Academy of PHYSICAL MEDICINE

Broadcast Summary

Hypermobility

With Josephine Halsall

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Josephine Halsall

- An osteopath, qualified at the BSO
- Medical Advisor to The Joint Hypermobility Syndrome Association
- Is herself a hypermobility sufferer, as was her mother and are her brother, niece and one daughter

- Very bendy as a child – good at gymnastics – not diagnosed/problem
- RTA triggered symptomatic JHMS
- Prof Rodney Graham has brought JHM to much greater prominence
- Hypermobile joints do not necessarily = JHMS

JHMS Criteria:

- Flexibility
- Pain in several areas
- Pain lasted longer than 3 months
- History of subluxations
- "Princess and Pea" syndrome

Diagnosis:

- Stretch skin – back of hand

Categorisation:

- Ehlers Danlos – 9 categories
  - 1&2: hypermobility much more extensive and debilitating
  - 3 = Benign JHMS – many don't know they have it
    - some have no symptoms
    - some have no symptoms until there's a trauma
    - some start to suffer in adolescence, possibly due to growth spurts (worse in girls)
    - 85% female problem
    - Asian people are more susceptible
    - Northern races less susceptible

- Marfans is a genetic mutation- there may be no familial history. However, some who look Marfanoid; have Ehrlers Danlos.
- Marfans is associated with serious vascular disorders (e.g. aortic aneurysm)
- GPs more likely to recognise hypermobility now. Response depends on GP. Few areas have a specific hypermobility clinic. Referrals have to be from rheumatologist. There is lots of red tape.
- More likely to be first diagnosed by physical therapist.
- Many practitioners (including GPs) may feel JHMS is a fad.
- But remember that not all problems may be due to hypermobility.

- Spotting the hypermobile:
    - The way they sit- fidget and unable to stabilise.
    - Wrap legs around chairs.
    - Leg up on chair while talking.
    - History of CDH could be a clue.
    - Sway back – produces long, weak hip flexors
- Horses suffer from hypermobility- dig holes in field

- Confirmation:
- 9 point Beighton scale
    - Passively dorsiflex the 5th Metacarpophalangeal joint>90 degrees (one point each side)
    - Passively appose the thumb to the volar aspect of the forearm (one point each side).
    - Passively hyperextend the elbow to> 10 degrees (one point each side).
    - Passively hyperextend the knee to >10 degrees (one point each side).
    - Actively place hands flat on the floor without bending the knees (one point).
- Low score on Beighton not necessarily JHMS – needs to be associated with pain.

- Important to diagnose condition as Ehrlers Danlos (Type 3): in some countries (Holland) sufferers may not be eligible for benefits.

Case history

- 55y/o woman
- born with congenital dysplasia hip (not tested at that time)
- walks with a stick
- Pressure from stick caused problems in shoulder through impact – changed ferrule to one with cushioning – had major effect.

- Sufferers tend to be good at adapting, developing compensatory patterns

- Treatment
  - Depends where problem is.
  - Treatment needs to be ultra specific.
  - Less use of long levers.
  - Stabilisation exercises using fit-ball very effective.

- Not yet recognised as a disability in schools (e.g. extra time in exams).
- Writing can cause pain- may need special pens (wrap tape around pen to help)/wrist support.
- Specialist support exists within hypermobility clinics e.g. Katherine Butler, London Hand Therapy (http://www.londonhandtherapy.co.uk/therapist/).
- JHMSA is a valuable educational resource.

- High incidence of postural orthostatic tachycardia – POTS (Prof Christopher Mathias).
- Clicky joints are often associated with hypermobility – if accompanied with pain, need stabilisation.
- HVTs? Not contraindicated, but more difficult to lock. Thoracic HVT can be very helpful.

- Pain relief: NSAIDs. More prone to hernias, therefore may be more prone to reflux NSAIDs may aggravate. Opioids for acute flare up. Amitriptyline can be very helpful. TENS can be useful.
- Many hypermobiles do not respond to local anaesthetics/epidurals (e.g. novocaine) Dentists may not be aware.
- Stretching – most hypermobiles like to get to their end range of movement. But need strengthening to complement. Start with open chain, but become more functional as they progress.
- Pilates can be helpful.
- JHMS often associated poor proprioception - not always (e.g. ballet dancers). Can improve with training – need 1:1 training.
- Is there any advantage in trying to reduce mobility in order to compensate (e.g. by building muscle)? Depends if instability present. CSP instability could be dangerous. Aim is to achieve what's normal for the patient.
- Taping can be beneficial.
- Joint artic helpful.
- Can we claim to treat JHMS? Evidence in osteopathy is anecdotal, but physiotherapists have reasonable research base.
- Effect in pregnancy? Can make matters difficult – especially PSD. Hard to deal with – belt may be the only solution.
- Sufferers need to understand the need to articulate their need for help – not obvious to those around.
- Overlap with fibromyalgia – often confused/misdiagnosed.
- Sufferers below the threshold: spectrum (older patients will be less flexible).

- Ehlers Danlos (ED)IV – life expectancy (average of 40) reduced due to bleeding – HVT contraindicated – less likely to visit clinic.
- Mitral valve prolapse: not a characteristic of ED III (it is in Marfans)
- Marfans need regular medical observations- refer any patient who may be Marfanoid.
- With JHMS patients may need more attention than others, may need more frequent top-ups.
- Will continuing to compete worsen the condition? Self-management- may need to set aside more time to recover. Many may ease as they age, due to natural tightening up.
- Familial history may be concealed by poor diagnosis in previous generations. Gene not yet identified in type III.
- Patients like to have a name for the condition/to be believed/to have it explained.
- Hypnotherapy – can be useful for pain relief.
- Within specialist teams, CBT available.
- Fit ball exercise (keep body upright)
    - Feet together move forward and back/left to right
    - Round the clock
    - Lift one leg and repeat
    - Repeat little and often- NB: Can be used in an office at work but too long is counter-productive.
- Pilates, yoga and decrease in workload can also have an effect.

- More likely to have hypermobile peripheral joints than spinal? Depends on the patient.
  – Perhaps the statistics are skewed, as smaller joints are more manageable.
- Use of resistance bands should not begin treatment but have their place; use of weights could be useful.
- There is no standard list of exercises for hypermobiles but normal exercises can be adapted for them.
- Sitting can be an aggravating factor depending on the seat.
  – However, sitting can be aggravating for everyone and hypermobiles are just more sensitive to it.