Guidance for Mothers-to-be and New Mothers

Pelvic Girdle Pain

and other common conditions in pregnancy

POGP
PELVIC OBSTETRIC & GYNAECOLOGICAL PHYSIOTHERAPY

EXCELLENCE MATTERS

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Your health carer has given you this leaflet to explain and provide advice about pelvic girdle pain (PGP) related to your pregnancy. The term PGP is used to describe pain experienced in the front and back of your pelvis (you may have previously heard the term symphysis pubis dysfunction [SPD] used; however, PGP is now the accepted name for this condition).

This leaflet has been written both by healthcare professionals who have cared for women with PGP and also by the women themselves. It will help you understand more about PGP, how you can adapt your lifestyle and how you can look after yourself.

There are sections relevant to your health during and after your pregnancy, as well as advice on giving birth and breast- or bottle feeding.

1. Introduction

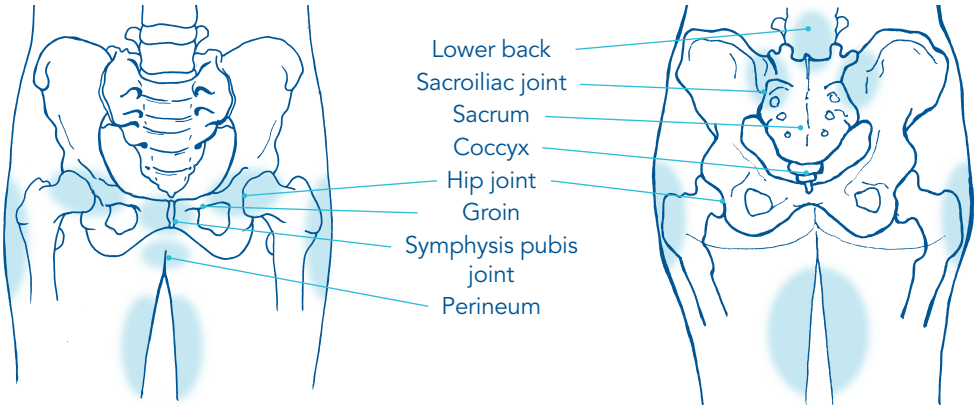
Pregnancy-related PGP is common.

The sooner it is identified and assessed, the better it can be managed.

- Around 1 in 5 pregnant women experiences mild discomfort in the back or front of the pelvis during pregnancy. If you have symptoms that do not improve within a week or two, or interfere with your normal day-to-day life, you may have PGP and should ask for help from your midwife, GP, physiotherapist or other health carer.
- Women experience different symptoms and these are more severe in some women than others. If you understand how PGP may be caused, what treatment is available, and how you can help yourself, this may help to speed up your recovery, reducing the impact of PGP on your life.
- A range of management options is available to you, based on the type of PGP you are found to have.

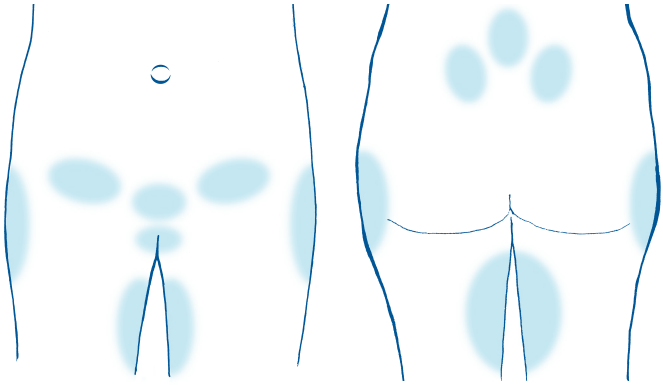
2. What is PGP and how is it diagnosed?

- PGP describes pain in the joints that make up your pelvic girdle; this includes the symphysis pubis joint (SPJ) at the front and/or the sacroiliac joints (SIJ) at the back.



The discomfort is often felt over the pubic bone at the front, below your tummy, or across one side of your lower back, or both sides.

- A diagnosis of PGP can be reached based on certain signs and symptoms that you may experience during the pregnancy or afterwards. Having one or more of them may indicate the need for **a physiotherapy assessment followed by advice on appropriate management**.
- You may experience pain in all or some of the areas shaded in the diagrams above.



You may also have:

- difficulty walking
- pain when standing on one leg (e.g. climbing stairs, dressing, or getting in or out of the bath)
- pain and/or difficulty moving your legs apart (e.g. getting in or out of the car)
- clicking or grinding in the pelvic area – you may hear or feel this
- limited or painful hip movements (e.g. turning over in bed)
- difficulty lying in some positions (e.g. on your back or side)
- pain during normal activities of daily life
- pain and difficulty during sexual intercourse

With PGP, the degree of discomfort you are feeling may vary from being intermittent and irritating to being very wearing and upsetting.

Your doctor, midwife or physiotherapist should always listen to what you say in order to assess the cause of your symptoms and give you advice on how to best manage your symptoms. They will decide if you need further referral to a physiotherapist. Your signs and symptoms should not be dismissed as just 'the normal aches and pains of pregnancy'.

3. How many women get PGP?

This is a common condition affecting about 1 in 5 pregnant women:

- there is a wide range of symptoms, and in some women, it is much worse than in others
- having some symptoms does not mean you are automatically going to get worse
- if you get the right advice and/or treatment early during pregnancy, it can usually be managed well: in some cases, the symptoms will go completely
- in a small percentage of women, PGP may persist after the birth of your baby. Your midwife or health visitor can refer you to a women's health physiotherapist for a post-natal pelvic assessment.

4. What causes PGP?

Sometimes there is no obvious explanation for the cause of PGP.

Usually, there is a combination of factors causing PGP including:

- the pelvic girdle joints moving unevenly
- a change in the activity of the muscles of your tummy, pelvic girdle, hip and pelvic floor, which can lead to the pelvic girdle becoming less stable and therefore painful
- a previous fall or accident that has damaged your pelvis
- a small number of women may have pain in the pelvic joints caused by hormones

Occasionally, the position of the baby may produce symptoms related to PGP.

5. Risk factors

Not all women have any identifiable risk factors, but for some, the following physical risks may apply:

- a history of previous low-back and pelvic girdle pain
- previous injury to the pelvis
- more than one pregnancy
- a hard physical job or workload/awkward working conditions/poor working postures
- PGP in a previous pregnancy
- increased body weight and body mass index before and/or by the end of pregnancy
- increased mobility of other joints in the body

Factors **not** associated with PGP include:

- time since last pregnancy
- age and height
- the contraceptive pill
- smoking
- breastfeeding

6. Management

To manage your PGP, you will need general advice (see Section 6a), and may need one or more of the following referrals:

- from a doctor (or midwife) to physiotherapy for assessment of your pelvic joints, followed by treatment and advice on how to manage your condition
- to other professions, such as occupational therapy, for equipment to help you to manage better at home
- to social services for advice on benefits, or a care package for help at home, if you have severe symptoms
- to the GP for medication for pain relief

Remember to;

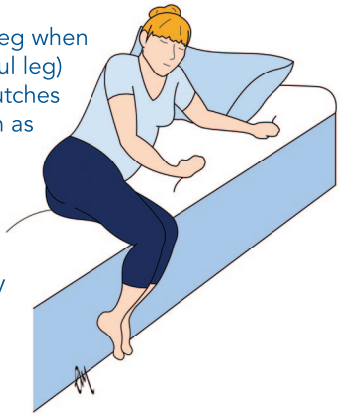
- ask for help early
- ask whether you can have your hospital appointments on the same day, or whether your midwife is able to visit you at home. This will assist with day-to-day living, not necessarily with recovery

a. General advice

You should be given advice that is relevant to your current level of function in your daily life and your lifestyle. If your daily activities do not increase your pain, or if you have had some treatment and the pain is controlled, then some of the following advice may not apply.

During pregnancy, DO:

- Walk in supportive footwear, swing arms and use a rucksack, rather than a handbag for symmetry and ease of movement. If walking is difficult and painful, try altering your stride length and speed
- Be as active as possible, keeping pain-free and avoiding activities that aggravate your pain
- Accept help when you need it
- Sit down to get dressed and undressed; avoid standing on one leg
- Try to keep your knees together when getting in and out of the car
- Place a pillow between your knees when sleeping on your side (diagram), and when turning over, keep your knees together as much as possible
- Try getting into bed or turning over in bed via hands and knees
- Do your pelvic floor exercises and low abdominal exercises as advised by your physiotherapist.
- Swimming may help, but the breaststroke kick may aggravate your pain
- Move from sitting to standing symmetrically (diagram)
- Take the stairs one at a time (lead with your less painful leg when going upstairs, and downstairs, lead with the more painful leg)
- Use a small rucksack to carry things if you need to use crutches
- Consider alternative positions for sexual intercourse such as side-lying or kneeling on all fours



Where possible, avoid activities that make the pain worse, which may include:

- standing on one leg
- bending and twisting to lift, or carrying a toddler or baby on one hip
- crossing your legs
- sitting on the floor
- sitting twisted
- sitting or standing for long periods
- lifting heavy weights (e.g. shopping bags, wet washing, vacuum cleaners and toddlers)
- vacuuming
- pushing heavy objects like supermarket trolleys
- carrying anything in only one hand

Don't take up any new high-impact sporting activity

This is not an exhaustive list.

b. Physiotherapy

The advice and exercises on the previous page may help your symptoms effectively, but some women will need a one-to-one assessment with a physiotherapist. A physiotherapist assesses the effect PGP has on your whole body, your family and your lifestyle, and offers a range of treatment options and advice.

Assessment will include:

- careful examination of your pelvic, back and hip joints, and the muscles around them, looking at how the joints move, and whether the muscles are strong enough to support your pelvis and spine
- looking at how well you move and carry out everyday activities

Treatment

The physiotherapist will discuss the plan for treatment with you. Physiotherapy treatment aims to improve your spinal and pelvic joint position and stability, relieve pain, and improve muscle function.

Treatment may include:

- **advice, including:**
  - back care
  - lifting
  - suggested positions for labour and birth
  - looking after your baby and any toddlers
  - positions for sexual intercourse
- **exercises** to retrain and strengthen your stomach, back, pelvic floor and hip muscles
- **manual therapy** to make sure your spinal, pelvic and hip joints are moving normally, or to correct their movement.
- **other types of pain relief** such as acupuncture or transcutaneous electrical nerve stimulation (TENS)
- **exercises in water**
- **provision of equipment** (if necessary after individual assessment), such as pelvic girdle support belts and walking aids to be used as directed by your physiotherapist.

How often will you need treatment?

- Your physiotherapist will see you during the pregnancy as necessary. For some women, the pain gets completely better and no more treatment is needed.
- Not everybody responds completely to physiotherapy, and you may need repeated visits for further reassessment and treatment to keep your pain under control.
- You should continue to heed any advice given to you by the physiotherapist, and if you have been prescribed exercises as part of your treatment, then these should be carried out regularly.
- Treatment should continue after you have had your baby if the pain persists. It is important to tell your physiotherapist if you feel you have not made a full recovery, and discuss the options for further treatment.

If an NHS physiotherapist is not available quickly, you may wish to see a private physiotherapist (see Section 12) or other professional, including an osteopath, chiropractor, or acupuncturist, who has training and experience in treating PGP. You should check that your therapist is appropriately qualified to deal with pregnancy-related PGP, and holds the relevant professional qualifications.

c. Exercise and sport

Avoid any activity that increases your pelvic girdle pain.

7. Emotional effects of PGP

The discomfort of PGP and difficulty with normal activities may make you feel low. Seeking help and advice as early as possible will help your pain, but if you are experiencing any emotional effects of PGP, help and support are available from the medical team looking after you. Do ask.

8. Labour and birth

Most women with PGP can have a normal vaginal birth

- Many women worry that the pain will be worse if they have to go through labour. This is not usually the case when good care is taken to protect the pelvic joints from further strain or trauma. You should be able to choose your place of birth as you wish, including birthing centre or home birth options.
- Most women with PGP manage to have a normal delivery and a Caesarean section is not normally recommended. However, you should discuss this with your midwife or doctor.

Before labour:

- Think about and practice moving between positions that are comfortable for you
- Record them in your birth plan and discuss with your birthing partner and/or midwife
- Labour and birth in water may be appropriate and comfortable for you
- Discuss coping strategies with your physiotherapist

During labour:

- use gravity to help the baby to move downwards by staying as upright as possible:
  - kneeling
  - on all-fours
  - standing

These positions can help labour to progress and avoid further strain on your pelvis.

- try to avoid lying on your back or sitting propped up on the bed - these positions reduce the pelvic opening and may slow labour
- the squatting position and birthing stool may be uncomfortable positions for labour
- moving between positions, and positions of symmetry are often most comfortable

Discuss with your midwife and try these gravity-assisted positions instead of lying on your back or sitting.

Pain-free range of movement
Some women have difficulty or pain moving their legs apart. You may find that, following physiotherapy treatment, you are able to open your legs further. However, if you still have some restriction while pregnant and/or after labour has started, your physiotherapist, midwife or birthing partner should measure how far apart your knees can separate without pain (your pain-free range) when lying on your back, or sitting on the edge of a chair with your feet apart. You should take care to keep your legs within your pain-free range of movement as much as possible during labour and birth to protect your joints, particularly if you have an epidural or spinal block. However, in a minority of births it may be necessary to move your legs wider apart in order to deliver your baby safely.

Assisted deliveries (forceps and ventouse)
Where you need forceps, ventouse delivery or stitching in the lithotomy position (i.e. feet up in stirrups), care should be taken by the midwives and doctors to lift both legs up at the same time, and to keep the distance apart within your pain-free range.

9. After you have had your baby

If you have pain or difficulty moving after the birth of your baby, do tell your midwife.

Be aware that:
- medication to relieve pain may cover up the discomfort of your PGP, so be very careful about doing things that were painful before you had your baby until after you have stopped taking your painkillers
- you should be referred to a physiotherapist for early assessment and treatment if you still have PGP pain or are still needing to take painkillers

After you have had your baby you may need extra help with personal care and caring for your baby. Ask your hospital or community if any extra help is available.

a. Feeding and caring for baby

Feeding:
- When possible, sit in a firm but comfortable chair to feed your baby.
- Make sure your back is well supported; placing a small, rolled towel behind your lower back helps.
- Ensure your feet are supported and flat on the floor.
- Stopping breastfeeding will not speed up recovery of PGP.

- Change nappies on a surface at waist height.
- Carry your baby in front of you; do not carry your baby on one hip.
- Kneel at the bath side rather than leaning over.
- Lower the cot side when lifting or lowering your baby.
- Keep your baby close to you when moving him/her in and out of a car seat.
- If you have to carry your baby in the car seat, hold it in front of you, not on your hip, or put it on a wheeled frame/buggy.
- Do not lift your baby in and out of high shopping trolleys.
- Do your pelvic floor muscle exercises daily.

b. Emotional well-being

It is important that your partner, family, friends and hospital staff give you as much support as possible while you are in hospital and when you get home. This will speed up your recovery and hopefully prevent problems from developing.

Remember:

- if PGP persists after your baby is born, it is important that you discuss its impact with your partner (and/or your family). In particular, you should discuss how best to care for your baby/toddler and how much help you need
- if you are feeling low, it is important to ask for help from your GP, midwife or health visitor as they may help you to recover more quickly

c. Physiotherapy referral

You can:

- ask to resume physiotherapy as soon as you feel able to attend
- have a physiotherapy reassessment of your spine and pelvis, and start treatment as needed

d. Sexual intercourse

- You may be able to avoid discomfort during sexual intercourse by considering alternative positions or other ways to be sexually intimate.
- There are sometimes other reasons for discomfort, such as scarring from stitches, so if you are concerned, talk to your midwife, doctor, health visitor or physiotherapist. You may find that using a vaginal lubricant might help.
- Stitches should not be painful after the first few weeks, but if they are, do not hesitate to ask for help.

e. Menstruation

- A minority of women report a return of PGP symptoms when their monthly period returns. For some, this may get better after a couple of months, but for others, it continues. The degree of pain varies considerably.

If this happens to you, you should ask for another assessment of your pelvis. You can take pain relief as necessary.

f. Exercise and sport

- keep doing your pelvic floor muscle exercises every day
- keep up the exercises given to you in hospital
- continue the gentle abdominal/tummy (and hip) exercises given to you by your physiotherapist when you were pregnant
- after your baby is born, continue to be careful when exercising until you are symptom-free
- avoid high-impact activity, such as aerobics, for a few months
- avoid any activity that brings back the pain

10. Planning your next pregnancy

- Some women may experience PGP again during their next pregnancy. However, the symptoms may not be as severe, especially if it is well managed.
- Between pregnancies, you should ensure that you continue with the exercises given to you by your physiotherapist; in particular, pelvic floor, abdominal/tummy and hip exercises.
- If you are considering a further pregnancy or if you are pregnant again, it is worth asking your GP if a referral to a physiotherapist is available. If it is, then the physiotherapist can check your pelvic joints and make sure you are as fit as possible for another pregnancy.

There is no particular advantage in leaving a long gap between babies, although some abdominal muscles may not have recovered fully 12 months after the birth of your baby.

- It is worth considering whether your toddler will be able to walk while you are pregnant in order to reduce the strain on your joints if you do have pain during any future pregnancy.
- It might be worth becoming fully fit, losing excess weight and reducing the symptoms of PGP before considering another pregnancy.

11. Further investigations

Further investigations should be considered if your symptoms do not improve once the baby is born and after physiotherapy treatment. These may include 'stork' X-rays (special X-rays to show whether there is any movement at the pubic joint), or MRI or ultrasound imaging. There is no recommended time-scale for this, but if you are concerned, talk to your GP.

Remember that:

- it is common, but not normal, to have PGP in pregnancy
- every woman is different
- PGP is a treatable and manageable condition
- with a team of health workers giving you the information, advice and treatment you need, your discomfort may be less severe

Ask for help as early as possible.

12. Other common conditions

As well as PGP there are other relatively common uncomfortable symptoms that you may experience during and after pregnancy. Usually, with good advice and education, these symptoms can be kept to a minimum and managed well.

However, if symptoms persist, or you feel like they are affecting your daily activities, then do seek advice and referral to a women's health physiotherapist

a. Postnatal backache

A new baby brings new postural challenges to your daily life. This, accompanied by the muscular and hormonal changes that occurred during pregnancy, can sometimes lead to upper and lower backache during the first few postnatal months.

Usually, these symptoms are uncomplicated, and can be reduced or even eliminated with good postural awareness.

When sitting and feeding your baby, prepare your seating arrangements whenever possible. Position your bottom far back in the chair, and place a small cushion or rolled up towel into the small of your back. You can lean back and your upper back is then also in good postural alignment. It can also help if baby is supported on a pillow on your knee, so that you are able to keep your shoulders back while feeding baby.

When changing your baby, the safe use of a changing table can be helpful to avoid low back pain. Curving the spine into flexion unduly loads the spine and back muscles, which can quickly cause backache.

When leaning forwards over baby, try to think about hinging from your hip joints and gently drawing your tummy button towards your spine. This helps to engage the core muscles that help to support the spine. This posture should also be adopted when lifting baby out of a cot, and as much as possible, when bathing baby.

Other activities that may contribute to postnatal backache are:

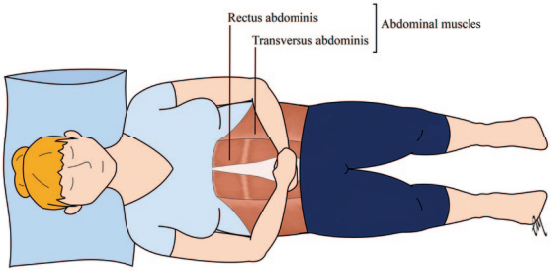
- pram handles being too low so that you have to be in a bent position to walk
- front baby carriers being positioned too low and putting a strain on the shoulders
- always carrying baby on the same side

If your backache is persistent and does not settle by correcting your posture, you should speak to your health visitor or midwife, and be referred to a physiotherapist.

The physiotherapist will assess your back pain, advise you regarding helpful exercises and treat your symptoms if necessary.

b. Diastasis rectus abdominis

The rectus abdominis (6-pack muscle) runs down the front of the abdomen. It has two muscle bellies that sit close together, attached to a fibrous band (the linea alba).



During pregnancy, the linea alba becomes thinner, stretches and the muscle bellies move apart to accommodate the growing bump. This increased gap (inter-recti distance) is termed diastasis rectus abdominis (DRA or RAD).

It is very common in pregnancy, (>60% in the 3rd trimester) and can continue postnatally. It is associated with repeated heavy lifting (including childcare), being older, and is much more common in women who do not exercise before, or during, pregnancy.

Symptoms

A gap of around 2 finger-widths at the belly button is considered to be normal. But even more important is whether the muscles can activate well.

The muscles need to be strong enough to help control movement around the pelvis and back to contribute to posture and breathing, and provide abdominal organ support.

With a DRA, you may experience bulging/doming, or sagging, of the muscles when straining or using your abdominals, such as when sitting up, getting out of bed or lifting the baby. Some women experience stomach or back pain, or pelvic floor problems.

Treatment

Regular exercise can reduce the risk of developing a DRA. For women with uncomplicated pregnancies, 150 minutes per week of moderate exercise is recommended.

Your physiotherapist will also advise you on specific core and abdominal exercises to strengthen your pelvic floor, and appropriate control of the core muscles.

Some improvement naturally occurs in the first 8 weeks following delivery. The focus postnatally should also be on activation of the pelvic floor and core muscles.

Exercises such as sit-ups, planks and high-impact exercises need to be avoided initially. Also avoid any activities that increase abdominal pressure, or cause doming of the abdominals, such as straining with constipation and repeated heavy lifting.

For some women, compression such as a tubigrip or belly band can help in the early stages, but seek the advice of a physiotherapist regarding this.

c. Carpal tunnel syndrome

The carpal tunnel is an inelastic structure located at the level of the wrist.

Many tendons which move the thumb and fingers pass through this carpal tunnel on their way to the hand. A nerve called the median nerve also sits in this tunnel with the tendons, so there is very little room.

The nerve is responsible for giving you feeling in the thumb and fingers, and also makes the tendons work properly.

Hormone changes during pregnancy can cause swelling in many parts of your body including the wrist and carpal tunnel.

Any swelling will increase the pressure on the median nerve inside the tunnel. This pressure on the nerve causes the symptoms known as carpal tunnel syndrome. Symptoms are most likely to occur from the fifth or sixth month of pregnancy.

You may feel one or more of the following symptoms:

- pain, pins and needles, numbness or burning in the thumb, index middle or ring fingers
- tingling or numbness of your entire hand
- weakness in the hand and forearm
- pain that shoots from your hands up the arm as far as the shoulder
- your symptoms are worse at night or first thing in the morning
- you may drop objects
- you may have trouble performing dextrous tasks such as writing because of reduced grip
- hands are swollen, hot and sweaty

Self-management of carpal tunnel syndrome

1. **Elevate** your arms with pillows or cushions when lying or sitting down – this can help to reduce swelling in the tunnel.
2. Apply **ice** cubes wrapped in a wet tea towel to the front of your wrist for 10-15 minutes, 3-4 times each day. Do not use ice if you can not tell the difference between hot and cold.
3. Speak to your pharmacist about **medication** that may help your pain but is safe to take throughout pregnancy.
4. Wear a **wrist splint**, if supplied by your physiotherapist. Always ensure the metal bar is flat and follow your physiotherapist's instructions for when and for how long you should use it.
5. Try to keep wrists in **a neutral position** when undertaking activities of daily living such as writing, eating and washing.
6. Try to **limit repetitive activities** such as typing or writing for long periods.
7. **Avoid** any **heavy lifting** as this will cause the tendons to swell and further reduce space within the carpal tunnel.
8. **Avoid** placing hands in **hot water** as this will further increase inflammation.
9. **Pace yourself** with hand actions or positions that make your symptoms worse (e.g. ironing, driving).

Carpal tunnel syndrome usually improves after your pregnancy ends.

If you do continue to have problems after you have had your baby, contact your physiotherapist or GP for further advice.

d. Varicose veins

Varicose veins are usually caused by weak vein walls and valves. This causes the veins to swell and enlarge, and usually occurs in the legs. The veins may appear blue or dark purple, and are often lumpy or bulging.

Other symptoms include:

- aching, heavy and uncomfortable legs
- swelling in the feet and/or ankles
- burning or throbbing in your legs
- muscle cramp in your legs, particularly at night
- dry, itchy and thin skin over the affected vein

How do they occur?

Sometimes the walls of the veins become stretched and lose their elasticity, causing the valves to weaken.

If the valves don't function properly, blood can collect in your veins, which become swollen and enlarged, causing the varicose veins.

During pregnancy, the amount of blood increases to help support the developing baby. This puts extra strain on your veins.

Increased hormone levels during pregnancy also cause the muscular walls of the blood vessels to relax, which also increases your risk.

Vulval varicose veins may also develop as the womb begins to grow and puts increased pressure on veins in the pelvic area.

Although being pregnant can increase your risk of developing varicose veins, most women find that their veins significantly improve after the baby is born.

Varicose veins are rarely a serious condition and they don't usually require treatment.

However, speak to your midwife, GP or obstetrician if:

- your varicose veins are causing you pain or discomfort
- the skin over your veins is sore and irritated
- the aching in your legs is causing irritation at night and disturbing your sleep

How can I prevent and ease varicose veins?

- Use compression stockings: discuss with your midwife, doctor or obstetrician beforehand.
- Exercise regularly.
- Avoid standing up for long periods.
- Elevate the affected area when resting.

Information taken from NHS choices - see https://www.nhs.uk/conditions/varicose-veins/ for more information.

13. Websites and contact details

- Pelvic, Obstetric and Gynaecological Physiotherapy (POGP) - pogp.csp.org.uk
- Pelvic Partnership - pelvicpartnership.org.uk
- Chartered Society of Physiotherapy (CSP) - www.csp.org.uk; tel. 020 7366 6666
- Manipulation Association of Chartered Physiotherapists (MACP) - macpweb.org
- Organisation of Chartered Physiotherapists in Private Practice (OCPPP) - www.physiofirst.org.uk
- Acupuncture Association of Chartered Physiotherapists (AACP) - www.aacp.org.uk
- The British Medical Acupuncture Society - www.medical-acupuncture.co.uk

With help, the woman should not become disabled during pregnancy, but if she does, the following website offers practical advice and support:

- Disability, Pregnancy and Parenthood International - www.disabledparent.org.uk

Appendix 1

Commonly used and misused terms for PGP

Names which may be used
Some people use other medical words to describe the condition of PGP

SPD - this was the word commonly used to describe PGP, but it now goes under the umbrella term of PGP
Symopholysis - sometimes used to describe pain around the pubic bone at the front of the pelvis
Osteitis pubis - this is inflammation of the pubic bone, which needs to be diagnosed using X-rays
SIJ pain - pain felt over the SIJs (see picture on page 3), or in one or both buttocks
Pelvic girdle relaxation
Low back pain
Hip pain
Diastasis symphysis pubis (DSP) - rare and diagnosed using X-rays

Comments

Getting help

If you have any difficulty following the advice or exercises in this booklet, or find that your symptoms are not improving, ask to be referred, or if available, refer yourself to a physiotherapist with experience in treating women with pelvic and pelvic floor muscle problems. They will be able to assess you and offer specific treatments/alternatives that are suitable for your needs.

To find your nearest specialist physiotherapist visit:
pogp.csp.org.uk

Further advice and information booklets are also available from
pogp.csp.org.uk

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