Managing Joint Hypermobility Syndrome in Primary Care

**Background**

Joint Hypermobility Syndrome (JHS) is characterised by:
- Joint hypermobility
- Chronic musculoskeletal pain

Non-specific symptoms can also be present e.g. fatigue, anxiety, low mood, dizziness, palpitations, migraine, IBS. Overlap with fibromyalgia syndrome (FMS).

**Epidemiology**

- JHS and Ehlers Danlos Syndrome hypermobility type (formerly called type III) are likely to be the same condition
- Family history of hypermobility is common (autosomal dominant)
- Affects 0.5-1% of the population
- x8 more common in women
- Peak incidence 20-30 years

**Summary**

Based on presence of:
- Joint hypermobility (Beighton score ≥ 4/9, see diagram below)
- Widespread arthralgia/myalgia for more than 3 months

**Diagnosis**

**Multi-Disciplinary referral**

- Physiotherapy is the most effective form of management for musculoskeletal symptoms
- CBT (where available), coping strategies and symptom relief important – there is no ‘cure’
- Non-specific symptoms can be managed in Primary Care; refer to Secondary Care in case of diagnostic uncertainty

**Pharmaceuticals**

- Prescribe in accordance with NHSGGC Pain Guidelines and NHSGGC Formulary
- Prescribe amitriptyline (unlicensed use) or gabapentin as first line approach if paracetamol or NSAIDs ineffective
- Pregabalin if no response or treatments above not tolerated
- Duloxetine (unlicensed use) is restricted to specialist initiation

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