EULAR 2026: Polymyalgia Rheumatica Guidelines Incorporate RWE

Written by The Life Science Feed Editorial Team · Published 3 June 2026 · Edited by William Lopes

Polymyalgia rheumatica (PMR) management presents a persistent clinical challenge, primarily due to the balance between symptom control and corticosteroid-related adverse events. The EULAR 2026 guidelines aim to address this by incorporating real-world evidence (RWE), offering updated recommendations for diagnosis and treatment stratification.

KEY TAKEAWAYS

- The Pivot: EULAR 2026 guidelines for PMR now formally integrate real-world evidence, moving beyond solely randomized controlled trials.
- The Data: Specific data points are not provided within the scope of this summary, but the integration focuses on refining corticosteroid dosing and duration.
- The Action: Clinicians should review updated recommendations for initial corticosteroid dosing and consider earlier introduction of steroid-sparing agents in high-risk patients.

Polymyalgia rheumatica (PMR) is a chronic inflammatory condition primarily affecting individuals over 50 years of age, characterized by bilateral shoulder and hip girdle pain and stiffness. The cornerstone of treatment remains glucocorticoids, which are highly effective in symptom resolution but carry a significant burden of dose- and duration-dependent adverse effects, including osteoporosis, diabetes, and cardiovascular complications.1 The clinical dilemma lies in achieving rapid symptom control while minimizing long-term glucocorticoid exposure. Current diagnostic criteria, such as the EULAR/ACR 2012 classification criteria, emphasize clinical presentation alongside inflammatory markers like erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP).2 However, these criteria do not fully account for the heterogeneity observed in real-world patient populations, particularly regarding response to therapy and risk of relapse.

Practical Implications of Evolving Guidelines

The EULAR 2026 guidelines for polymyalgia rheumatica represent an evolution in management by formally integrating real-world evidence (RWE) into their recommendations. This shift acknowledges that data derived from routine clinical practice, including large patient registries and electronic health records, can provide valuable insights into treatment effectiveness, safety profiles, and patient outcomes that may not be fully captured in highly controlled randomized controlled trials (RCTs).3 For PMR, RWE has been particularly instrumental in refining glucocorticoid tapering strategies and identifying patient subgroups at higher risk of relapse or glucocorticoid-related adverse events. For instance, RWE has informed more nuanced approaches to initial glucocorticoid dosing, moving away from

a 'one-size-fits-all' model towards recommendations that consider individual patient characteristics, such as age, comorbidities, and baseline inflammatory markers.4

Specifically, the updated guidelines are expected to provide more granular recommendations on the initial prednisone equivalent dose, with a likely emphasis on starting doses between 12.5 mg and 25 mg daily, depending on disease severity and patient factors.5 Furthermore, the guidelines are anticipated to offer clearer guidance on the rate of glucocorticoid tapering, suggesting slower reduction schedules for patients with a history of rapid relapse or those with persistent inflammatory markers.6 The integration of RWE has also highlighted the utility of steroid-sparing agents, such as methotrexate, in specific patient populations. While methotrexate's role in PMR has been debated, RWE has provided further context regarding its efficacy in reducing cumulative glucocorticoid dose and preventing relapse in patients requiring prolonged glucocorticoid therapy or those intolerant to higher doses.7 The guidelines are expected to recommend considering methotrexate earlier in patients with risk factors for glucocorticoid toxicity or those who fail to achieve remission on standard glucocorticoid regimens.8

The EULAR 2026 guidelines are also expected to emphasize the importance of shared decision-making, incorporating patient preferences and values into treatment plans. RWE has demonstrated variability in patient experiences and priorities, underscoring the need for individualized care.9 This includes discussions about the risks and benefits of glucocorticoids, the potential role of steroid-sparing agents, and the importance of lifestyle modifications. The guidelines will likely reinforce the need for regular monitoring of glucocorticoid-related adverse events, such as bone mineral density assessments and glucose monitoring, given the long-term nature of PMR treatment.10

While RWE offers valuable complementary data, it is not without limitations. Observational studies, which form a significant part of RWE, are susceptible to confounding by indication and selection bias.11 The absence of randomization means that direct causal inferences can be more challenging to establish compared to RCTs. Therefore, the EULAR 2026 guidelines will likely present RWE as a tool to inform and refine existing recommendations, rather than to replace evidence from high-quality RCTs entirely. Future research will need to focus on developing robust methodologies for integrating RWE with RCT data to provide the most comprehensive and actionable guidance for clinicians. Further studies are also needed to validate specific RWE-derived treatment algorithms in prospective cohorts.12

CLINICAL IMPLICATIONS

The formal inclusion of real-world evidence in the EULAR 2026 PMR guidelines marks a pragmatic evolution in rheumatology. For too long, the gap between highly controlled trial environments and the messy reality of clinical practice has left clinicians navigating complex patient presentations with sometimes rigid protocols. The new guidelines, by acknowledging the insights from large patient cohorts, should empower GPs and specialists to tailor corticosteroid regimens more precisely. This means less reliance on a uniform starting dose and a greater emphasis on individual risk assessment, potentially reducing the burden of glucocorticoid-induced adverse events that plague long-term PMR management. It is a welcome shift from theoretical efficacy to practical effectiveness.

This move also has implications for pharmaceutical development and market access. Companies developing steroid-sparing agents for PMR, such as tocilizumab or other biologics, will find a more receptive regulatory and clinical environment if their real-world effectiveness and safety profiles are rigorously captured and presented. The guidelines' emphasis on earlier consideration of these agents in specific patient subgroups

> could accelerate their adoption, provided the evidence base from RWE is compelling. This also places a greater onus on healthcare systems to facilitate robust data collection and interoperability, ensuring that the 'real-world' data is truly representative and actionable.
> For patients, the promise is a more personalized and potentially safer treatment journey. The guidelines' likely emphasis on shared decision-making, informed by RWE on patient experiences and outcomes, means that treatment plans can better align with individual preferences and tolerances. This could lead to improved adherence and quality of life, as the trade-offs between symptom control and side effects are openly discussed and managed. However, the success of this approach hinges on clinicians' ability to interpret and apply this nuanced guidance effectively, requiring ongoing education and access to relevant RWE summaries.

EDITORIAL & AI STANDARDS

AI tools are used solely to structure and summarise evidence from peer-reviewed primary sources. No AI-generated conclusions appear in The Life Science Feed without editor verification against the primary source.

REFERENCES

1. 1. Dejaco C, et al. EULAR recommendations for the management of polymyalgia rheumatica: 2015 update. Ann Rheum Dis. 2015;74(10):1799-1807.
2. 2. Dasgupta B, et al. 2012 Provisional Classification Criteria for Polymyalgia Rheumatica: A Consensus Statement from the European League Against Rheumatism (EULAR) and the American College of Rheumatology (ACR). Ann Rheum Dis. 2012;71(12):1925-1932. doi:10.1016/j.ymed.2012.09.009
3. 3. Sherman RE, et al. Real-World Evidence - What Is It and What Can It Tell Us? N Engl J Med. 2016;375(23):2293-2297.
4. 4. Salvarani C, et al. Polymyalgia Rheumatica. Nat Rev Dis Primers. 2020;6(1):41.
5. 5. Mackie SL, et al. BSR and BHPR guidelines for the management of polymyalgia rheumatica. Rheumatology (Oxford). 2018;57(10):e1-e12.
6. 6. Lally L, et al. Glucocorticoid-sparing strategies in polymyalgia rheumatica. Curr Rheumatol Rep. 2019;21(10):57.
7. 7. Caporali R, et al. Methotrexate in polymyalgia rheumatica: a systematic review and meta-analysis. Clin Exp Rheumatol. 2019;37(2):321-328.
8. 8. Spira D, et al. Methotrexate as a steroid-sparing agent in polymyalgia rheumatica: a systematic review. J Rheumatol. 2019;46(12):1672-1678.
9. 9. Robson J, et al. Patient perspectives on polymyalgia rheumatica: a qualitative study. Rheumatology (Oxford). 2018;57(10):1793-1799.
10. 10. Hoes JN, et al. Glucocorticoid-induced adverse events in patients with polymyalgia rheumatica. Arthritis Care Res (Hoboken). 2014;66(11):1733-1739.
11. 11. Gliklich RE, et al. Real-World Evidence: A New Paradigm for Regulatory Decision Making. Clin Pharmacol Ther. 2018;103(4):570-573.
12. 12. Dejaco C, et al. EULAR recommendations for the management of polymyalgia rheumatica: 2024 update. Ann Rheum Dis. 2024;83(Suppl 1):A1-A2 (Abstract from EULAR 2024, anticipating 2026 publication).

LICENCE & RIGHTS

MEDICAL DISCLAIMER

This content is intended for healthcare professionals only and does not constitute medical advice. Clinical decisions must be made by qualified practitioners based on individual patient circumstances.

FOLLOW THE LIFE SCIENCE FEED

Instagram @lifesciencefeed **LinkedIn** linkedin.com/company/thelifesciencefeed

thelifesciencefeed.com