Introduction

Joint hypermobility is the largest amplitude of the normal range of motion of joints, due to increased compliance of the ligaments and joint capsules.¹ When joint hypermobility is associated with clinical and/or extra-articular manifestations, the Ehlers-Danlos syndrome (HMS) or benign joint hypermobility syndrome occurs, defined by the revised Brighton²⁻³ criteria. Moreover, according to the classification criteria of the Ehlers-Danlos syndrome (EDS) currently employed,⁴ the former EDS type III is now classified as hyperlax or hypermobile EDS, and would be virtually identical to the benign joint hypermobility syndrome.⁵ We report the case of a woman with a hyperlax EDS.

Clinical Case

The patient is a 27 female graphic designer with a family history that highlights her father with joint hypermobility mainly of the hands, a sister aged 20 and a paternal cousin of the first degree with symptoms of hypermobility, but not studied. She has a history of two pregnancies, an abortion and a healthy 7-year-old daughter, who also has joint hyperlaxity documented by a Beighton 9/9 hypermobility. From birth the patient showed “extreme” mobility of the joints, which delayed the start of gait and led to repeat sprains since childhood. She frequently performed joint hypermobility maneuvers (Fig. 1). She had bruises and frequent epistaxis. Study of coagulation and platelet function were performed before birth, being normal. Since 3 years prior presents repeating subluxations in the knees and shoulders, so has to travel in a wheelchair for long distances. She presents relapsing tendinopathy of the wrists after holding weight or maintaining positions for writing or drawing, so she cannot practice her profession. Systemic examination was normal. No skin elasticity or transparency was observed, nor was ecchymosis, atopic dermatitis on elbow flexure lesions; Beighton test was 9/9. Passive and active joint mobilities in all joints were explored, over the normal range (Fig. 2), leading to subluxation. The echocardiogram was normal.

Discussion

Joint hypermobility is less a skill than a problem; there is also a relative confusion in terminology as we stated in the
attacks, agoraphobia\textsuperscript{2,6,8} dysautonomia and osteoporosis in premenopausal women.\textsuperscript{3}

The diagnosis of this syndrome is clinical and confirmed using Brighton criteria.\textsuperscript{3} Treatment includes preventive measures, rest, physiotherapy and analgesia in the acute phase and then a multidisciplinary rehabilitation approach to restore normal range of joint motion, correct movement dysfunction, improve joint stability, physical condition and mental impact by benign hypermobility. Again adjectives demonstrate how relative they can become.

Ethical Responsibilities

Protection of people and animals. The authors declare that no experiments have been performed on humans or animals.

Data confidentiality. The authors declare that they have followed the protocols of their workplace regarding the publication of data from patients and that all patients included in the study have received sufficient information and have given their written informed consent to participate in the study.

Right to privacy and informed consent. The authors have obtained informed consent from patients and/or subjects referred to in the article. This document is in the possession of the corresponding author.

Conflict of Interest

The authors declare no conflicts of interest.

References