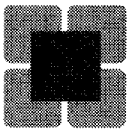

WILLIAM S. WILKE, MD, EDITOR

DIFFICULTIES IN DIAGNOSING AND TREATING POLYMYALGIA RHEUMATICA

Polymyalgia rheumatica (PMR) is a common disease in the population over age 50 years; the incidence approaches 0.01%. Because this syndrome is often associated with giant cell arteritis (GCA), which if untreated can cause blindness and death, early recognition and treatment is necessary.

DIAGNOSIS

The most commonly used diagnostic criteria for PMR have been arrived at by convention and consensus. Recently, a British group led by H.A. Bird established the sensitivity and specificity of a large number of signs and symptoms thought helpful in the diagnosis of PMR. Seven of these features were most discriminative: 1) bilateral shoulder pain, 2) onset over a period of two weeks or less, 3) initial Westergren sedimentation rate of 40 mm/h or greater, 4) morning stiffness lasting one hour or longer, 5) age over 65 years, 6) depression or weight loss and, 7) bilateral upper arm tenderness. When three or more of these criteria or one criterion and palpable abnormality of the superficial temporal artery were present, the likelihood that the diagnosis would be PMR was 92% sensitive and 75% specific.

TREATMENT

Many authorities suggest that PMR should be treated initially with daily doses of prednisone ranging from 15 to 60 mg. Many of these same authorities feel that if GCA is present, 40 to 60 mg of prednisone per day should be given and continued for at least four weeks. Another British group headed by A.R. Behn reported a prospective study of 176 patients with PMR and/or GCA. An initial daily dose of prednisolone 10 mg for PMR and 20 mg for GCA adequately controlled disease signs and symptoms in more than 90% of patients. This work has recently been corroborated by others. Studies like this suggest that we must look critically at the use of high-dose corticosteroid in the treatment of either of these syndromes.

These studies also allow the use of lower-dose corticosteroid in selected patients with these diseases, such as patients with insulin-dependent diabetes, in whom high-dose corticosteroid would likely result in a serious adverse effect.

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PASSIVE SMOKING: NUISANCE OR HEALTH RISK?

Without question, sidestream smoke emitted from the tip of a burning cigarette is biologically hazardous. Indeed, it is more dangerous than mainstream smoke inhaled by the smoker. Sidestream smoke, which is not filtered through the unburned tobacco and cigarette filter, has a lower combustion temperature. Consequently, all substances in tobacco smoke are in greater concentration in sidestream smoke, and in vitro it is more carcinogenic than mainstream smoke. The issue is whether nonsmokers' exposure to sidestream smoke, or "passive smoking," is enough to pose a health hazard is a subject of much scientific and public debate.

Only two aspects are no longer debated: Children exposed to parental smoking clearly are at risk of impaired health, and passive smoking by adults does not result in clinically significant chronic obstructive pulmonary disease (COPD). The data on lung cancer are controversial; the data on asthma are limited to individuals whose asthma was stable or well controlled at the time of testing. Few studies have been done on the relationship between involuntary smoking and cardiovascular disease.

INFANTS AND CHILDREN

It is well documented that parental smoking