Case Report

Pleural and Pericardial Effusion in a Patient With Polymyalgia Rheumatica: A Case Presentation

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A B S T R A C T

Polyarthritis rheumatica is an inflammatory rheumatic disease that presents with bilateral pain and stiffness affecting mainly proximal muscles. It affects individuals over 50 years of age and it is usually associated with a raised erythrocyte sedimentation rate. Classically, treatment with low-dose corticosteroids results in a dramatic improvement in both symptoms and laboratory findings.

We report the case of an 80-year-old patient presenting polymyalgia rheumatica coinciding with pleuropericardial effusion. The patient had a very good response to treatment with rapid improvement in the symptomatology and laboratory findings.

Polyarthritis rheumatica is a common disease but it is rarely associated with pleuropericardial effusion. It should be considered in the differential diagnostic in patients presenting with pleuropericardial effusion over 50 years of age due to the good response to treatment.

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Introducción

Polyarthritis rheumatica (PMR) is an inflammatory disease of unknown cause characterized by pain and morning stiffness in the cervical region, shoulders and shoulder girdle.

Its frequency is increased in patients over 50 years and is two times more common in women. The annual incidence in Europe and in the United States varies between 1.3 and 11.3 per 10,000 individuals over the age of 50 years.

The association of pericardial effusion (PE) and PMR has rarely been reported. So far, three cases of PMR*–† associated with PE have been documented and only one with pericardial and pleural effusion. 2 cases of associated cardiac tamponade with PMR have also been recorded.[7,8]

Case Presentation

Here we present the case of an 80-year-old man with a history of hypertension, type 2 diabetes mellitus and chronic atrial fibrillation without anti-coagulant and with a history of gastrointestinal bleeding, who was admitted for asthenia, anorexia and...
weight loss of 3 months duration. Coinciding with this, he had pol-
varticular pain and morning stiffness, especially in the shoulders
and hips, preventing him from walking in the last 3 months. He
had no headache.

He was under treatment with omeprazole, domperidone,
amlopidine, digoxin, furosemide, metformin and ramipril.

Physical examination showed mild mucocutaneous pallor and
decreased breath sounds of the left thorax; the remainder of the
examination was normal.

The initial laboratory results highlighted a normocytic,
normochromic anemia, Hb 10.2 g/dl, normal leukocytes and platelets.
The erythrocyte sedimentation rate (ESR) was 105 mm/h, CRP
13 mg/dl and proteins 6.3 mg/dl. Renal function tests were per-
formed and anemia was studied measuring ferritin, vitamin B12, and
folic acid, all of them being normal. Proteinogram showed increased
alpha 2 and normal tumor markers (CA 19-9, CEA, AFP, chorionic
gonadotropin), all negative, TSH normal, Mantoux negative. ANA
and ANCA negative, complement (C3 and C4) normal.

The chest X-ray showed cardiomegaly on admission, with no
other findings. A few days later the patient presented an associated
bilateral pleural effusion, predominantly on the left side (Fig. 1).
A CT of the chest and abdomen reported a pericardial and pleural
effusion, moderate in amount and of free morphology, causing a
passive collapse of the basal segments of both lower lobes with the
rest showing no abnormalities.2

A thoracentesis allowed us to examine the pleural fluid with the
following results: LDH 104 U/l, protein 3.1 g/dl, glucose 116 mg/dl,
pH 7.52 and normal ADA (transudate characteristics, but in
the threshold between exudate and transudate). Fluid cytology:
serosanguineous, absence of neoplastic cells.

Subsequently, echocardiography showed: left ventricular
hypertrophy, with conserved size and systolic function, mild
mitral and aortic insufficiency, with the rest of the valves normal,
slight pulmonary hypertension and moderate anterior pericardial
effusion and moderate to severe posteriorly with fibrin without
collapse during dyastole of the right chambers (Fig. 2).

Since the patient had criteria compatible with PMR (age
>50 years, pain of the proximal muscles, shoulders and hip, ESR
>40 mm/h and we excluded other diagnoses), we confirmed
the diagnosis and the patient was treated with prednisone at a dose of
15 mg daily.

Clinical improvement was evident in the first 48 h, with
increased mobility and a clear decrease in rigidity, especially at
the level of the shoulder girdle, with the patient being able to
walk. Likewise there were decreased inflammatory markers and
the X-rays showed a marked decrease of the pleural effusion. The
echocardiography performed after one month showed that the
pericardial effusion had completely disappeared with only a slight
right pleural effusion.

Discussion

PMR patients present bilateral discomfort involving the prox-
imal parts of the limbs and joints in relation to synovitis of proximal
joints.

The combination of persistent pain for at least a month, with
pain and morning stiffness in the neck region, the shoulder
girdle and the pelvic girdle, lasting at least 30 min, associated with
an increase in ESR of at least 40 mm per hour, is highly indica-
tive of polymyalgia reumatica.9 Musculoskeletal pain worsens with
movement of the affected areas and typically interferes with activ-
ities of daily living.

Shoulder pain is present finding in most of patients (70%–95%),
however the hips and neck are less frequently affected (50%–70%).
In the shoulders and pelvic girdle pain usually radiates distally into
the elbows and knees. The discomfort may start on one side but
quickly becomes bilateral.1

Systemic symptoms are common, being present in one third of
patients, and include fever, fatigue, anorexia and weight loss.2,9 In
our case, the reason for admission was mainly fatigue and weight
loss, but after asking specific questions the patient informed us of
proximal muscle pain.

On examination, there is limitation of active movements and,
often, also passive movements are limited due to pain.

Generally, the diagnosis is made after 2 or 3 months since the
onset of symptoms.

Analytically, most patients have mild anemia of chronic disor-
ders, as in our case, and one third of patients have altered liver
function tests.2 Rheumatoid factor and ANA are usually negative.

Corticosteroids are used to treat patients at a dose of 10–20 mg.
The response to corticosteroids is rapid, with resolution of symp-
toms within days it after the start of therapy. A lack of improvement
should lead us to question the diagnosis. The initial dose is usually
maintained for 2–4 weeks, and subsequently it can be gradually
reduced every week or every two weeks at a maximum rate of 10%
every two weeks from the total daily dose. If the steroid dose is
reduced or withdrawn too quickly, symptoms may recur. However,
approximately 30%–50% of patients have spontaneous exacerbations,
and a course of treatment for one or two years is often
required. Some patients have a relapsing course and may require low-dose corticosteroids for several years.\textsuperscript{3,10}

Given the clinical presentation of anorexia and weight loss associated with pleural and pericardial effusion, different diagnoses such as tumors, tuberculosis and autoimmune diseases might be suspected, all of which are reasonably discarded when the CT is normal, and Mantoux ADA are negative and, for the case of autoimmune diseases, ANA and ANCA and complement, were negative and clinical presentation was not consistent with these diseases. The diagnosis of rheumatoid arthritis was also considered, which seemed unlikely due to the clinical presentation; in rheumatoid arthritis peripheral joints are more commonly affected, and is characterized by a negative rheumatoid factor. The acute edematous polysynovitis of the elderly (RS3P3), is also a diagnosis that should be considered when joint pain occurs in older people and is characterized, as is PMR, by an excellent prognosis with low doses of corticosteroids; this was excluded since the patient had no synovitis of the distal joints and showed no edema of the back of the hands.

In our patient, clinical improvement was evident within days of initiation of low-dose corticosteroids. One month after treatment, the pericardial effusion completely disappeared and pleural effusion improved considerably.

The presentation of joint pain and stiffness of long duration, accompanying systemic symptoms (anorexia and weight loss), laboratory data (increased ESR and CRP) and a fast response to steroids confirmed the diagnosis of PMR.

Ethical Responsibilities

Protection of People and Animals. The authors state that no experiments were performed on humans or animals.

Data Confidentiality. The authors state that no patient data appears in this article.

Right to Privacy and Informed Consent. The authors state that no patient data appears in this article.

Conflict of Interest

The authors declare no conflict of interest.

References