Pelvic Girdle Pain in Pregnancy

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Guideline for the process of referral for pelvic girdle pain in pregnancy.

This guideline is for use by the following staff groups:
Midwives
Health Visitors
Consultants in Obstetrics and Gynaecology
Pelvic Health Physiotherapists
All other HCPs involved with Antenatal and Postnatal care as relevant

Lead Clinician(s)

Jennifer Westley	Physiotherapist
Approved by *Maternity Governance Meeting* on:	17th March 2023
Review Date: This is the most current document and should be used until a revised version is in place	17th March 2026

Key amendments to this guideline

Date	Amendment	Approved by:
30/11/2022	• Amendment to aetiology and introduction to PGP based on more up to date evidence • Amendment to process map/referral pathway to ensure early identification and referral to physiotherapy with no delays • Adjustment to include other HCPs as clinically indicated • Amendment to highlight postnatal early referral if ongoing symptoms	Maternity Governance Meeting

Introduction - Pelvic Girdle Pain

Pregnancy related pelvic girdle pain (PGP) describes pain in the lumbosacral, sacroiliac and/or symphysis pubis joints. It is important to acknowledge that pregnancy related PGP is a common, recognised condition. It is common, but not normal, to have PGP in pregnancy and the condition affects around 1 in 5 women.

Symptoms include pain at the front and/or back of the pelvis and commonly, difficulty walking, climbing stairs, turning over in bed and single leg activities such as putting socks on for example.

PGP is best managed with prompt identification and together with assessment and appropriate treatment, and good recovery can be anticipated with treatment. It can be treated safely at any stage or during pregnancy (or after birth) as soon as symptoms arise. Without treatment symptoms can continue for months or years after birth, so early intervention is essential to reduce long-term pain and dysfunction.

The causes of PGP are multi factorial and are likely to be a combination of factors that include:

- Altered pelvic girdle biomechanics due to altered activity in the spinal, abdominal, pelvic girdle, hip and /or pelvic floor muscles.
- Increased load on joints due to increased fluid, weight gain and growing baby.
- Change in hormone levels increasing laxity of joints and muscles and sensitivity to pain.
- Change of activity levels once a woman becomes pregnant

The Role of the Midwife Caring for Women with Pelvic Girdle Pain

1. Presentation

Refer for specialist pelvic health physiotherapy input as soon as pain is first mentioned, via Badgernet. Prompt referral can improve outcomes.

Give advice leaflet/s. (Appendix 1)

2. Third trimester

The majority of women will be able to have a normal spontaneous vaginal birth with the right support, and their options should be discussed, and their choices supported
Discussion of options should include:
-Pain relief
-Water birth
-Mode of birth
-Labour and birth position

3. Active birth

Women should be encouraged to be upright and mobile during labour. Alternative positions for the birth could be

-All fours
-Supported kneeling
-Side lying with pillows/knees to chest
-Labour and birth in water.

If symptom are very severe and all treatments have been exhausted, a discussion with Consultant Obstetrician needs to be held to explore all risks associated with induction of labour and risks of Caesarean section. If IOL is being considered prior to 40 weeks gestation a Vaginal Examination should be performed to assess favourability and consideration given to steroids for fetal lung maturation and the complications of early term deliveries.

4. Labour Care

At onset of caring for a woman with PGP, document clearly in notes that PGP is present.
a) Assess mobility limitations and “the pain free gap”. This is measured with the woman lying flat or in supported lying position with her needs bent and feet together. Care should be taken not to exceed the pain free range of abduction, particularly if epidural or spinal anaesthesia is used, as this might mask pain and cause damage to pelvic joints.

Forced hip abduction may be required for the safe delivery of baby and should only be used as part of McRoberts procedure for shoulder dystocia. If this has occurred, extra care should be taken postnatally and urgent referral back to physiotherapy for assessment and treatment will be needed.
b) If lithotomy position used for birth/suturing, ensure shortest possible time and careful lifting and lowering of legs symmetrically and at the same time.

5. Post Natal Care

a) Document in care plan that PGP is an ongoing problem and refer to specialist pelvic health physiotherapist for outpatient review via Badgernet (if not already arranged)
If already been seen in the Antenatal period advice to continue with advice given. If not already been seen ward physio can review if needed (Monday to Friday between 08:30-10:30) – contact the ward physio whilst they are there or bleep 302 for review within these times
b) Ensure the woman has close access to toilet/shower facilities, or if possible offer a side room with en-suite facilities.
c) Encourage partner to stay and help whilst recovery ongoing.
d) Bed rest is not encouraged, gentle mobility is to be recommended
e) Analgesia will likely be needed.
f) Depending on how limited mobility is, thromboprophylaxis may need considered.
g) If required Occupational Therapist to be contact for any aids required at home(if not already seen in the antenatal period)
h) Discharge home with follow up physio appointments, analgesia and mobility aids (as required)

If PGP onset occurs during intrapartum period, refer to physio as soon as possible, with the above care.

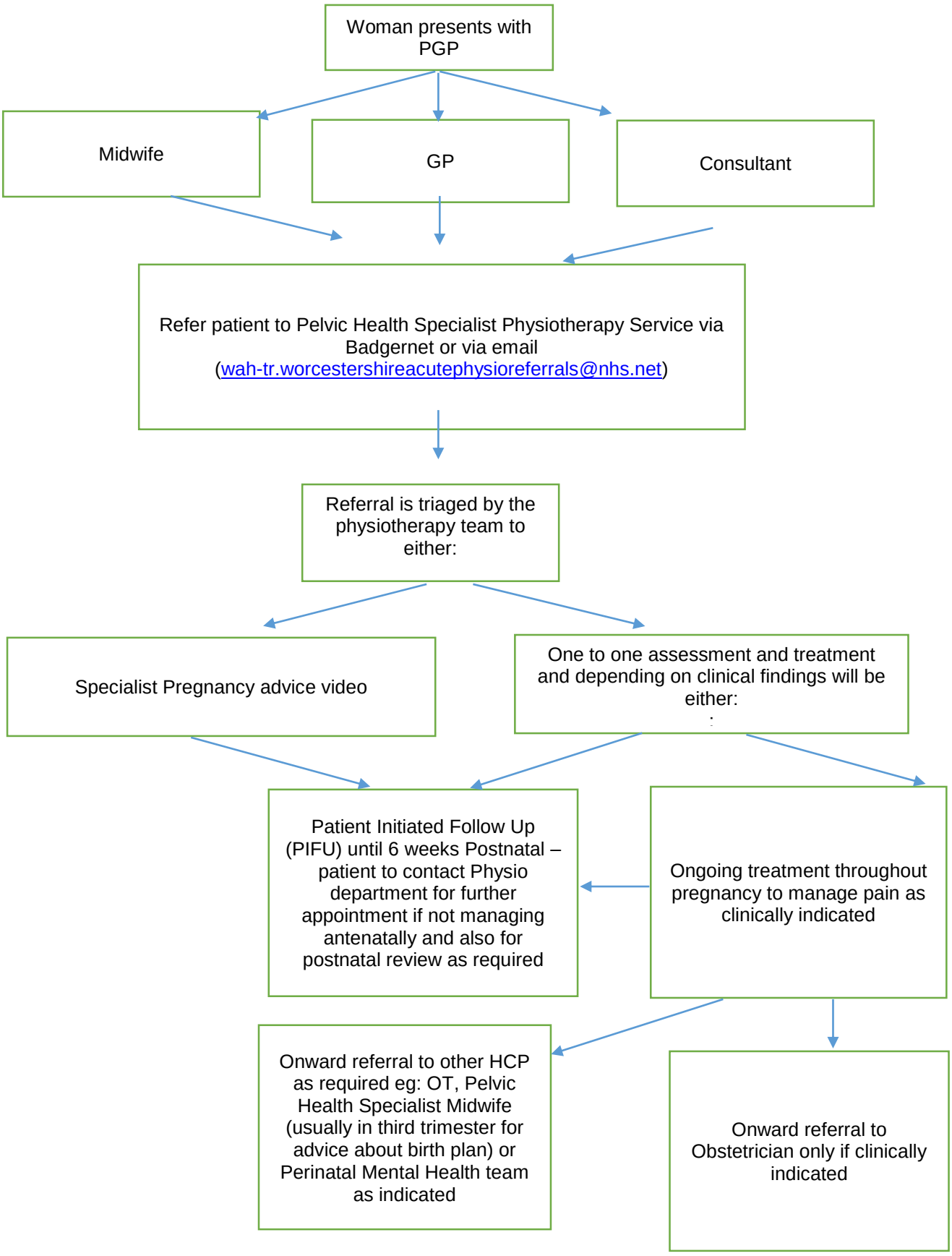
6. Post Natal Community Care

a) Continue to observe progress in own environment. Advise on rest where possible and encourage family/friends to help out with household chores.

b) Observe for signs of postnatal depression as long-term chronic pain during antenatal period and now caring for a new born can have a big impact on emotional and psychological wellbeing.

Arrange postnatal physio reassessment and treatment if not already organised.

Flowchart


Woman presents with PGP
Midwife
GP
Consultant
Refer patient to Pelvic Health Specialist Physiotherapy Service via Badgernet or via email (wah-tr.worcestershireacutephysioreferrals@nhs.net)
Referral is triaged by the physiotherapy team to either:
Specialist Pregnancy advice video
One to one assessment and treatment and depending on clinical findings will be either:
Patient Initiated Follow Up (PIFU) until 6 weeks Postnatal – patient to contact Physio department for further appointment if not managing antenatally and also for postnatal review as required
Ongoing treatment throughout pregnancy to manage pain as clinically indicated
Onward referral to other HCP as required eg: OT, Pelvic Health Specialist Midwife (usually in third trimester for advice about birth plan) or Perinatal Mental Health team as indicated
Onward referral to Obstetrician only if clinically indicated

Appendix One:

Fit for Pregnancy | POGP (thepogp.co.uk)

Fit for Birth | POGP (thepogp.co.uk)

Fit and Safe: Exercise in the Childbearing Year | POGP (thepogp.co.uk)

Pregnancy Related Pelvic Girdle Pain For mothers to be and new mothers | POGP (thepogp.co.uk)

Exercise and Advice After Pregnancy | POGP (thepogp.co.uk)

Pelvic Floor Exercises During and After Pregnancy	https://youtu.be/kME0N1YToDk
Posture and Positioning in Pregnancy and Following the Birth	https://youtu.be/3Q8Qwy-HT_8
Constipation During and After Pregnancy	https://youtu.be/Kl1kTA-YJ7g
Back and Pelvic Pain During and After Pregnancy	https://youtu.be/1arNYQ3Dcwg
Exercise During Pregnancy	https://youtu.be/e7I7P9xPNgg

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Number of Referrals	Data is collected through a spreadsheet of referrals in and letters sent	At the point of referral	All triaging staff fill out the spreadsheet and our Pelvic Health Assistant or administration staff send letters and file the referrals securely. We analyse the data at quarterly points in the year depending on need.	Physiotherapy Outpatients	Quarterly – 4 times a year we pull the data 12 times a year we are assessing general throughput

References

Dufour S, Vandyken B, Forget MJ, Vandyken C. **Association between lumbopelvic pain and pelvic floor dysfunction in women: A cross sectional study**. Musculoskelet Sci Pract. 2018 Apr;34:47-53. doi: 10.1016/j.msksp.2017.12.001. Epub 2017 Dec 9. PMID: 29268147. https://pubmed.ncbi.nlm.nih.gov/29268147/

Miles D, Bishop M. Use of Manual Therapy for Posterior Pelvic Girdle Pain. PM R. 2019 Aug;11 Suppl 1:S93-S97. doi: 10.1002/pmrj.12172. Epub 2019 Jun 26. PMID: 31020812. https://pubmed.ncbi.nlm.nih.gov/31020812/

National Guideline Alliance (UK). Management of pelvic girdle pain in pregnancy: Antenatal care: Evidence review U. London: National Institute for Health and Care Excellence (NICE); 2021 Aug. (NICE Guideline, No. 201.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK573945/ https://www.ncbi.nlm.nih.gov/books/NBK573945/

Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.