Low-Dose Steroids and Slow Taper Safe in PMR

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NEW YORK — Prednisone starting at 10 mg per day with a slow taper over 17 months was effective in controlling polymyalgia rheumatica in 93% of 189 elderly patients treated, based on a case series presented at the Fourth International Conference on Giant Cell Arteritis and Polymyalgia Rheumatica.

The regimen was associated with lower total steroid doses, fewer adverse events, and similar or fewer relapses and recurrences than have been seen in other series of patients given higher steroid doses.

The initial prednisone dose recommended for polymyalgia rheumatica (PMR) is 10-20 mg/day. In reality, the doses used generally are closer to 20 mg/day than to 10 mg/day, due to concerns about the risk of treatment failure, said Dr. Luis J. Catoggio, head of rheumatology at the Hospital Italiano de Buenos Aires. However, his analyses suggest that rapid tapering of the steroid, not a low initial dose, is associated with poor outcomes in PMR.

Dr. Catoggio reported on 209 patients (164 women) with PMR seen between 1983 and 2002 and treated with 10 mg of prednisone in single morning dose. The patients' mean age was 71 years. Median disease duration at diagnosis was 2 months. Median erythrocyte sedimentation rate (ESR) at baseline was 56 mm/hr.

The shoulder girdle and pelvic girdle were affected in 96% and 87%, respectively. The neck and torso were affected in 62%, and synovitis was present in 24%.

Prednisone was initiated at 10 mg/day or less in 189 patients (90%), 12.5-15 mg/day in 16 patients (8%), and over 15 mg/day in 7 patients (3%). Dr. Catoggio explained that patients given doses above 10 mg/day were initially treated at other centers. Median time to clinical response was 10 days. Median time to ESR of less than 30 mm/hr was 60 days.

Five of the 15 patients with initial treatment failures had started on prednisone doses of 7.5 mg/day and subsequently responded to 10 mg/day.

The other 10 had started on 10 mg/day and later responded to 15 mg/day. Three patients (1.4%) relapsed within 3 months of initiating therapy and 74 (35%) relapsed later. Median time to relapse was 15 months, and mean steroid dose at relapse was 4.3 mg/day.

By the data cutoff date, 95 patients (45%) had been able to discontinue treatment. Recurrences were seen in 22, with a median time to recurrence of 7 months, but 11 ultimately were able to discontinue their steroids. In patients who finally discontinued prednisone, median duration of treatment was 19 months.

The schedule that employs a 20 mg/day starting dosage sustains that dosage for 1 month. The dose is then tapered by 2.5 mg every 2 weeks unless symptoms recur. (For the 17-month schedule used at Dr. Catoggio's hospital, see chart.)

The 20 mg/day schedule represents a minimum treatment period of 4.5 months and a total steroid dose of 1,650 mg. It was initially successful in only 4 of 27 patients (15%) in one study. The remaining patients all required upward adjustment of their steroids or longer duration of therapy (Ann. Intern. Med. 1999;159:577-84).

Compared with another study where the mean cumulative dose was 8,400 mg, the mean total dose of prednisone in Dr. Catoggio's cohort was 2,900 mg.

Adverse events were seen in 49 patients (23%). These included vertebral fractures in 11, hip and other fractures in 4, cataracts in 7, and hyperglycemia in 5. ■

Schedule for Tapering Prednisone in Polymyalgia Rheumatica

Prednisone dose (per day)	Duration (in months)	Mean cumulative dose
10 mg	3	900 mg
7.5 mg	2	450 mg
7.5-5.0 mg	2	375 mg
5.0 mg	3	450 mg
5.0-2.5 mg	2	225 mg
2.5 mg	3	225 mg
2.5-0 mg	2	75 mg
Total	17 months	2,700 mg

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