



## A patient's diary

A 71-year-old farmer worked a large and successful farm in the South Island without any medical problems apart from a hip replacement, and vague occasional pains around the neck. He retired to the Bay of Plenty at 70 years.

In April 2005 he felt acutely weak, ill, and tired: something he had not experienced before. He kept a diary of his illness which is recorded here:

- For several weeks he noticed tenderness over the right side of his scalp, as if the skin there was sunburnt. At the same time there was constant dull headache above the eyes on the lower forehead; the neck and temples were also painful. The neck was especially painful behind the right ear. When he chewed solid food his jaw muscles became painful, but this stopped when he stopped eating.
- His general practitioner, a locum tenens, suggested a blood test for polymyalgia rheumatica. He referred the patient to a neurologist.
- The neurologist noted that the erythrocyte sedimentation rate (ESR) was normal, and felt that there were no particular features of temporal arteritis. His neurological examination was normal. He commented that the thoracic spine was slightly kyphotic, and there was mild limitation of neck movements. Cervical spine X-rays showed moderate degenerative changes with marked disc-narrowing. He considered that the headache did not emanate from the neck, but as it had lasted for 6 weeks (which was unusual for the patient), he requested a computed tomography (CT) brain scan to exclude meningioma—the scan was normal.
- The GP prescribed synflex and nortryptilline, with no effect. Nurofen Plus (2 tablets 4 hourly) achieved some pain relief.
- His usual GP then explained that he did not have polymyalgia, because the ESR was “too low”, but he would keep this diagnosis at the back of his mind. The patient questioned the level of 7 mm fall in 1 hour, in the context of polymyalgia.
- The patient in late June instigated eye tests and bought new spectacles due to continuing headaches.
- An orthopaedic surgeon, recommended by golf friends, was persuaded to undertake an MRI scan of the patient's cervical spine, which confirmed degenerative changes at C3/C4, but no nerve compression. There was no pressure or distortion of the spinal cord. He did not recommend surgery.
- In July, August, and September, the patient's headache symptoms progressively worsened and additional symptoms occurred: sore shoulders, weak arms and thighs, difficulty in standing up, and the first three steps when attempting to walk were tentative. Pain extended to his buttocks and knees. The neck became extremely painful: “...feels like a concrete block—worse at night and in the morning”. An osteopath performed therapeutic massage, with no effect.

- Fortuitously, the patient's aunt came to stay for a short holiday in September. She said that she had polymyalgia and observed that the symptoms of the patient were exactly the same as hers. What is more, she had immediate relief from prednisone!
- The patient then saw his GP, related this conversation, and asked to be put on prednisone. He pleaded: "In the short term what have I got to lose?" With reluctance, the GP prescribed prednisone 30 mg per day.
- Within 15 hours there was significant pain relief of headaches and scalp pain, neck pain, buttock pain, and knee pain. Within 3 days there was complete cessation of pain in every part of his body. By September 24 he had his first night's sleep for 5 months. The patient slowly reduced his dose of prednisone, but kept to a small dose. He has had no further pain.

**Comment and discussion**—The patient's diary gives a clinically relevant narrative indicating temporal arteritis and polymyalgia rheumatica, described in his own vernacular. Frustration in coping with unrelenting pain prompted his problem-solving that was complementary to his GP's.<sup>1</sup> Diagnosis and treatment eventually emerged by serendipity (the aunt's arrival). She even provided a medical reference paper (by Dr JG Jones of Rotorua). The patient got more information from the Internet.

In both conditions, the ESR is usually high, but may be within normal range in about 25% of cases. Undue reliance on a single ESR misleads. Temporal arteritis and polymyalgia are commonly associated conditions in the elderly, but the respective aetiologies may be different.<sup>2</sup>

Temporal arteritis is a systemic vasculitis that targets medium and large arteries. Granulomas in the artery wall are formed by CD4 T cells and macrophages, provoking intimal hyperplasia and vessel occlusion. Clinical manifestations relate to tissue ischaemia (the patient experienced claudication of jaw vessels). Headache may take any form, and may resemble any primary headache.<sup>3</sup> Corticosteroids are the cornerstone of treatment.

Polymyalgia rheumatica is an inflammatory condition of unknown origin, comprising aching and stiffness in the shoulder and pelvic girdles, and in the neck. Arthroscopic, radioisotopic, and magnetic resonance imaging investigations identify synovitis around proximal limb joints and periarticular structures, causing pain. Recent studies have not implicated vasculitis. Normal ESR does not exclude the diagnosis. Corticosteroids are the main treatment.<sup>4</sup>

Ronu R Ghose  
Physician, Tokoroa Hospital  
Tokoroa, South Waikato  
([dastidar@actrix.co.nz](mailto:dastidar@actrix.co.nz))

## References:

1. Charon R. Narrative and medicine. *New Engl J Med.* 2004;350:862–4.
2. Cantini F. Are polymyalgia rheumatica and giant cell arteritis the same disease? *Semin Arthritis Rheum.* 2004;33:294–301.
3. Ward TN. Headache in giant cell arteritis and other arteritides. *Neurol Sci.* 2005;26(Supp 2):S134–7.

4. Best SC. Polymyalgia rheumatica. *Pract Res Clin Rheumatol*. 2004;18:705–22.