Managing Joint Hypermobility Syndrome in Primary Care

Background

Summary

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

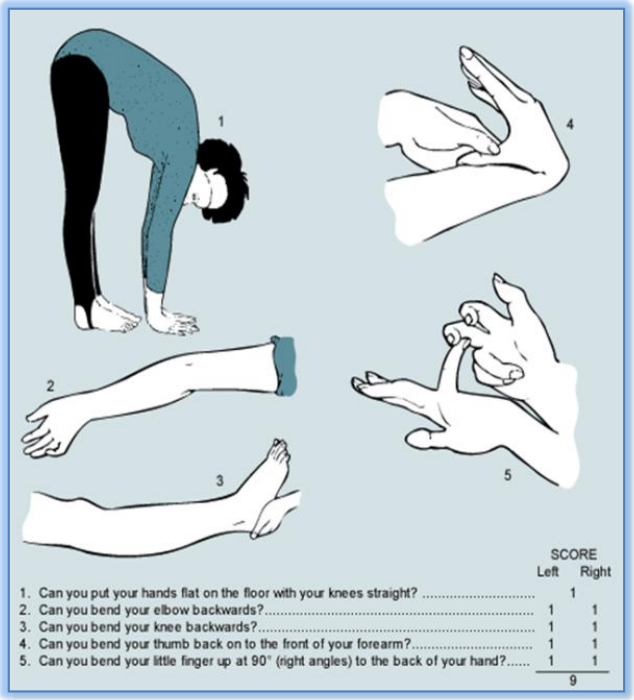
- JHS and Ehlers Danlos Syndrome hypermobility type (formerly called type III) are likely to be the same condition
- Family history of hypermobility is common (autosomal dominant)
- Affects 0.5-1% of the population
- x8 more common in women
- Peak incidence 20-30 years

Diagnosis

Diagnosis

Based on presence of:

- **Joint hypermobility** (Beighton score ≥ 4/9, see diagram below)
- **Widespread arthralgia/myalgia** for more than 3 months



Management

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