

Joint Hypermobility in Chiropractic Practice: Part 2: Manipulation safety and evidence-based rehabilitation

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Manus prompt:

Provide a 2 paragraph summary of Henry Pollard's paper 'Joint Hypermobility in Chiropractic Practice: Part 2: Manipulation safety and evidence-based rehabilitation' using professional clinical language and provide 3 multi-choice quiz questions and 3 true/false question with answers

Manus response:

Pollard characterises symptomatic joint hypermobility as primarily a stability and load-tolerance disorder, rather than a condition requiring additional mobility. Excessive joint excursion occurs alongside deficient passive ligamentous restraint, impaired proprioception, suboptimal neuromuscular control, and reduced tolerance to mechanical loading. Although spinal manipulation may produce short-term analgesia through neurophysiological mechanisms, it does not restore ligamentous restraint or correct the dominant impairment of instability. Repeated high-velocity, low-amplitude manipulation of already lax segments may contribute to end-range irritability, recurrent symptom cycling, and dependence on passive care; consequently, manipulation should be used selectively, incorporated within multimodal management, and avoided when clinical findings indicate instability or an unfavourable risk profile.

Cervical management requires structured differential assessment for cervical arterial dysfunction and craniocervical instability, with greater emphasis on the history, symptom behaviour, and appropriate escalation than on provocative vertebral basilar insufficiency testing alone. Findings such as a new unilateral or progressive headache, anterior neck or periorbital pain, pulsatile tinnitus, transient neurological symptoms, partial Horner syndrome, syncope, or symptoms following minor trauma should constrain thrust-based intervention and may warrant referral. Long-term management should be active, progressive, and function-oriented, beginning with low-load, mid-range control and advancing through muscular endurance, proprioceptive and sensorimotor retraining, spinal motor control, functional strengthening, and graded return to activity. Education, pacing, and kinetic-chain assessment complement this programme, with progression determined by symptom stability, movement quality, and sustained control under increasing demand.

Multiple-Choice Questions

1. According to Pollard, which description best reflects the principal clinical impairment in symptomatic joint hypermobility?

- A. Restricted joint mobility caused by capsular shortening
- B. Instability with impaired control and reduced load tolerance
- C. Acute inflammatory arthropathy requiring immobilisation
- D. Fixed structural deformity requiring repeated mobilisation

Answer: B.

2. What is the most appropriate response when a hypermobile patient requesting cervical manipulation reports a new unilateral headache, pulsatile tinnitus, and syncope?

- A. Perform cervical manipulation after a negative positional provocation test
- B. Apply aggressive anterior cervical soft-tissue pressure instead of manipulation
- C. Defer thrust manipulation, conduct an appropriate differential assessment, and refer or escalate care where indicated
- D. Provide repeated manipulation because prior treatment produced brief relief

Answer: C.

3. Which intervention is most appropriate during the initial phase of rehabilitation for an irritable, unstable hypermobile joint?

- A. Maximal-resistance exercise through end range
- B. Repeated passive manipulation without active rehabilitation
- C. Low-load, mid-range isometrics, joint-setting exercises, and foundational trunk activation
- D. Immediate sport-specific impact training

Answer: C.

True-or-false questions

1. Spinal manipulation can restore deficient ligamentous restraint in a hypermobile segment.

Answer: False. Manipulation may provide transient analgesia, but it does not restore ligamentous stability.

2. Proprioceptive and sensorimotor training are relevant because impaired joint-position sense can contribute to functional instability.

Answer: True.

3. Rehabilitation progression should be based solely on elapsed time, irrespective of symptom stability or movement control.

Answer: False. Progression should reflect symptom response, movement quality, functional capacity, and control under increasing load.