Abstract #: 05

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Title: Polymyalgia rheumatica and interstitial lung disease: a case series

Objective(s): We aimed to describe a series of patients with the rare co-existence of polymyalgia rheumatica (PMR) and interstitial lung disease (ILD).

Method(s): Consecutive patients referred to the Centre hospitalier de l'Université de Montréal (CHUM) rheumatology-ILD clinic with an initial diagnosis of PMR from 2012 to 2022 were included. Demographic, clinical, serological and outcome data were extracted by retrospective chart review.

Result(s): Out of 1027 ILD patients referred to rheumatology, only 8 (0.8%) had a concomitant diagnosis of PMR. They were aged 64 to 84 years and were mostly men (88%) and ex-smokers (63%). All had elevated C-reactive protein at time of PMR diagnosis, negative rheumatoid factor and anti-CCP antibodies, and normal creatine kinase levels.
Two patients had pre-existing PMR which was inactive (with and without Prednisone) at time of ILD diagnosis 3 and 6 years later. Both were men aged over 80 years with past smoking and usual interstitial pneumonia (UIP) radiological pattern, suggestive of idiopathic pulmonary fibrosis (IPF).
Two other patients had ILD 3 and 6 years prior to developing myalgias. The first was a female with ILD of NSIP pattern diagnosed as hypersensitivity pneumonitis (HP) from bird feather exposure. The second patient was a 65 year-old male with ILD of indeterminate or possible non-specific interstitial pneumonia (NSIP) pattern. He developed myalgias initially diagnosed as PMR, but had minimal response to 20 mg per day of Prednisone. Notably, he had muscle claudication in the forearms, thighs and calves, mild distal lower extremity sensitive polyneuropathy, and positive MPO-ANCA (>8). He was initiated on high-dose corticosteroids for probable MPO-ANCA vasculitis.
Four additional patients had concomitant diagnoses of PMR with incidental asymptomatic ILD detected on chest imaging and normal pulmonary function tests. One patient also had giant cell arteritis (biopsy-confirmed) and large vessel vasculitis (on PET scan). All had adequate initial responses to intermediate-dose glucocorticoids, but two had multiple relapses upon steroid tapering, with addition of tocilizumab in one patient. ANA, DNA, ENA and myositis panel were negative, and ANCA was done and negative in one patient. Radiological pattern was NSIP in two patients, NSIP-organizing pneumonia (OP) in one patient and possible UIP in one patient.

Conclusion(s): The co-existence of confirmed PMR and ILD was very rare in our cohort. Over half of patients had non-synchronous and likely non-autoimmune lung diseases (IPF/HP) or non-PMR diagnosis. The diagnosis of PMR in the setting of ILD should be evaluated in depth to rule out alternative diagnoses.