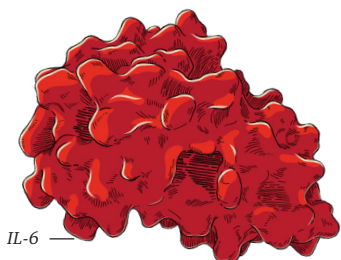
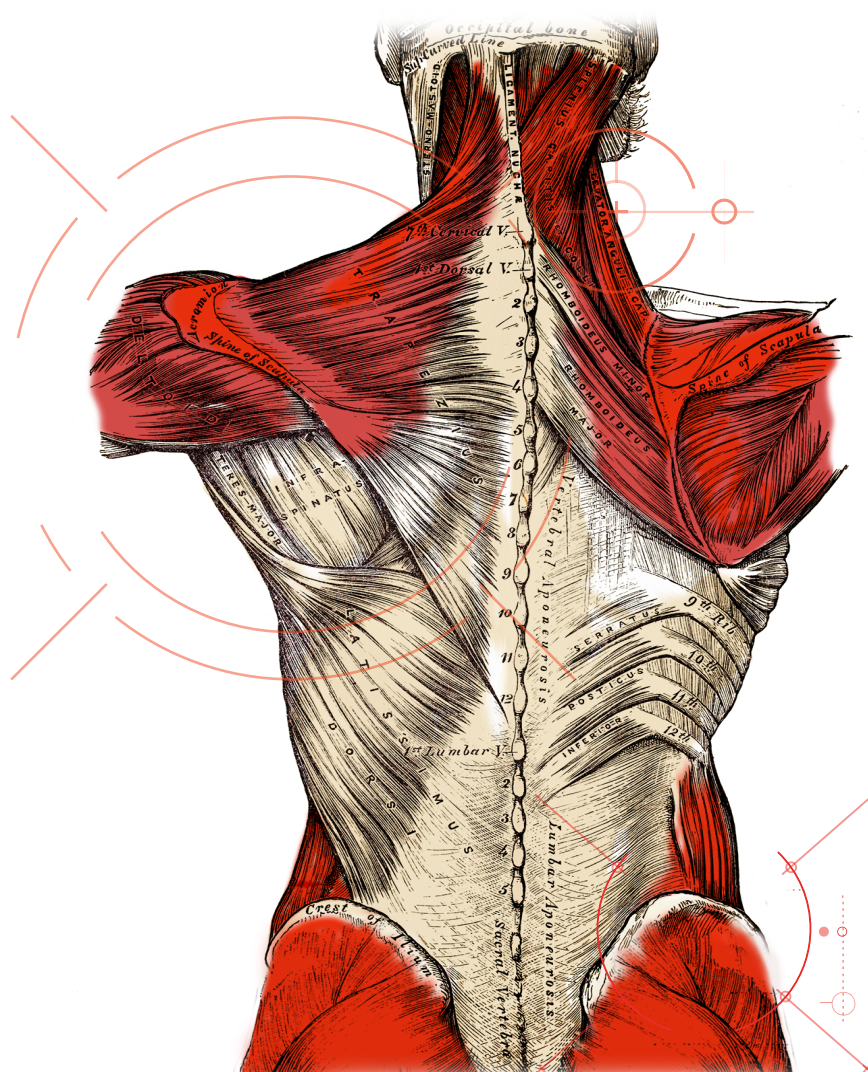


UNDERSTANDING PMR



IL-6

Key hallmarks associated with polymyalgia rheumatica (PMR), such as painful inflammation, can be attributed, in part, to certain immune cells and cytokines, such as interleukin-6 (IL-6).^{1,2}

Current guidelines establish glucocorticoids (GCs) as the standard of care; however, challenges remain such as time on therapy, relapses, and risks with the increase of GC-related toxicities.³⁻⁶

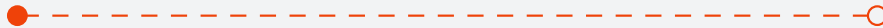
There is an unmet need for a PMR treatment strategy that minimizes the use of GCs.⁵

PMR is the second most common inflammatory rheumatic disease after rheumatoid arthritis (RA)⁴

The residual lifetime risk
of developing PMR in both
men and women⁷


IS GREATER
THAN

The risk of developing
RA, as well as other
inflammatory rheumatic
diseases in individuals
age 60 or older⁷



The lifetime risk of PMR in the US⁸

2.4%
FOR WOMEN

1.7%
FOR MEN

“

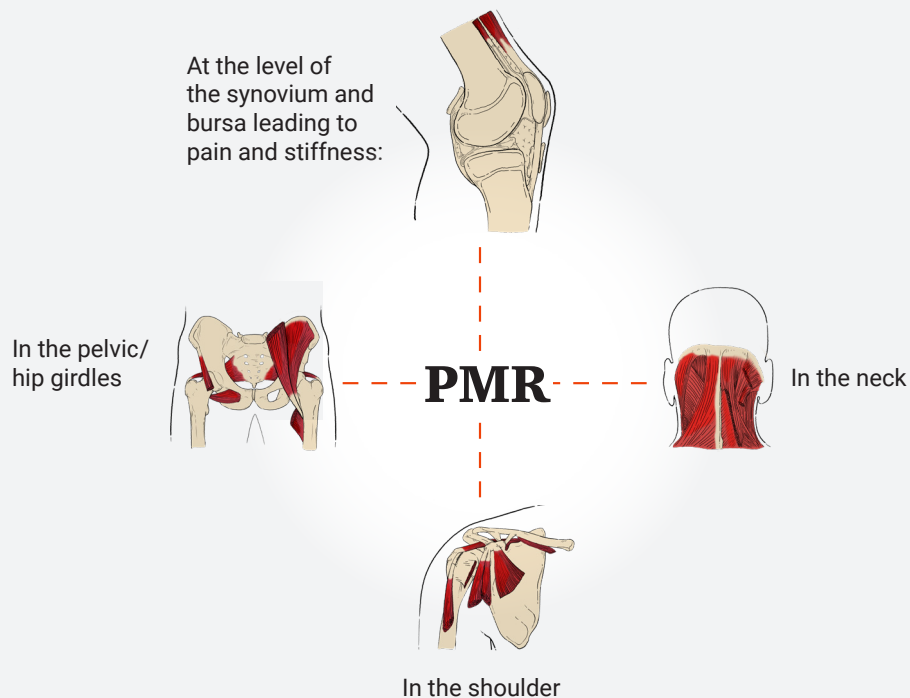
I work out regularly, I thought it was muscle pain. I tried heat, I tried ice, I went to the chiropractor. I asked my PCP to send me to physical therapy. Finally, I was sent to a rheumatologist.

– Patient living with PMR

”

PMR is characterized not only by inflammation and stiffness, but also by significant pain^{1,9}

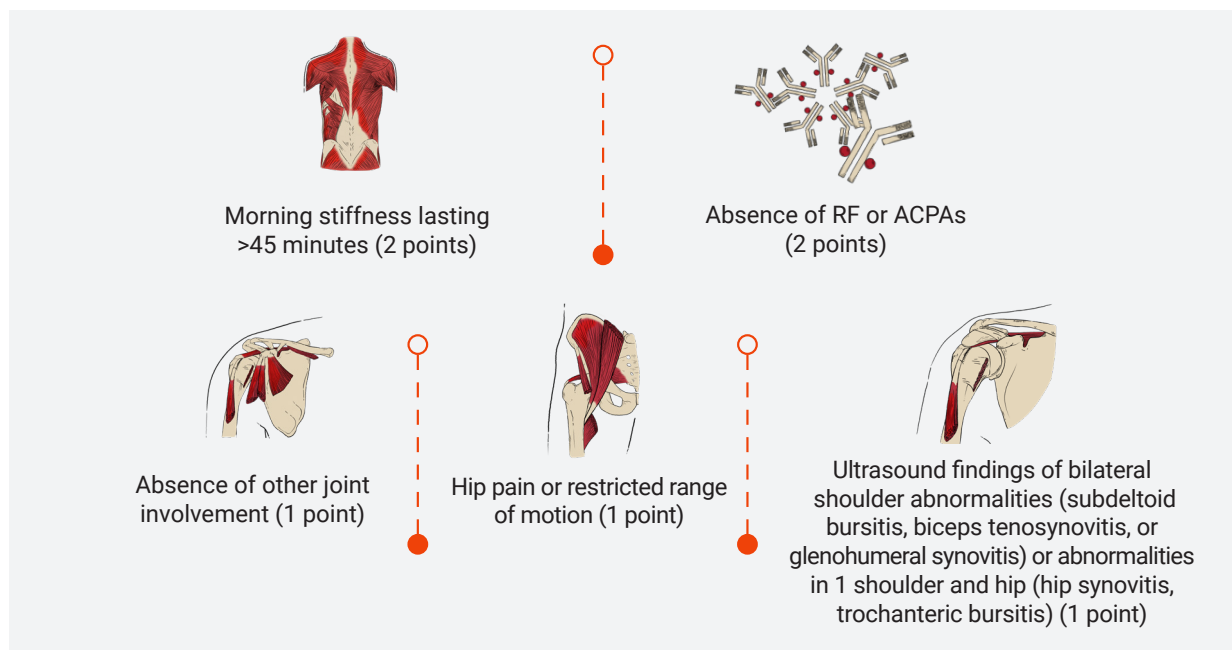
PMR symptoms have a typical distribution pattern of inflammation¹⁰



PMR pain can be distinguished from mechanical because inflammatory pain from PMR can improve with physical activity^{1,9}

Diagnosing PMR has its challenges¹¹

The American College of Rheumatology and the European Alliance of Associations for Rheumatology propose classification criteria for diagnosing PMR as people aged ≥ 50 years with bilateral shoulder aching and abnormal C-reactive protein concentrations or ESR, plus at least 4 points (without ultrasound) or 5 points or more (with ultrasound) from¹:



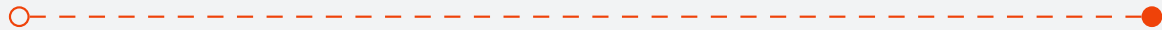
“ My rheumatologist asked me to get up and down out of my chair, lift my arms. He said this looks like classic PMR, we’ll run blood work and start prednisone. – Patient living with PMR ”

ACPA=anti-citrullinated protein antibody; ESR=erythrocyte sedimentation rate; RF=rheumatoid factor.

The pathogenesis of PMR is multifaceted¹⁰

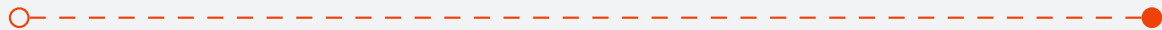
It involves both innate and adaptive immune systems¹⁰:

- These are in response to unknown triggers¹⁰
- Inflammation experienced by patients with PMR suggests that cytokines such as IL-6, IL-1, IL-17, IL-10, and TNF α play a role in the pathogenesis^{10,12}



PMR could occur simultaneously with giant cell arteritis (GCA), a systemic vasculitis affecting the large arteries¹:

- GCA is diagnosed in an estimated 10% to 30% of patients with PMR¹
- According to published data, 40% to 50% of patients with GCA have PMR manifestations¹



It mimics other conditions:

- Diagnosis of PMR involves recognizing clinical symptoms of PMR and excluding other conditions that may have a similar clinical presentation⁹

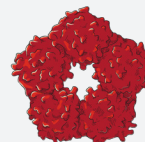
There are no diagnostic tests specific to the condition, therefore careful consideration and exclusion of conditions that may mimic PMR are important¹¹

In PMR, IL-6 is a major driver of acute-phase response and systemic inflammation^{1,13}

IL-6 stimulates increases in¹⁰:

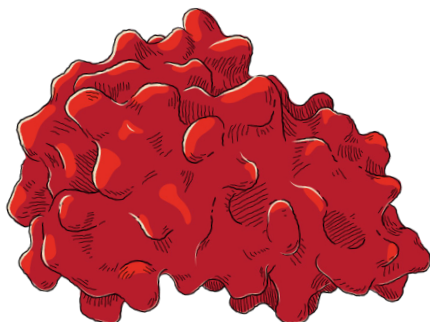


Erythrocyte sedimentation rate (ESR)



C-reactive protein (CRP)

And plays an important role in pain, **independent from inflammation**.¹⁴

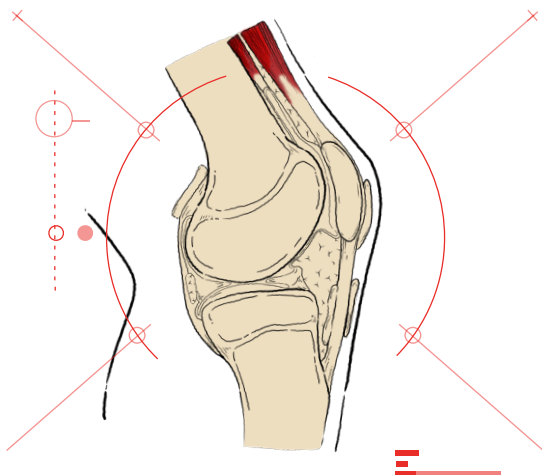


IL-6 levels also correlate with PMR disease activity²

- Elevated concentrations of plasma IL-6 are a characteristic feature in patients with PMR vs healthy controls²
- A study of patients with PMR demonstrated that muscle pain and stiffness concurrently developed when IL-6 concentrations were increased²
- Synovitis observed in PMR is a type of inflammation accompanied by increased levels of IL-6 in the synovial fluid¹⁵⁻¹⁷

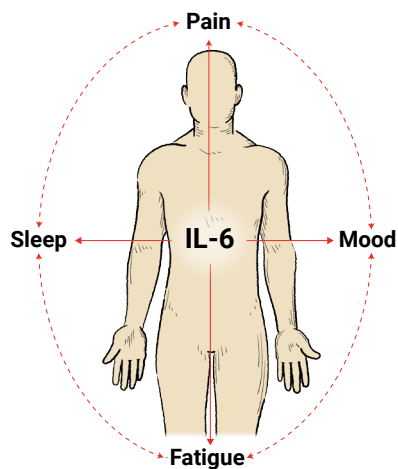
In certain instances, the degree of IL-6 elevation appears to correlate with the magnitude of pain¹⁴

IL-6 is central to the pathogenesis of PMR¹⁸



- IL-6 concentrations (along with sIL-6R) are increased with PMR^{2,19}
- The increase of is associated with fatigue, impaired sleep, and mood disorders, particularly anxiety and depression^{4,20}

“
[PMR feels like] when you spill coffee—it’s unexpected and it touches everything. Everything you are doing.
– Patient living with PMR”



sIL-6R=soluble interleukin-6 receptor.

The standard of care for PMR starts with GCs³⁻⁶

To manage PMR, EULAR/ACR strongly recommends:

- Using GCs instead of NSAIDs, with the exception of possible short-term NSAIDs and/or analgesics in patients with pain related to other conditions²¹
- Using a minimum effective individualized duration of GC therapy²¹
- Against the use of anti-TNF α agents²¹



Treating PMR varies by rheumatologist²¹

- GC dose-tapering strategies²¹
- Use of disease-modifying antirheumatic drugs (DMARDs)²¹
- Duration of treatment²¹

GC

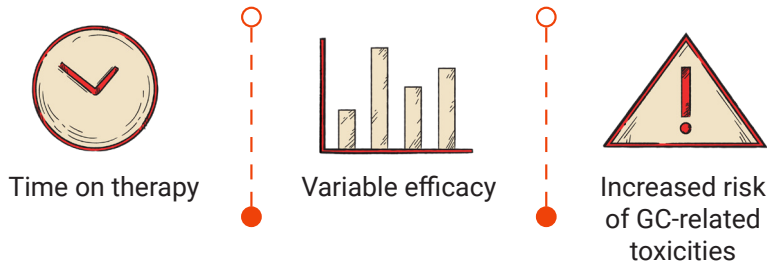
GCs typically lead to a dramatic improvement in symptoms within the first few days^{22,23}

- Once symptoms resolution is stable, the tapering process may start^{22,23}
- However, not all patients are able to taper off steroids^{22,23}
- Stopping steroids or tapering can be challenging due to potential of relapse^{22,23}

There is no FDA-approved treatment indicated for PMR

NSAIDs=nonsteroidal anti-inflammatory drugs.

Although there is a standard of care,
challenges still remain³⁻⁶



GCs may not be appropriate for all patients

- As much as 43% of patients taking GCs relapse within 1 year⁵
- The risk of GC-related complications exists even at low doses of long-term GC use in patients with rheumatic diseases like PMR²⁴
- Use of GCs leads to risk of medication-related complications such as cardiovascular disease, osteoporosis, and diabetes²¹
- Patients with comorbidities that are commonly seen in older adults—osteoporosis, uncontrolled hyperglycemia, diabetes mellitus, glaucoma, joint infection, and uncontrolled hypertension—should consider using GCs with caution²⁵
- Some patients may not achieve adequate management of symptoms with GCs and thus have limited treatment options³

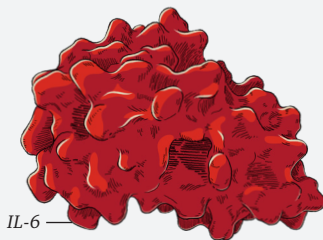
GCs do not always correct the underlying mechanisms of PMR²

There's a need for advancement

There is no FDA-approved treatment indicated for PMR

The residual lifetime risk of developing PMR is higher in both men and women than the risk of developing RA, as well as other inflammatory rheumatic diseases in individuals age 60 or older.⁷

PMR is characterized by inflammation, stiffness, and significant pain.^{1,9}



- Key hallmarks associated with PMR can be attributed in part to certain immune cells and cytokines such as IL-6^{1,2,26}
- In PMR, IL-6 is a major driver of acute-phase response and systemic inflammation^{1,13}
- IL-6 plays an important role in peripherally induced pain, and in some instances, the degree of IL-6 elevation appears to correlate with the magnitude of pain¹⁴

Visit PMRandIL6.com to learn more.

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