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POLYMYALGIA RHEUMATICA AND COLON MALIGNACY - CASE REPORT

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Abstract

Polymyalgia rheumatica (PMR) is relatively common disorder in elderly. When the relationship between polymyalgia rheumatica and giant cell arteritis (GCA) is weel recognized there is still controversy about PMR and malignancy. We are presenting a patient with the PMR and adenocarcinoma of the sygmoid colon and hypothesize a paraneoplastic relationship.

Keywords: polymyalgia rheumatica, colon cancer, paraneoplastic syndrome

Polymyalgia rheumatica (PMR) is clinical syndrome of the midle aged and elderly, characterized by pain, stiffness of the shoulder and pelvic girdles, elevated sedimentation rate (ESR), and rapid clinical response to

small doses of corticosteroids (1). Polymyalgia rheumatica is a common inflammatory disease in adults over age 50, particularly in women (2). The diagnosis of polymyalgia rheumatica is still based on diagnostic criteria because no clear diagnostic test exists. Several clinical diagnostic criteria sets have been suggested and recently a European collaborating PMR group suggested the Bird 1979 (3) or Hunder 1982 (4) criteria for use whenever possible (5). EULAR response criteria for PMR are developed too (6). When the relationship between polymyalgia rheumatica and giant cell arteritis (GCA) is weel recognized there is still controversy about PMR and malignancy.

Case report

A 75 –yr-old female was reffered to the rheumatology department and diagnosis of PMR established according Bird 1979 criteria. She presented with pain and stiffness of her arms and pelvic girdle, morning stiffness >1 hours, Sedimentation rate (ESR) 90 mm/h. Other haematology and biochemistry tests were normal. There was no history of headache, visual changes and weight loss. She was treated with prednisolone 15 mg in fast reduction manner with the rapid clinical response. ESR after 1 month droped to 20 mm/h, physical function recovered. She continue 5 mg of prednisolone during 2 years. Six months after corticosteroids were stoped she returned with the same symptoms: pain and stiffness in both shoulders, pelvic girdle, general weekness, fatigue and constipation The investigation revealed ESR 88 mm/h, CRP 136 mg/dL, erytrocite 3.81, haemoglobin 11.7g/dL, white blood cell 7.6, Fe 5, UIBC 34, TIBC 39, repeated occult blood test was positive. Other haematology and biochemistry findings were normal. Chest x-rays was normal. Brest and gynecologic examination without patology. Ultrasound finding of abdomen shows cholelihiasis. Colonoscopy showed malignoma of the sygmoid colon and computed tomography (CT) no affection of the

regional lymph nodes. Patohystology (PHD) showed well differentiated tumour (DUKES – A) invaded to submucosis. Laparascopic resection of the sygmoid colon was performed. She recovered shorthly after surgery, she was without rheumatic symptoms, ESR dropped to 20 mm/h, CRP to 12mg/dL. One year later the patient was still asymptomatic.

Discussion

Polymyalgia rheumatica is a relatively common disorder in patients over the age of 50. Genetic predisposition, infection and immunological abnormalities contribute to the etiology of polymyalgia rheumatica. In the past PMR was considered a manifestation of giant cell arteritis (GCA) or a variant of elderly-onset rheumatoid arthritis (7). Many infectious causes have been suggested for polymyalgia rheumatica and/or giant cell arteritis but the results of the investigations are still controversial and it is not yet possible to sustain the hypothesis of an infectious cause for polymyalgia (8). The association between HLA-DR4 and HLA-DRB1 and polymyalgia rheumatica are contradictory regarding geographic area and ethnic bacground (9,10,11). The giant cell arteritis and polymyalgia rheumatica have been considerd as closely related conditions that form a spectrum of diseases. In a number of patients with typical polymyalgia and no symptoms from the cranial arteritis biopsies shown arteritic changes in 10-15 % (1). The association of PMR with malignancy is still controversial. Several prospective studies have shown that patients with classic PMR not have an increased risk of developing malignancy. In contrast kidney, lung and colon cancer are found in patients presenting wuth atypical PMR (12).To identify rheumatic syndromes associated with cancer is difficult because the malignant tumours may be complicated by the rheumatic symptoms and coversely rheumatic disorders may be complicated by tumours. Several cases of PMR and

malignancy association have not done a true causal relationship (13,14,15,16). When polymyalgia rheumatica and malignancy are associated by chance or by a paraneoplastic relationship is still questionable. In our case after treatment of neoplasia musculoskeletal symptoms were completely resolved and we can hypothesize that in our patient PMR was a paraneoplastic manifestation. Although generally held that an extensive search for occult malignancy is not recommended, if the rheumatic disorder is accompanied by findings suggestive malignancy a wider screen for searching occult neoplasia is justified (17).

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