Worcestershire Acute Hospitals NHS Trust

Multidisciplinary Guidelines for the Management of Pelvic Girdle Pain (PGP)

(Formerly known as SPD)

In line with the European Guidelines) the term Pelvic Girdle Pain (PGP) is now the accepted umbrella term.

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Key Amendments

Date	Amendments	Approved by

Aetiology

The causes of PGP are multi factorial and often there is no obvious explanation.

PGP is more likely to be a combination of factors that include:

The pelvic joints moving asymmetrically

Changed pelvic girdle biomechanics due to altered activity in the spinal, abdominal, pelvic girdle, hip and /or pelvic floor muscles.

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 pelvic, and difficulty walking, climbing stairs or turning over in bed.

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 Role of the Midwife Caring for Women with Pelvic Girdle Pain

1. Presentation-Refer to physio using white referral outpatient physiotherapy request card. Sign and print your name and designation. Send it to the nearest women's health physio and continue to support during pregnancy. Prompt referral can improve outcomes.
   -If Pelvic Girdle Pain is identified, give advice leaflet. (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.
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) Bedrest may be required until pain is controlled - regular analgesia will be needed.
e) Depending on how limited mobility is, thromboprophylaxis may need considered.
f) Early access to hospital physio for ongoing treatment.

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.

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.

Online Resources:

www.backpaineurope.org

www.pelvicpartership.org.uk

www.pogp.csp.org.uk

Pathway for Pelvic Girdle Pain Management