How common is PMR/GCA?

Population based studies showed:

59 out of 100,000 people > age of 50 will develop PMR in a one year period

According to Vasculitis foundation:
Lifetime risk for developing PMR is 2.4% in women and 1.7% in men

BSR/BHPR Guidelines 2010
GCA 2.2/10,000 patient years in the UK
Objectives

- Diagnosis
- Investigations
- Education
- Managing Co-morbidities
- Flares
- Long term management
Investigations

- Blood tests
- Chest X-Ray
- Blood Pressure
- Ultrasound scan
- Urinalysis
- TAB if GCA
- +/- PET scan
Empathy is...
seeing with the eyes of another,
listening with the ears of another,
and feeling with the heart of another.
According to RCN 2010 guidelines

Nurses must:

- treat everyone with care, dignity and humanity
- make informed choices and shared decision
- have up to date knowledge, working with insight and understanding, meeting individual needs
- work closely with own team and other professionals
- lead by example, influencing the way care is given
Patient response to DIAGNOSIS

- **Fear**
  Condition
  Unknown
  Side effects of Steroids

- **Relief**
  The condition can be treated

- **Education**
  Time to discuss causes/ treatment and answers any questions the patient may have
GCA/PMR Assessment
Please clearly PRINT at each entry:
- Date and time of entry
- Name and bleep or contact number
- Expected date of discharge for in-patients

Affix PAS label:
NHS No: __________________________
Unit No: ________________________
Name: __________________________
DoB: ________________________ Sex:____________

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Date of diagnosis and initial presenting symptoms:</th>
<th>Investigations:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CRP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BP /</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Weight</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EMS _________ Mins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HAQ _________/3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pain VAS _______/100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co-Morbidities:</th>
<th>Co-Morbidities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Warfarin</td>
</tr>
<tr>
<td>OA</td>
<td>Leg Ulcer?</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Skin Bruising?</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Other Skin Problems?</td>
</tr>
<tr>
<td>Smoking</td>
<td>Any other Disability?</td>
</tr>
<tr>
<td>Respiratory Problems</td>
<td></td>
</tr>
</tbody>
</table>

Medications:

Signature: __________________________ Print Name: __________________________ Date: __________________________
<table>
<thead>
<tr>
<th>Headache</th>
<th>Yes ☐ No ☐</th>
<th>Visual Disturbances</th>
<th>Yes ☐ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jaw</td>
<td>Yes ☐ No ☐</td>
<td>Night Sweats</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Claudication/Pain on chewing</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temple Tenderness</td>
<td>Yes ☐ No ☐</td>
<td>Good Appetite</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Scalp Tenderness</td>
<td>Yes ☐ No ☐</td>
<td>Systemic Symptoms</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

Details: 

Proximal arm muscle tenderness | Yes ☐ No ☐ | Sleep
Quads tenderness | Yes ☐ No ☐ |

Details: 

Comments: 

Management Plan: 

Blood Test Frequency: 
Next OPD: 
Other Investigations Required: 

Signature: ___________________ Print Name: ___________________ Date: ___________________
Steroids

medication list
Compliance
Blood results

Symptoms........
cause ............
Inflammatory/Mechanical

Management plan - documented
Diagnostic/symptom Query

- Repeat blood test  ? Infection or other cause of raised CRP
- Blood pressure       ? Hypertension as cause of headaches
- Vision -              ? Optician / Ophthalmology
- Examination         ? OA neck, shoulders and hips
- Ultrasound scan
- PET scan                  if persistently raised CRP and systemic symptoms
High risk patients

At diagnosis consider:

- Co-morbidities
- Inflammatory markers
- Patients symptoms

*Early consideration of introducing a DMARD*
Sight loss and GCA

- Depression
- Reduced mobility
- Fear
- Despondence

loss of independence
reduced confidence
anger
petrified
Co-Morbidities

- Diabetes
- Skin Ulceration
- Infection
- Cataract
- Obesity
- Hypertension
- Warfarin
- Bruising
- Gastric symptoms
- Osteoporosis
- Osteo-Arthritis
- Reduced mobility
- Other disability
- Depression
- Mental health issues
Advice Line

PMR – follow up patients
Monday – Friday (office hours)
Secretary - CNS/Doctor

GCA
Fast track pathway for new patients
Follow up patients -
Monday – Friday
Secretary – Doctor/CNS

Patient seen within 24 hours if necessary
Advice given over telephone if follow up patient

Otherwise GCA patients are advised to see out of hours Dr/Accident Centre
if evening or weekend
Case study
J.M  Age 80

**Diagnosis**  GCA  (strongly biopsy +VE and ultrasound +ve july 2014)

**Symptoms:**
hospital admission – symptoms for one month
severe headaches double vision; constitutional symptoms including night sweats and anorexia

**Investigations**  CRP 59;  HB 117; platelets 584

**PMH:** irritable bowel syndrome; spinal disease; Right arm thrombus 1990’s
TREATMENT

- Prednisolone 60mg od
- Omeprazole 20mg od, increased to 40mg due to indigestion
- Fentanyl patches
- Adcal D3
- Paracetamol
- Topical eye drops
- Zolendronic acid given
AUGUST 2014

- CRP 5
- HB 129
- PLATELETS 295

- STILL experiencing some headaches; prednisolone increased from 50mg back to 60mg od
September 2014

- CRP 4
- Prednisolone 40mg daily
- Experiencing side effects - trembling, shaking and poor sleep

Plan:
- Reduce prednisolone to 30mg daily 2/52; 20mg daily 2/52, 17.5mg daily for 2/52 then 15mg od
- Reduced omeprazole back to 20mgd od
- BP 116/71
October 2014 - Ophthalmology, normal vision and normal intra-ocular pressure

November 2014 – continue to reduce prednisolone by 2.5mg per month

December 2014 – telephone call – unilateral headache; increased prednisolone back to 12.5mg
Feb 2015 Advice line call - head pain above eyebrows and above ears for two months - given Pregabalin for nerve pain

CRP <1

Pain management appointments and conservative management. Facet joint injections or epidural
March 2015

- Patient contacted the department - thrombus right arm
- GCA - under good control
Medications:

Prednisolone 7mg OD
Rivaroxaban 20mg Od
Adcal d3 Caplets
zolendronic acid infusion
Omperazole

Herbal remedies: cod liver oil; omega 3 l; multivitamins; probiotic capsules;
September 2015

CRP 2; HB 128
Prednisolone 3mg daily

Blood pressure 111/60;

Independent with ADL’s - HAQ 1.625
Low mood
Disturbed sleep
October 2015

Telephone call to clinic
Urgent opd

Flare – steroids back to 30mg - ultrasound +ve

CRP 39
August 2016

- CRP 8
- Blood pressure: 113/67
- Prednisolone 4mg daily
- Systemically well but fatigued with back pain

Plan: Remain on prednisolone 4mg daily for another three weeks; then 4mg and 3mg alt days for 6 weeks
• Co-morbidities

• Severe OA
• Eye – early cataracts
• Hiatus hernia
• IBS
• Cardio-vascular
• Low mood
• Holistic approach to care
  • Medication
  • Blood results
  • Signs and Symptoms
  • Co-Morbidites - involvement of MD team – PHYSIOTHERAPY
    Pain management
  • Sleep
  • Mood
  • Fatigue
  • ADL’s
PMR/GCA SCOTLAND/UK