

SPLIT HAPPENS: A STRETCH TOO FAR - PUBIC SYMPHYSIS DIASTASIS IN PREGNANCY

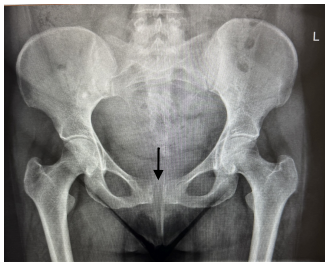
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INTRODUCTION

Pubic symphysis diastasis is a rare and under-reported complication of pregnancy with an incidence ranging from 1 in 300 to 1 in 30,000. Postpartum pain is mostly dismissed and ascribed to labour and childbirth which delays the diagnosis of PSD with diagnosis sometimes missed altogether. Mismanagement of PSD can lead to significant functional disability and chronic pain. While multiple risk factors have been highlighted, it could occur in low-risk pregnancies and deliveries as well.

CASE REPORT

37-year-old primiparous woman, singleton pregnancy presented twice to the maternity triage 15 days post NVD with complaints of groin pain worse with activities which significantly reduced her mobility requiring Zimmerframe for support. There was no history of trauma. She had significant tenderness over the pubic symphysis on examination and neurological examination was unremarkable. X-ray of the pelvis showed pubic diastasis measuring 12mm.



She was reviewed by the orthopaedic team and the plan was for conservative management with analgesia and physiotherapy. The patient had progressive improvement of her symptoms.

DISCUSSION

Pubic symphysis diastasis is a relatively rare complication in the postpartum period. During pregnancy, relaxin and progesterin result in the relaxation of fibrocartilage structures in preparation for delivery. These changes occur especially in the first trimester and during childbirth. The maximum physiologic separation does not exceed 10 mm and PSD can be diagnosed with radiological pubic symphysis separation greater than 10mm. Risk factors include multiple gestation, nulliparity, prolonged labor, connective tissue disorders, cephalopelvic disproportion, fetal macrosomia, and instrumental deliveries.

Patients present with pelvic pain and reduced mobility. Patients can experience pain with passive and active leg raises and diagnosis is made clinically. X-rays or ultrasound can be used as radiological evidence to support the diagnosis. Management options are conservative or surgical treatment. Conservative treatment is commonly used and recommended for separation of less than 4cm. It involves the use of pelvic binders, NSAIDS , bed rest and physical therapy. Functional recovery can be achieved but is associated with prolonged recovery time. Surgical treatment is recommended for separation greater than 4–6 cm, as this has an increased association with sacroiliac joint disruption. Patients should be informed of the protracted course of treatment and recovery time and provided support with care for their newborn.

CONCLUSION

Pubic symphysis diastasis should be considered as a differential diagnosis of pelvic pain in postpartum women. Awareness of this condition is crucial for clinicians to ensure timely diagnosis and management of patients as delaying treatment may lead to pelvic instability and chronic pain. A conservative approach including pelvic rest, NSAIDS and physiotherapy is an effective management option

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