7. Management of Articular Complications in the Hypermobility Syndrome

Hypermobile patients can be spared much unnecessary suffering by the establishment of the correct diagnosis. As indicated in Chap. 6, hypermobility is one of the great mimics in rheumatology. Many hapless individuals are misdiagnosed as suffering from rheumatoid arthritis (both adult and juvenile). Needlessly they are forced to suffer the anguish of living with that diagnosis and are exposed to the dangers of the slow-acting anti-rheumatoid drugs and other potentially hazardous treatments. Others, in the absence of observed physical signs to explain their symptoms (joint hypermobility is often overlooked), are labelled as neurotic. They either accept this and become resigned to a life of misery and disability, or reject it and go from one specialist to another in their quest for relief. Not surprisingly many seek help from practitioners of alternative medicine. It is self-evident that reassuring the patient that he or she has neither a potentially crippling disease nor, for that matter, a psychological one can have a profoundly beneficial effect on morale!

General Management

Although the precise cause of pain in hypermobility syndrome (HMS) is often undetermined, most patients can offer information concerning exacerbating and relieving factors. The majority recognise the adverse effects of physical activity and it is often possible to restrict exercise to within reasonable levels of tolerance. This may entail avoidance of strenuous sporting pursuits, change of occupation, or modification of the manner of performance of a particular job. The journey to and from the place of employment may provoke more symptoms than the actual work itself. Most children with HMS can relate their symptoms to performance of specific activities or sports (Biro et al. 1983). Such information can form the basis for helpful counselling, which may be of therapeutic benefit. It follows that in this respect time spent in taking a detailed history will pay dividends.
Specific Management

The reader is recommended to consult the standard texts on rheumatology, orthopaedics and physiotherapy for a full account of the management of the wide variety of complications that may be associated with joint hypermobility. A summary of the principal methods of management is given below.

Rest

After acute soft-tissue injury, immobilisation, i.e. resting the affected part, is beneficial in the short term. Care is needed to avoid excessive rest as this may lead to loss of function. Chronic or repeated “overuse” injury such as chronic tenosynovitis, often the result of occupational activities, may require total avoidance of all pain-inducing activities (TAPIA) for from 5 to 8 months (Fry 1986). Local rest in the form of splinting combines pain relief and avoidance of contracture formation, whilst dynamic splinting permits simultaneous restoration of function. These techniques are particularly useful in small finger joint strains so commonly seen in hypermobile subjects (Wray et al. 1984).

Local Steroid Injection

The treatment of choice in many of the soft tissue lesions associated with hypermobility is the carefully applied topical infiltration with hydrocortisone acetate or methylprednisolone with lignocaine. These entities include tennis and golfer’s elbow (lateral and medial epicondylitis, respectively), bicipital and supraspinatus tendinitis, adhesive capsulitis, tenosynovitis, bursitis and ligamentous and capsular tears. Longer acting corticosteroid preparation should be used with caution in extra-articular conditions, as they may lead to severe connective tissue atrophy with consequent weakening of collageneous tissues. The injection of steroid directly into a tendon should be avoided, as this can result in tendon atrophy, weakness and even rupture. Local steroid injection is also effective in stenosing tenosynovitis – the cause of “trigger finger” or “trigger thumb”. A recent study reported a 72% success rate – mean follow-up period 25 months (Rhoades et al. 1984).

A small volume of a potent steroid preparation, such as hydrocortisone or methyl prednisolone, gives excellent results in the treatment of persistent synovitis of joints and of the carpal tunnel syndrome. In the treatment of discogenic sciatica or cruralgia, epidural corticosteroid injections given as in-patients bring relief in over two-thirds of cases, whether or not hypermobility is a predisposing factor (Dilke et al. 1973). As out-patients, 17 (90%) of 19 patients responded to the active injection in the short term, compared