology input earlier after a relapse** by returning to the last effective prednisolone dose for 2–4 weeks, then consider a slower taper; consider discussing the person with rheumatology after any relapse, using a pathway such as NHS Advice and Guidance; refer to rheumatology after a second relapse. rather than waiting until someone has been on steroids for a long time. Many people relapse while reducing their dose, and the aim is to avoid repeated cycles of higher doses.

7. Are there other medicines besides steroids?

2009: Other medicines were mentioned only briefly, as something to consider after two relapses.
Now: The guideline is much clearer about when other medicines may be considered for selected people:

- **Methotrexate** (a tablet that calms the immune system) may be considered **early** in selected people, rather than only after repeated relapses.
- **IL-6 receptor antagonists** (a newer type of biologic medicine) has been marked as something that may be considered in the future.

Not everyone will need these. Your specialist will discuss whether they could be suitable for you.

8. Does the guideline say anything about protecting bones?

Yes. Steroids can thin the bones over time, and bone protection is highlighted as an important part of PMR care.
2009: Bone protection was based on risk. People aged 65 or over, or who had previously had a fragility fracture, were advised to have a bone-protecting medicine plus calcium and vitamin D. Others were advised to take calcium and vitamin D and have a bone density (DEXA) scan.
Now: Prescribe bisphosphonates for people with PMR starting glucocorticoid therapy unless contraindicated. Adequate calcium and vitamin D status should also be ensured. This is stronger than simply saying bone health is placed at the centre of care. Ask your GP or specialist about your own bone health if it hasn't been discussed.

9. How will side effects be monitored?

2009: Regular reviews were suggested in the first year (weeks 0, 1 to 3 and 6, then months 3, 6, 9 and 12) to check response, side effects and symptoms of giant cell arteritis (GCA).
Now: The new guideline puts more emphasis on **monitoring for steroid side effects** (such as raised blood pressure, raised blood sugar, bone thinning, weight gain and mood or sleep changes) generally at least three-monthly review during the first year; more frequent review during a faster taper;
thereafter, an annual review as a minimum, adapted to individual need. It covers bone health, diabetes, cardiovascular risk, eye checks, weight, mental health, sleep, fatigue, infection risk and vaccinations, as well as steroid sick-day rules. If you notice new symptoms while taking steroids, tell your healthcare team.

10. When should someone with PMR be referred to a rheumatologist?

2009: Referral was advised mainly for atypical features (for example, onset under 60 years old), poor response to steroids, being unable to reduce the dose, or needing steroids for longer than two years.
Now: The guideline gives practical thresholds for **discussing or referring** people to rheumatology and advises considering this **earlier**, particularly after a relapse. In addition to relapse, the guideline text says rheumatology input is advisable where tapering is complicated by possible withdrawal or adrenal insufficiency, and states that patients should be referred after 18 months or more of steroid therapy. Referral may also be appropriate earlier for diagnostic uncertainty, atypical features, treatment toxicity, clinical complexity or inadequate response.

11. What does the guideline say about patient information and shared decision-making?

This is a bigger theme than in 2009. The guideline stresses that:

- treatment decisions should be made **together** with you, based on your circumstances and preferences;
- you should receive clear information about PMR and its treatment;
- you should be supported to recognise **relapse**, **steroid side effects** and **possible symptoms of GCA** (see below).

12. What about giant cell arteritis (GCA)?

GCA is a related condition that can affect some people with PMR. It's treated under a separate guideline, but the PMR guidance highlights that patients and professionals should know the warning signs: a new, severe headache, scalp tenderness, jaw pain when chewing, or any changes in vision. **If you have these symptoms, seek urgent medical advice the same day.**

13. What does this mean in practice for me?

If you have PMR, you may notice:

- more conversation with your GP or specialist about your steroid plan;
- more attention to bone health and steroid side effects;
- earlier discussion of other medicines or specialist referral if you relapse or struggle to reduce steroids.

It's reasonable to ask your team: *Do I have a plan for reducing my steroids? Has my bone health been considered? What should I do if my symptoms come back?*

14. Where can I find out more?

- BSR blog on the updated guideline
- Interview with Professor Max Yates
- 2009 BSR/BHPR PMR guideline
- The PMRGCAuk helpline 0300 111 5090 and our other PMR information found here: What is PMR? - PMRGCAuk

Quick comparison: 2009 vs new guideline

Topic	2009 guideline	New BSR guideline
Main treatment	Prednisolone	Prednisolone, with more focus on safe, individual use
Starting and reducing	15 mg start, set stepwise taper over 1 to 2 years	Individualised plan; recognises relapse risk; faster taper option
Relapse	Increase dose; consider DMARD after two relapses	Consider rheumatology input earlier
Other medicines	Brief mention (DMARD)	Early methotrexate and IL-6 receptor antagonists in selected people
Bone health	Risk-based	Central to care
Side-effect monitoring	Scheduled reviews	Stronger emphasis on steroid toxicity monitoring
Referral	Mainly atypical features or poor response	Practical thresholds; earlier referral after relapse

Patient involvement	Information booklet	Shared decision-making and education as a core theme