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Evaluation and management of symphysis pubis dysfunction (SPD).

1. Definition or Key Clinical Information (Department of Health, 2020; Howell, 2012; Royal College of Obstetricians and Gynaecologists, 2015):

Symphysis pubis dysfunction is characterized by pain in the pubic joint area and/or sacroiliac joints due primarily to relaxed ligaments and joints. It is triggered by shearing movements that shift your pelvis apart (one side forward and one side back), such as getting in and out of bed or a car, lunges or one-sided exercises, and climbing stairs.

2. Assessment

i. Risk Factors (Department of Health, 2020; Howell, 2012; Pierce et al. 2012)

SPD in previous pregnancy, family history, multiparity, overweight, high stress, hypermobility, limited amount of exercise, history of back or pelvic injury

ii. Subjective Symptoms (Howell, 2012; Royal College of Obstetricians and Gynaecologists, 2015; University College Cork, 2019)

Pain in front of pelvis, or over sacrum, pain when climbing stairs, getting in and out of bed, in and out of the car, pain when putting on pants, shoes, and socks, clicking or grinding heard in pelvis, painful intercourse

iii. Objective Signs (Howell, 2012)

- visible waddling
- tenderness in sacroiliac joints, pubic symphysis joints, piriformis muscles
- palpable gap in pubic symphysis
- positive screening test

v. Clinical Test Considerations (Pierce et al. 2012; Walters et al., 2018)

- Active straight leg raise test (ASLR)
- Trendelenburg test
- Posterior Pain pelvic provocation test (P4)
- Pubic symphysis palpation
- FABER test
- Menell's Test

vi. Differential Diagnosis (Howell, 2012; Walters et al., 2018)

- round ligament pain
- sciatica
- UTI
- ectopic pregnancy
- pelvic inflammatory disease

Practice Guideline for SPD

Updated Winter 2024

- femoral vein thrombosis
- STDs
- postpartum fracture
- chorioamnionitis
- diastasis of pubic symphysis
- preterm labor

3. Management plan

i. Therapeutic measures to consider within the CPM scope (Howell, 2012; Royal College of Obstetricians and Gynaecologists, 2015; University College Cork, 2019)

- keep legs together when getting in and out of car and bed and minimize actions that cause pain
- Use a pillow between knees when laying or sleeping
- Stretching and exercise: ball squeeze stretch, pelvic tilts, QL stretch, cat cow, seated hip stretch
- belly breaths/TA hold
- Pelvic girdle belt
- Prenatal pilates
- acupuncture
- warm bath/hydrotherapy

ii. Therapeutic measures commonly used by other practitioners (Howell, 2012; Walters et al., 2018)

- Webster-trained chiropractic care
- Physical Therapy

iii. Ongoing care (Royal College of Obstetricians and Gynaecologists, 2015; University College Cork, 2019, Walters et al., 2018)

Check in at each prenatal to see if SPD is improving or worsening. In the case of worsening pain, refer to a physical therapist. Keep SPD in mind during delivery, as severe pain could interfere with delivery position. Also, consider the history of SPD in future pregnancy and consider prophylactic actions.

iv. Indications for Consult, Collaboration, or Referral (Walters et al., 2018)

If pain continues or worsens and therapeutic measures are ineffective, refer to a physical therapist who specializes in pregnancy and assist in finding Webster-trained chiropractor if not already done.

v. Client and family education

- Handout on prenatal posture and core - standing, walking, and moving
- Educate on function of pelvis and core muscles
- Instruct in transverse abdominis holds

4. References

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