

This poster aims to discuss about pubic symphysis diastasis and its potential debilitating effects intrapartum and postpartum. Pelvic girdle pain (PGP) is a common pregnancy presentation causing pain in the pubic symphysis and/or either one or both the sacroiliac joints and the gluteal region, often exacerbated with mobility and movement (1). In rare occasions, PGP can result in pubic symphysis diastasis during the peripartum and postpartum period, which is defined as a disruption of >1cm of the pubic symphysis joint and ligamentous structures (2) during labour.

CASE

A 43-year-old female, G1P0 at 38+2 weeks, presented with SROM and early labour, where she was brought in by wheelchair due to her worsening mobility from PGP. She reported a history of progressively worsening PGP throughout the pregnancy, which particularly exacerbated over the last week. She had presented to the assessment unit multiple times for review due to her increasing pain and reduced mobility.

This was a moderate risk pregnancy due to her background of AMA, hence she had serial growth scans that showed a normally grown fetus on the 50th percentile. The patient herself was fit and well, BMI 23, with no previous lumbar or pelvic issues, with an athletic background 20 years ago. She first experienced PGP symptoms around 30 weeks' gestation where she was managed conservatively with physiotherapy, supportive pregnancy belts and simple exercises. Despite these measures, her symptoms were not improving and gradually worsened causing debilitating effects towards the end of the pregnancy.

In the week leading up to the peripartum period, she reports a complete inability to walk, difficulty performing simple ADLs independently, requiring the assistance of family for simple tasks such as toileting, going into bed etc. She presented to the hospital multiple times in view of this but was discharged home with ongoing conservative management, physiotherapy review and simple analgesia. She denied any red flag symptoms of urinary or bowel incontinence, paraesthesia or hemiparesis. No imaging or further investigations were undertaken at that stage.

She eventually delivered via non-elective caesarean section due to obstructed labour, but continued to experience pain and immobility post operatively, requiring mobility aids and support. She received daily physiotherapy reviews and was discharged home with the plan for ongoing follow up as an outpatient.

Given her symptoms and presentation, there is a strong suspicion that the patient may have developed pubic symphysis diastasis however no imaging modalities were done during her inpatient stay to confirm the diagnosis. On follow up during her postpartum period, the patient reported an improvement in her pain and mobility with ongoing physiotherapy however still had not returned to her normal function. Should she have had a vaginal delivery, she may have ended up experiencing even more debilitating complications.

DISCUSSION

Pubic symphysis diastasis is a rare but frequently dismissed diagnosis in the peripartum and postpartum period that may lead to long term complications such as prolonged pain and immobilization (2). The physiologic widening of the cartilaginous pubic symphysis joint helps to expand the birth canal for a successful delivery (3). However when there is non-physiological pubic diastasis exceeding >1cm, it could lead severe debilitating effects to mobility and even disrupting the sacroiliac joint potentially necessitating surgical management or even urinary incontinence (4). Imaging modalities such as ultrasound and MRI are useful for confirmation of diagnosis however the degree of separation does not correlate with the severity of symptoms (4).

Due to misdiagnosis, the incidence rate is between 1:300 to 1:30000 (3). Treatment is often conservative with the use of pelvic binders together with physiotherapy, non-weight bearing with bedrest; in severe cases may require orthopaedic or surgical input for consideration of closed reduction or anterior external fixation (3). With regular physical therapy and conservative management, patients often experience full recovery and complete resolution of their symptoms in 3-6 months (3).

REFERENCES

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