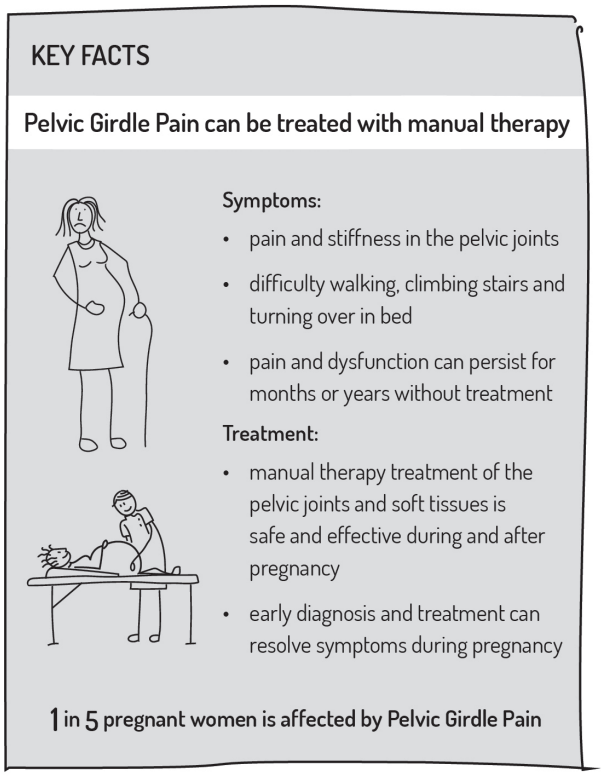
Leaflet review

How Can We Improve Care for Women with Pelvic Girdle Pain?

The Pelvic Partnership, Harwell, Oxfordshire, 2015, 2 pages, leaflet, £0.00
www.pelvicpartnership.org.uk

Last year, *Frontline* magazine published an article by the chair of the Pelvic Partnership entitled "Pain is not normal" (Fishburn 2015). Members of the Chartered Society of Physiotherapy also received a copy of the new Pelvic Partnership "Stickmum" leaflet (Pelvic Partnership 2015a), *How Can We Improve Care for Women with Pelvic Girdle Pain?* (Pelvic Partnership 2015b). The aims of the article and leaflet are to: spread the word about the impact of pregnancy-related pelvic girdle pain (PGP); promote the idea that it can be treated with manual therapy; and encourage discussion with a view to changing physiotherapy practice.

I work in a busy Midlands National Health Service (NHS) trust that deals with more than 10 000 births a year, and approximately 25 women with perinatal lumbopelvic pain are referred to us every week. Therefore, the article and leaflet attracted my attention, and merited a meeting of my women's health physiotherapy team to discuss the content and implications of the Pelvic Partnership's views. Consisting of rotational band 5 and 6 physiotherapists, and static POGP members on bands 6, 7 and 8A, the members of the team have varying levels of knowledge, skills and experience. In the first instance, we tried not to reflect on what we teach, or have been taught or read, but to bring clinical experience derived from our own patient caseload to the discussion.



Our first impressions of the *Frontline* article (Fishburn 2015) were as follows:

- We acknowledged the work of the Pelvic Partnership in raising the profile and awareness of PGP, and promoting discussion of the physiotherapist's role in its treatment.
- It was disappointing to read that the Pelvic Partnership thinks that the traditional physiotherapy approach to treating PGP involves "belt, crutches and advice" (Fishburn 2015, p. 22). We believe that this is not the norm, and that physiotherapists provide a more comprehensive management package. Certainly, treatment plans are individualized within our trust. On the basis of our assessments, these may include posture and movement analysis and correction, neuromuscular evaluation, and interventions, which are likely to take the form of an individualized exercise programme. We may also consider hands-on soft-tissue release techniques, and for some women, manual therapy for articular dysfunction. Approximately 10% of our patients are fitted with support belts, which are always used in conjunction with other treatment, and very few need crutches. All patients with PGP receive education and advice.
- The Pelvic Partnership implies that manual therapy is always indicated, and makes the impressive claim that "[w]omen confirm that receiving manual therapy and walking out of the clinic with reduced pain and increased function, reaches far beyond that session, giving confidence that the problem can be resolved, that they can function and be pain-free again" (Fishburn 2015, p. 22). On assessment, approximately 20% of our patients present with intrapelvic joint malalignment and/or asymmetry of joint movement, and we do consider and use manual therapy. Sometimes, we also see

"the amazing impact that hands-on treatment can have in resolving symptoms" that the article describes (Fishburn 2015, p. 22), but not every time!

- We should be more consistent with our use of outcome measures, but we are confident that we are effective: we do improve pain and function, and reduce the duration of sick leave for our patients.
- We strongly agree with the Pelvic Partnership that "[n]ot treating early can prolong recovery and increase costs" (Fishburn 2015, p. 22). However, we do not agree that it is always necessary to provide manual therapy "as soon as symptoms start" (Fishburn 2015, p. 22). We concur that manual therapy has its place, and physiotherapists assessing and treating PGP should seek to acquire hands-on treatment skills. However, in our experience, manual therapy is not always indicated or advisable.
- The Pelvic Partnership claims that women with PGP are more likely to require induction of labour and a Caesarean section. This does not reflect our experience: our plan involves keeping women on their feet, and helping them to practise labour and delivery positions. Our obstetric teams very much agree that spontaneous vaginal delivery should be facilitated whenever possible.

Overall, our view is that this article has huge implications for patients with PGP. Specifically, it raises their expectation that they must have hands-on treatment to resolve their pain, and risks reducing their confidence in and compliance with other treatment strategies. This passive patient approach and a unilateral treatment plan is inconsistent with physiotherapy interventions for other types of musculoskeletal pain and dysfunction.

What follows next is a summary of our discussion of the "Stickmum" leaflet (Pelvic Partnership 2015b):

- *How Can We Improve Care for Women with Pelvic Girdle Pain?* is an interesting and cleverly produced leaflet that features rhyming verses and stick-figure diagrams. Its aim is to inform healthcare professionals and women with PGP that this condition can be effectively and quickly treated with manual therapy. The leaflet briefly explains what PGP is and describes its symptoms, but the discussion of treatment for the condition focuses exclusively on manual therapy. There is no acknowledgement of the efficacy of other therapeutic modalities or self-help.
- The Pelvic Partnership encourages the adoption of a management strategy for labour and birth, and a multidisciplinary approach to the treatment of PGP. However, the leaflet does not specifically mention midwives, whom we believe have an important role to play in giving some effective stand-alone advice and ongoing support to women with PGP during and after pregnancy.
- The leaflet is intended for both health professionals and women with PGP, and does look very much like a patient advice pamphlet. We have concerns about it being used in this context. Some of the terminology used (e.g. "disabled" and "squawk") is alarming, and a diagram of a wheelchair implies that this will be the potential outcome should a woman be unable to access a manual therapist.

We need to keep an open mind and look closely at the literature, which recommends that physiotherapists should play a key role in helping pregnant women with PGP, to see whether the direct message and impressive claims made by the Pelvic Partnership are supported. In particular, the *Frontline* article (Fishburn 2015) should remind us all to keep up to date with the evidence, and encourage us discuss our management of this common patient group.

A Cochrane Review by Pennick & Liddle (2013) found that design limitations or imprecision meant there was only moderate-quality evidence from individual studies to suggest that osteomanipulative therapy significantly reduced low back pain (LBP) and functional disability, and that acupuncture or craniosacral therapy improved pelvic pain more than usual prenatal care. The evidence that pain and functional disability, but not sick leave, were significantly reduced following a multimodal intervention for LBP and pelvic pain involving manual therapy, exercise and education was largely of low quality for the same reasons.

In a systematic review by Van Benten *et al.* (2014), all of the studies of exercise therapy, as well as most of those of interventions combined with patient education, reported that treatment had a positive effect on pain, disability and/or sick leave. Evidence-based recommendations can be made for the use of exercise therapy for the treatment of lumbopelvic pain during pregnancy.

The sacroiliac joint (SIJ) is a complex articulation that is a commonly involved in LBP. A

review by Hamidi-Ravari *et al.* (2014) reported that patient presentation is often non-specific, and that diagnostic physical examination manoeuvres have low diagnostic value. The current gold standard for diagnosis is the performance of a diagnostic block. Treatment options include activity modification, physical therapy, modalities, orthosis, manipulation, injections, radiofrequency procedures and surgery. Because of the complex anatomy and biomechanics of the SIJ, diagnosis and treatment will probably remain a challenge in the future.

In a review of pain practice, Vermani *et al.* (2010) found that individualized treatment in the form of patient education, exercises, pelvic belts, analgesics and acupuncture can be of benefit. There is a need for further research into the use of different forms of therapy, such as acupuncture, transcutaneous electrical nerve stimulation and epidural analgesia, either in isolation or as complementary interventions, for the safe and effective management of these conditions.

Van Kampen *et al.* (2015) reported that most therapies for LBP/PGP (e.g. support belts, exercises and craniosacral therapy) reduced pain. However, no optimal from of treatment could be recommended because the results the 54 randomized controlled trials that these authors systematically reviewed were inconclusive.

A systematic review by Boissonnault *et al.* (2012) supported the use of exercise for the treatment or prevention of PGP, either alone, or in combination with acupuncture, advice and/or support belts.

The European guidelines for the diagnosis and treatment of PGP (Vleeming *et al.* 2008) recommend the provision of adequate information and reassurance, individualized exercises for pregnant women, and a customized multifactorial treatment programme for other patients.

Stuge *et al.* (2006) compared two studies (Mens *et al.* 2000; Stuge *et al.* 2004). They concluded that "exercises that initially focused on local muscles, and then gradually added global muscles showed a significant, positive effect" (Stuge *et al.* 2006, p. 337).

After reading the guidelines, systematic reviews and papers discussed above, we made some notes and had a further team discussion. We agreed that evidence is emerging about the effectiveness of manual therapy for pregnancy-related PGP. However, the consensus of the systematic reviews and guidelines is that patients should be treated with a combination of modalities, as indicated by their assessments. Further research is required, but our conclusion is that a multifactorial treatment approach is effective. This complies with the current evidence, and is consistent with our own clinical experience. Therefore, practice at our NHS trust remains unchanged.

The *How Can We Improve Care for Women with Pelvic Girdle Pain?* leaflet can be downloaded from the Pelvic Partnership website (Pelvic Partnership 2015b), and printed out in an information sheet format. Two free hard copies can also be ordered from the site (www.pelvicpartnership.org.uk/free-stickmum-leaflet/view/form). Larger quantities of the leaflet can also be ordered for the price of postage and packaging.

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