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Original Article RHEUMATOLOGY

Diagnosis and management practices in polymyalgia rheumatica among Turkish rheumatologists: An online cross-sectional survey

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ABSTRACT

OBJECTIVE: To evaluate real-world diagnostic and therapeutic approaches to polymyalgia rheumatica (PMR) among Turkish rheumatologists and compare them with international guideline recommendations.

METHODS: A cross-sectional online survey was conducted among rheumatologists practicing in Turkiye between September and October 2025. A self-administered 29-item questionnaire was distributed through professional communication networks. The survey was developed with reference to the 2012 European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) classification criteria and international management guidelines. It assessed self-reported diagnostic approaches, screening practices for giant cell arteritis (GCA), treatment strategies, and follow-up and monitoring practices. Data were recorded and analyzed in a de-identified manner using descriptive statistics.

RESULTS: A total of 101 rheumatologists participated in the survey. Diagnostic approaches varied substantially: use of the 2012 EULAR/ACR criteria was reported by 65 (64.4%), referral to the 2010 British Society for Rheumatology/British Health Professionals in Rheumatology (BSR/BHPR) guideline by 10 (9.9%), and primary reliance on clinical judgment by 76 (75.2%). Elevated erythrocyte sedimentation rate and/or C-reactive protein (ESR/CRP) were considered necessary for diagnosis by 92 (91.1%). Use of imaging modalities, including ultrasonography (US), magnetic resonance imaging (MRI), and positron emission tomography (PET), was highly heterogeneous, and routine screening for giant cell arteritis (GCA) was reported by 25 (24.8%). Glucocorticoid (GC) monotherapy was the preferred first-line treatment among 76 participants (75.2%), with most clinicians selecting guideline-recommended starting doses (12.5–25 mg/day) and initiating tapering between weeks 4 and 8. Disease-modifying antirheumatic drugs (DMARDs) were most commonly introduced at first relapse (55, 54.5%). Although osteoporosis risk assessment was reported by 86 (85.1%), the use of dual-energy X-ray absorptiometry (DXA), the Fracture Risk Assessment Tool (FRAX), and referral for exercise programs remained inconsistent.

CONCLUSION: Although initial GC therapy was generally consistent with guideline recommendations, considerable heterogeneity was observed in diagnostic approaches, imaging use, screening for GCA, and long-term monitoring practices, indicating persistent gaps between guidelines and real-world clinical practice.

Keywords: Giant cell arteritis; glucocorticoid; polymyalgia rheumatica; questionnaire; rheumatologist; survey.

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Polymyalgia rheumatica (PMR) is a common inflammatory rheumatic condition occurring almost exclusively in adults over 50 years of age and characterized by bilateral shoulder, neck, and hip girdle pain with prominent early morning stiffness, reflecting inflammation of periarticular structures [1]. In the absence of a dis-

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ease-specific biomarker, PMR remains a clinical diagnosis of exclusion. Assessment relies on typical symptom patterns, physical examination, and nonspecific laboratory abnormalities [2]. Although the 2012 European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) provisional criteria [3] provide a standardized framework, they were designed primarily for research settings, limiting their diagnostic utility in routine care. Furthermore, despite evidence that shoulder and hip ultrasonography (US) improves diagnostic accuracy, its uptake remains inconsistent across centers.

Diagnostic uncertainty has also been demonstrated in primary care. In a large UK multi-methods study, general practitioners frequently reported difficulty distinguishing PMR from mimicking conditions and often relied on glucocorticoid (GC) responsiveness to support the diagnosis [4]. Recommended investigations to exclude alternative inflammatory, infectious, or neoplastic disorders were inconsistently performed, and concerns regarding long-term GC monitoring were widespread [4]. As this work focused exclusively on primary care, it did not capture specialist-level decision-making. Complementary evidence from a multinational survey involving general practitioners (n=394) and rheumatologists (n=937) revealed substantial heterogeneity in referral pathways, timing of specialist assessment, initial GC dosing, and imaging practices, with many patients already started on prednisolone before rheumatology evaluation [5]. Together, these observations indicate that variability in PMR management arises at multiple levels of care.

This reliance on clinical judgment may contribute to variability in diagnostic and therapeutic decision-making in PMR. Despite the availability of structured management algorithms in international guidelines, including the 2015 EULAR/ACR recommendations and the 2010 British Society for Rheumatology/British Health Professionals in Rheumatology (BSR/BHPR) guideline [6, 7], real-world practice remains heterogeneous, particularly with regard to initial GC dosing, tapering strategies, and the use of disease-modifying antirheumatic drugs (DMARDs).

Clinical overlap between PMR and giant cell arteritis (GCA) is well recognized: approximately half of individuals with GCA develop polymyalgic symptoms during the disease course, and nearly one-fifth carry a prior PMR diagnosis [8]. Despite increasing recognition of subclinical GCA, contemporary guidelines provide limited guidance on this issue. Both the 2024 BSR guideline scope [9] and the 2015 EULAR/ACR recommendations [6] explicitly exclude concomitant or suspected GCA from their remit, offering no standardized approach to vascular imaging in PMR. This gap is particularly relevant given the increasing use of imaging modalities such as US and positron emission tomography (PET) in selected settings. In routine practice, screening for subclinical vasculitis remains uncommon and is generally limited to patients with suggestive clinical features [10]. Unrecognized vasculitis has been proposed to contribute to higher initial GC requirements and more gradual tapering strategies, raising questions regarding the potential role of baseline vascular imaging in PMR [11]. Consequently, approaches to GCA screening vary widely among rheumatologists, reflecting the absence of unified guidance and further contributing to heterogeneity in real-world practice.

In Turkiye, the absence of national PMR guidelines, variability in postgraduate rheumatology training, and structural differences in access to imaging and referral pathways between secondary and tertiary care settings are likely to further contextualize this variability within the Turkish healthcare system. Although international rheumatology guidelines have gained substantial academic prominence in recent decades [12], evidence on their consistent implementation in routine clinical practice, particularly across different healthcare settings, remains limited. To date, no nationwide study has evaluated how Turkish rheumatologists interpret and implement international PMR guidelines. Therefore, this survey aimed to describe real-world diagnostic and management practices for PMR in Turkiye including approaches to imaging and screening for GCA and to compare these practices with contemporary international guideline recommendations.

Highlight key points

- Initial GC initiation and tapering practices for polymyalgia rheumatica were largely consistent with international guideline recommendations, while considerable variability was observed in diagnostic approaches and screening strategies for giant cell arteritis.
- The use of imaging modalities, including musculoskeletal ultrasonography, magnetic resonance imaging, and positron emission tomography, showed marked heterogeneity among rheumatologists, despite their inclusion in contemporary classification criteria and management guidelines.
- Gaps between guideline recommendations and real-world practice highlight unmet needs in imaging access, standardized assessment, and follow-up–related management in PMR.

MATERIALS AND METHODS

Study Design and Participants

This nationwide, cross-sectional survey was conducted among rheumatologists currently practicing in Turkiye, including rheumatology fellows in training and practicing specialists. Data were collected using a self-administered online questionnaire disseminated through professional communication networks between 15 September and 20 October 2025. Participation was voluntary, and completion of the questionnaire was considered to indicate implied informed consent. Responses were collected and analyzed in a de-identified manner. As the survey was distributed through professional networks, the total number of rheumatologists who received or viewed the invitation could not be determined, and a response rate could therefore not be calculated. No formal a priori sample size calculation was performed, and all responses received during the survey period were included in the final analysis.

Survey Instrument

The questionnaire was developed with reference to the 2012 EULAR/ACR classification criteria [3] and international management guidelines, including the 2015 EULAR/ACR recommendations [6] and the 2010 BSR/BHPR guideline [7]. It was administered electronically as a self-completed online survey using Google Forms® (Google LLC, Mountain View, CA, USA). Draft versions were reviewed by senior rheumatologists to ensure clarity, face validity, and clinical relevance before dissemination.

The final survey contained 29 items structured into the following domains:

- Demographics and professional profile (Q1–6): Gender, age, years in rheumatology practice, academic rank, institution type, and geographic region.
- PMR case volume (Q7): Number of patients diagnosed with PMR in the past 6 months.
- Diagnostic approach (Q8–16): Use of classification/diagnostic criteria, reliance on erythrocyte sedimentation rate (ESR) and/or C-reactive protein (CRP), imaging preferences including US, magnetic resonance imaging (MRI), and PET, and screening for GCA.
- Treatment preferences (Q17–20): Initial therapeutic choices (GC alone or in combination with DMARDs), use of nonsteroidal anti-inflammatory drugs (NSAIDs), preferred initial GC starting dose, and tapering strategy.
- Follow-up and monitoring practices (Q21–27): Criteria for initiating DMARD therapy, relapse management, referral for individualized exercise programs, assessment of osteoporosis and fracture risk, and use of dual-energy X-ray absorptiometry (DXA) and the Fracture Risk Assessment Tool (FRAX).
- Barriers to guideline adherence (Q28): Main obstacles to full adherence to PMR management guidelines.
- Open-ended item (Q29, optional): Main challenges encountered in PMR management.

The survey was designed with reference to the Checklist for Reporting Results of Internet E-Surveys (CHERRIES) guidelines and reported accordingly [13]. The full survey questionnaire is provided in Appendix 1.

Ethics Approval

The study protocol was approved by the Ethics Committee of Goztepe Prof. Dr. Suleyman Yalcin City Hospital (Approval No: 2025/0112; Date: 11 September 2025). This study was conducted in accordance with the principles of the Declaration of Helsinki and its subsequent amendments.

Statistical Analysis

Survey responses were exported to Microsoft Excel and analyzed using SPSS software (version 25.0; IBM Corp., Armonk, NY, USA). Categorical variables were reported as frequencies and percentages, while continuous variables were summarized as means with standard deviations (SD) or medians with interquartile ranges (IQR), as appropriate. The primary analyses were descriptive. Exploratory analyses were limited to trend assessment between years of clinical experience and selected practice patterns using linear-by-linear association, where applicable. A two-tailed p value of <0.05 was considered statistically significant.

RESULTS

A total of 101 rheumatologists completed the survey. The cohort was predominantly female (71, 70.3%), with most participants falling within the 31–40-year age group (67, 66.3%). Nearly half of the participants reported 5–10

years of clinical experience in rheumatology (50, 49.5%), whereas only a minority had more than 20 years in practice (4, 4.0%). Specialists represented the largest professional subgroup (52, 51.5%), followed by associate professors (23, 22.8%) and fellows (14, 13.9%). Participants were employed across a range of healthcare settings; city hospitals were the most common workplace (32, 31.7%), while university hospitals and training and research hospitals each accounted for 24 participants (23.8%). Representation was obtained from all geographic regions of Turkiye, with the highest proportion originating from the Marmara region (39, 38.6%), followed by Central Anatolia (27, 26.7%). A comprehensive summary of the demographic and professional characteristics of the study population is provided in Table 1.

The majority of participants reported diagnosing five or fewer patients with PMR in the preceding six months, and no statistically significant differences were observed in PMR case numbers across the geographic regions of Turkiye. Regarding diagnostic resources, use of the 2012 EULAR/ACR provisional classification criteria was reported by 65 (64.4%), referral to the BSR/BHPR guidelines by 10 (9.9%), and primary reliance on clinical judgment by 76 (75.2%). The diagnostic approach did not differ significantly across levels of professional experience. However, linear-by-linear association analysis suggested that increasing years of practice were associated with decreased reliance on the 2012 EULAR/ACR criteria and greater reliance on clinical judgment (p=0.021). In contrast, no significant association was found between experience and the use of the 2010 BSR/BHPR guideline.

Elevated acute phase reactants (CRP and/or ESR) were considered necessary for diagnosis by 92 participants (91.1%). Figure 1 displays the percentage distribution of participants' self-reported use of imaging modalities, including US, MRI, and PET, and their main clinical indications. PET imaging was requested most frequently in cases of suspected malignancy by 70 participants (69.3%), followed by suspected GCA by 55 participants (54.5%) and steroid-resistant disease by 40 participants (39.6%). No statistically significant differences were observed within this sample between healthcare institutions in the use or ordering of imaging modalities.

Screening for GCA only in the presence of suggestive clinical signs or symptoms was reported by 76 participants (75.2%), whereas routine GCA screening in all patients with suspected PMR was reported by 25 (24.8%).

Table 1. Demographic and professional characteristics of the participants

	n	%
Sex		
Female	71	70.3
Male	30	29.7
Age Range		
≤30	1	1
31-40	67	66.3
41-50	28	27.7
≥51	5	5
Experience (years)		
<5	30	29.7
5-10	50	49.5
11-20	17	16.8
>20	4	4
Title		
Fellow	14	13.9
Specialist	52	51.5
Faculty Member	8	7.9
Associate Professor	23	22.8
Professor	4	4
Institution		
State hospital	15	14.9
University hospital	24	23.8
Private healthcare	6	5.9
Training and research hospital	24	23.8
City hospital	32	31.7
Region		
Marmara	39	38.6
Mediterranean	9	8.9
Aegean	11	10.9
Central Anatolia	27	26.7
Southeastern Anatolia	3	3
Eastern Anatolia	3	3
Black Sea	9	8.9

GC monotherapy was the preferred first-line treatment in 76 participants (75.2%). An initial GC dose of 12.5–25 mg/day (prednisolone equivalent) was selected by 73 (72.3%), and 55 (54.5%) reported beginning tapering between weeks 4 and 8. More than half of the

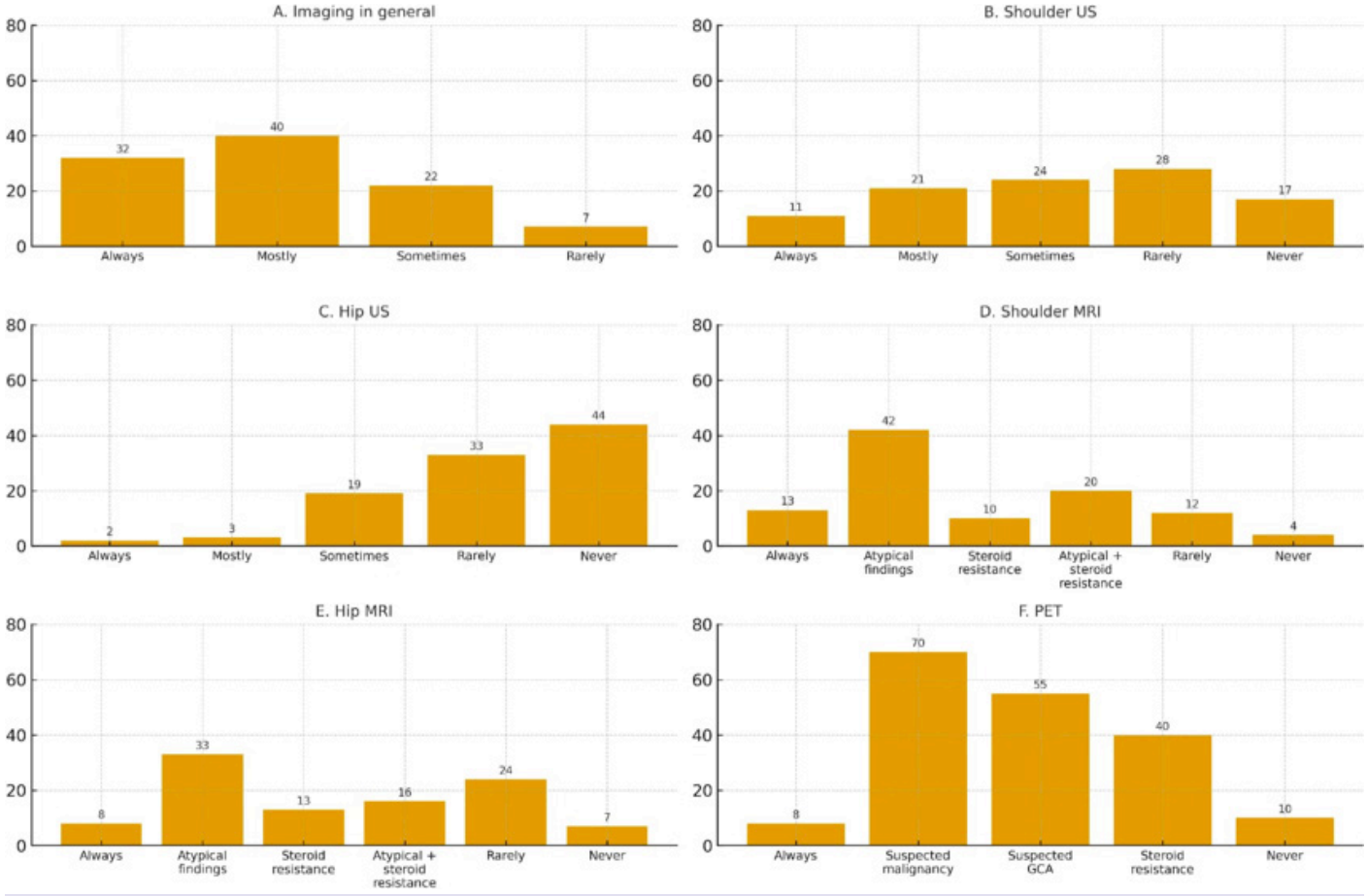


Figure 1. Imaging practices among Turkish rheumatologists for suspected PMR.

All values are expressed as percentages of respondents. A: General use of imaging; B: Frequency of shoulder ultrasonography C: Frequency of hip ultrasonography; D: Indications for shoulder MRI; E: Indications for hip MRI; F: Reported indications for PET imaging.

participants (55, 54.5%) initiated DMARD therapy at the first relapse. As shown in Table 2, increasing the GC dose (87, 86.1%) and adding a DMARD (85, 84.2%) were the most frequently used strategies for relapse management, while smaller proportions used tocilizumab (30, 29.7%), requested imaging (30, 29.7%), or screened for GCA (44, 43.6%).

Approximately half of the participants reported that their patients had been receiving treatment for 1–2 years, 51 participants (50.5%), while 43 (42.6%) indicated treatment duration longer than 2 years and 7 (6.9%) reported durations shorter than 1 year. The most frequently reported barrier to guideline adherence was patient non-adherence, reported by 36 participants (35.6%), followed by concerns regarding treatment side effects (31, 30.7%), time constraints in clinical practice (25, 24.8%), limited access to guideline-recommended medications (7, 6.9%), and patient comorbidities (2, 2.0%).

A total of 86 participants (85.1%) reported routinely evaluating patients diagnosed with PMR for osteoporosis and fracture risk, and 53 (52.5%) reported ordering DXA. Additionally, 79 participants (78.2%) stated that they did not routinely refer patients for personalized exercise planning or calculate FRAX scores. There were no significant differences between healthcare institutions regarding DXA requests, FRAX score calculation, or referrals for exercise planning.

Themes identified from the open-ended question (answered by 39 participants) were derived through descriptive categorization rather than formal qualitative analysis. Concerns about side effects and comorbidities were reported most frequently (16, 41.0%), followed by patient non-adherence issues (14, 35.9%). Additional challenges included issues related to insurance coverage for medications and institutional limitations (7, 17.9%), difficulties in differential diagnosis (5, 12.8%), lack of specific markers reflecting disease activity (2, 5.1%), and challenges in managing relapses (1, 2.6%).

Table 2. Treatment preferences, glucocorticoid dosing, tapering strategies, and relapse management approaches among Turkish rheumatologists

	n	%
First line treatment[a]		
GC monotherapy	76	75.2
GC and MTX	38	37.6
GC and another DMARD	11	10.9
NSAID use for treatment of PMR	15	14.9
GC starting dose (prednisolone, mg/day)		
2.5-7.5	0	0
7.5-12.5	21	20.8
12.5-25	73	72.3
25-30	6	5.9
≥30	1	1
GC taper time		
Week 2	28	27.7
Week 8	9	8.9
Week 4-8	55	54.5
Week 8-12	7	6.9
Week 12	2	2
DMARD[a]		
From the beginning	36	35.6
First relapse	55	54.5
Second relapse	27	26.7
In case of GC side effect	46	45.5
Relapse[a]		
GC dose increase	87	86.1
Add DMARD	85	84.2
Tocilizumab	30	29.7
Imaging	30	29.7
Screen GCA	44	43.6

GC: Glucocorticoid; MTX: Methotrexate; DMARD: Disease-modifying antirheumatic drug; NSAID: Nonsteroidal anti-inflammatory drug; a: Percentages may exceed 100% because participants could select more than one option.

DISCUSSION

To our knowledge, this is a nationwide evaluation of real-world diagnostic and therapeutic practices for PMR among rheumatologists in Turkiye. Our findings show substantial heterogeneity across key aspects of care: only 64.4% reported using the 2012 EULAR/ACR criteria, 24.8% routinely screened for GCA, and recommended osteoporosis assessments such as DXA and FRAX were performed by 52.5% and 21.8% of clinicians, respectively. In contrast, GC monotherapy and guideline-consistent starting doses (12.5–25 mg/day in 72.3%) were widely adopted, highlighting a gap between diagnostic/monitoring recommendations and routine practice.

The low PMR case volumes reported by rheumatologists in our survey are consistent with previous epidemiologic data from Turkiye [14]. In a population-based study from northwestern Turkiye, the annual incidence rates for GCA and PMR in individuals aged ≥50 years were 1.13/100,000 and 3.15/100,000, respectively [14] markedly lower than Scandinavian rates, where incidence exceeds 20/100,000 and prevalences reach 68.3/100,000 in Denmark [15] and 50/100,000 in Sweden [16]. This low background incidence likely contributes to the fact that nearly all rheumatologists in our cohort diagnosed five or fewer PMR patients within the preceding six months.

Another notable finding was the inverse relationship between clinical seniority and use of standardized diagnostic frameworks. More experienced clinicians were less likely to rely on the 2012 EULAR/ACR criteria, echoing observations from other rheumatologic disorders [3]. These patterns may reflect experience-related variation, combined with the absence of a diagnostic gold standard in PMR, influencing how consistently clinicians use guideline-based tools.

It should be emphasized that the 2012 EULAR/ACR criteria were developed as classification criteria rather than diagnostic criteria [3]. Their primary purpose is to standardize patient selection for research, not to establish a definitive diagnosis in individual patients. In routine clinical practice, clinicians often integrate these classification frameworks with comprehensive clinical judgment, longitudinal follow-up, and treatment response. This distinction is particularly relevant in PMR, where no disease-specific diagnostic biomarker exists, and may partly explain the variable reliance on the 2012 EULAR/ACR criteria observed in our survey.

Diagnostic uncertainty may also stem from atypical presentations. A Turkish study found normal ESR and CRP values in 14% of clinically diagnosed PMR patients [17], demonstrating that inflammatory markers are not invariably elevated. Nonetheless, ESR and/or CRP remain central to routine diagnostic reasoning and the 2012 EULAR/ACR classification criteria [3]. In line with this, 91.1% of participants in our survey required at least one elevated acute-phase reactant for diagnosis.

Even in the validation cohort of the 2012 EULAR/ACR criteria, the final diagnosis changed in 7.8% of patients [3], underscoring the limitations of relying on clinical judgment alone without supportive imaging or longitudinal assessment. Accordingly, imaging is recommended in situations such as atypical presentations, normal inflammatory markers, inadequate GC response, suspected large-vessel GCA, or high risk of GC toxicity [18]. In our survey, imaging practices showed considerable variation. US, MRI, and particularly PET scans were used inconsistently; PET was requested most commonly when malignancy was suspected, followed by suspected GCA and steroid-resistant disease. Screening strategies for GCA also varied widely. Differences in GCA screening approaches among Turkish rheumatologists may be influenced by local contextual factors. The absence of national PMR guidelines in Turkiye, heterogeneity in access to vascular and musculoskeletal imaging across institutions, variability in clinical service delivery between tertiary centers and peripheral hospitals, and differences in clinicians' experience may collectively shape these practices. Such system-level disparities may help explain why substantial variation persists, even when international recommendations are uniform.

Initial treatment practices in our cohort were largely aligned with international guideline recommendations [6, 7]. GC monotherapy was preferred by 75.2% of clinicians, with most selecting a starting dose within the recommended 12.5–25 mg/day range and initiating tapering between weeks 4 and 8, consistent with both the 2015 EULAR/ACR recommendations and the 2010 BSR/BHPR guideline [6, 7]. In contrast, relapse management demonstrated greater variability: increasing GC doses (86.1%) and adding a DMARD (84.2%) were the most commonly adopted strategies, while tocilizumab was used less frequently (29.7%). This pattern reflects current guidance, which conditionally recommends early methotrexate (MTX) in patients at high risk of relapse or prolonged GC exposure and reserves biologic therapy for refractory disease [6]. In this context, the limited use of tocilizumab and the absence of TNF inhibitors appear appropriate and may reflect a cautious, stepwise approach to biologic therapy, particularly in healthcare settings without nationally endorsed PMR guidelines.

Observational studies indicate that prolonged GC exposure is common in PMR: up to 85% of patients experience GC-related adverse events, half remain on treatment after 2 years, and one-quarter continue beyond 5 years [6, 19]. Our survey showed similar patterns, with 50.5% of clinicians treating patients for 1–2 years and 42.6% for more than 2 years. Despite guideline emphasis on minimizing GC duration [7], prolonged courses remain common, underscoring real-world challenges in tapering.

The 2015 EULAR/ACR recommendations also emphasize patient education, fracture prevention, and referral for individually tailored exercise programs [6]. Although most clinicians (85.1%) reported routinely evaluating osteoporosis risk, implementation gaps were evident: only 52.5% ordered DXA, and the majority did not calculate FRAX scores or refer patients for exercise planning. Limited access to allied health services, time constraints, or uncertainty regarding benefit may contribute to this discrepancy.

The challenges reported by participants including concerns about GC toxicity, patient non-adherence, system-level obstacles, diagnostic uncertainty, and difficulties in managing relapses—closely mirror observations from other healthcare settings. In a large UK multi-methods study, general practitioners similarly described diagnostic uncertainty, frequent reliance on GC responsiveness, and inconsistent investigation of alternative diagnoses, along with widespread concerns about long-term GC adverse effects and variable monitoring practices [4]. These international parallels indicate that the difficulties identified in our survey are not unique to Turkiye but rather reflect broader, system-level challenges inherent to PMR management.

This study has several strengths. It provides nationwide representation by including rheumatologists from all major regions of Turkiye, offering a comprehensive overview of specialist-level PMR management. Unlike prior studies focused on primary care, this survey specifically reflects the practices of rheumatologists, who are primarily responsible for diagnostic evaluation, longitudinal monitoring, and treatment escalation. The questionnaire captured multiple domains—including diagnostic criteria use, imaging strategies, GCA assessment, GC dosing and tapering, relapse management, and osteoporosis prevention—allowing a multidimensional evaluation of real-world practice patterns across different levels of clinical seniority.

Nevertheless, several limitations should be acknowledged. The cross-sectional, self-reported design carries risks of recall and social desirability bias, and voluntary participation may have introduced selection bias. As the survey was disseminated through professional communication networks, the total number of rheumatologists

who received or viewed the invitation could not be determined, precluding calculation of a formal response rate and limiting full assessment of sample representativeness. Moreover, because the data reflect self-reported practice patterns rather than audited patient-level records, the findings indicate perceived concordance with guideline recommendations rather than objectively measured adherence. The absence of patient-level clinical data further restricts the ability to link reported management strategies with actual outcomes. Future research should therefore focus on prospective, patient-level studies evaluating diagnostic pathways, imaging strategies, and longitudinal outcomes, including GC exposure, relapse rates, and treatment-related adverse events. Mixed-methods approaches incorporating qualitative interviews may also help elucidate system-level and behavioral barriers to guideline implementation.

Conclusion

This nationwide survey provides a comprehensive assessment of specialist-level PMR management in Turkiye and demonstrates marked variability across key domains of care. Although initial GC treatment was largely aligned with international guideline recommendations, substantial inconsistencies were observed in the use of classification criteria, imaging modalities, screening strategies for GCA, and follow-up–related management. These findings underscore persistent gaps between guideline recommendations and real-world clinical practice, likely reflecting the absence of a diagnostic gold standard, heterogeneity in clinical experience, and structural constraints within the healthcare system. Overall, our results highlight the need for more standardized and context-sensitive approaches to PMR care in Turkiye.

Ethics Committee Approval: The Goztepe Prof. Dr. Suleyman Yalcin City Hospital Non-Interventional Clinical Research Ethics Committee granted approval for this study (date: 11.09.2025, number: 2025/0112).

Informed Consent: Written informed consents were obtained from patients who participated in this study.

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Appendix 1. Survey Questionnaire

1. Sex
   - Female
   - Male
2. Age
   - ≤30 years
   - 31–40 years
   - 41–50 years
   - ≥51 years
3. Years working in rheumatology (including fellowship)
   - <5 years
   - 5–10 years
   - 11–20 years
   - >20 years
4. Professional title
   - Rheumatology fellow
   - Rheumatologist
   - Assistant professor
   - Associate professor
   - Professor
5. Institution type
   - State hospital
   - University hospital
   - Training and research hospital
   - City hospital
   - Private institution
   - Other
6. Geographic region
   - Marmara
   - Aegean
   - Mediterranean
   - Central Anatolia
   - Black Sea
   - Eastern Anatolia
   - Southeastern Anatolia
7. Number of PMR patients diagnosed in the last 6 months
   - 0–5
   - 6–10
   - 11–15
   - 16–20
   - >20
8. Criteria used for PMR diagnosis (multiple answers allowed)
   - 2012 EULAR/ACR criteria
   - 2010 BSR/BHPR guideline
   - Clinical judgement
   - Other
9. Requirement of elevated CRP or ESR for PMR diagnosis
   - Yes
   - No
10. Use of imaging in suspected PMR
    - Always
    - Most of the time
    - Sometimes
    - Rarely
    - Never
11. Shoulder ultrasonography in suspected PMR
    - Always
    - Most of the time
    - Sometimes
    - Rarely
    - Never
12. Hip ultrasonography in suspected PMR
    - Always
    - Most of the time
    - Sometimes
    - Rarely
    - Never
13. Indications for shoulder MRI (multiple answers allowed)
    - All patients
    - Atypical clinical/lab findings
    - Inadequate steroid response
    - Rarely
    - Never
14. Indications for hip MRI (multiple answers allowed)
    - All patients
    - Atypical clinical/lab findings
    - Inadequate steroid response
    - Rarely
    - Never
15. Indications for PET imaging (multiple answers allowed)
    - All patients
    - Suspected malignancy
    - Suspected GCA
    - Steroid-resistant disease
    - Never
    - Other
16. GCA screening strategy in PMR
    - All patients
    - Only if GCA symptoms present
    - Inadequate response during follow-up
    - Other

Appendix 1 (cont). Survey Questionnaire

17. Preferred initial PMR treatment (multiple answers allowed)
    - Glucocorticoids alone
    - Glucocorticoids + methotrexate
    - Glucocorticoids + other DMARD
18. Use of NSAIDs in PMR treatment
    - Yes
    - No
19. Preferred initial glucocorticoid dose (mg/day)
    - <7.5
    - ≥7.5
    - ≥12.5
    - ≥25
    - ≥30
20. Timing of glucocorticoid tapering
    - From week 2
    - Weeks 4–8
    - From week 8
    - Weeks 8–12
    - From week 12
21. When DMARD therapy is considered (multiple answers allowed)
    - From onset
    - At first relapse
    - After multiple relapses
    - Steroid adverse effects
    - Other
22. Relapse management strategies (multiple answers allowed)
    - Increase steroid dose
    - Add DMARD
    - Start tocilizumab
    - Request imaging
    - Reassess for GCA
    - Other
23. Referral for individualized exercise programmes
    - Yes
    - No
24. Assessment of osteoporosis and fracture risk
    - Yes
    - No
25. Routine DXA request
    - Yes
    - No
26. Routine FRAX calculation
    - Yes
    - No
27. Average PMR treatment duration
    - <1 year
    - 1–2 years
    - >2 years
28. Main barrier to guideline adherence
    - Patient non-adherence
    - Adverse effect concerns
    - Time constraints
    - Limited access to medication
    - Other
29. Greatest challenge in PMR management (optional)
    - Open-ended response