



Standard of Care: Post-Partum Symphysis Pubis Pain/Separation

Physical Therapy Management of the patient with post-partum symphysis pubis pain/separation.

Case Type / Diagnosis: (diagnosis specific, impairment/ dysfunction specific)

- This standard of care applies to any patient with post-partum symphysis pubis pain and/or separation.

Indications for Treatment:

- Subjective reports of pain localized to anterior pelvis and groin
- Limited bed mobility
- Decreased ability to stand and/or ambulate
- Imminent discharge planning

Precautions for Treatment:

1. Be aware of delivery complications such as tearing (perineal, rectal, episiotomy), infant issues (size, position during delivery, health of infant).
2. Be aware of pain medication needs.
3. Avoid excessive activity and fatigue as aggressive exercise or activity can increase pain.
4. Monitor patient for emotional reactions to situation.

Examination:

- Medical History: Assess patient's past medical/surgical history by chart review.
- History of Present Illness: Assess hospital course by chart review.
- Social History: Assess patient's social history and prior functional level including recreation and exercise routines, by chart review and interview with patient.
- Medications: Assess patient's current medications and schedule/dosing information by chart review and discussion with nurse. Standard medications are Percocet and Motrin.
- Examination (Physical / Cognitive / applicable tests and measures / other)
This section is intended to capture the minimum data set and identify specific circumstance(s) that might require additional tests and measures.

Acute (Inpatient—Post-Partum):

1. Subjective complaints of pain (via visual/verbal analog scale) and functional limitations.
2. Active and assisted lower extremity range of motion.
3. Upper and lower extremity strength (measured grossly and within pain tolerance).

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4. Sensation testing by patient report and light touch screen.
5. Level of bed mobility and transfers.
6. Ability to ambulate.
7. Home environment, including layout and presence of stairs.
8. Infant care needs.
9. Social support available to patient from family and friends.

Evaluation / Assessment:

- Establish Diagnosis and Need for Skilled Services (see Discharge section)
- Problem List
 1. Subjective report of pain
 2. Limited bed mobility and transfers
 3. Decreased ability to stand, ambulate, or negotiate stairs
 4. Knowledge deficit
- Prognosis:
Patient will return to prior level of functional mobility and independence within 6-8 weeks after delivery.
- Goals:

Short Term Goals—to be met by time of discharge from hospital (2-3 days for vaginal delivery; 3-5 days for c-section):

1. Patient demonstrates understanding of her problem/current condition and is able to identify potential problems involving care of infant and functional mobility.
2. Patient demonstrates good problem-solving skills and modified body mechanics to achieve independence with bed mobility and transfer skills (Independent supine to sit, sit to stand; ≤min A sit to supine).
3. Patient's pain decreased with use of abdominal binder/SI belt and follow through with patient education regarding activities and medication for pain.
4. Patient demonstrates independent ambulation with walker or other assistive device for ≥ distance to bathroom (distance may vary).
5. Patient able to perform stairs with or without assist (depending on home environment and amount of assist available).
6. Patient and family demonstrate good understanding of discharge plan, safety awareness with mobility, pacing of activity, and anticipated progression of activity.

Long term Goals—to be met in 6-8 weeks post delivery:

1. Maximize functional mobility recovery with return to prior functional level of mobility and independence.

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Treatment Planning / Interventions

Established Pathway ___ Yes, see attached. X No

Established Protocol ___ Yes, see attached. X No

- Interventions most commonly used for this case type/diagnosis.
This section is intended to capture the most commonly used interventions for this case type/diagnosis. It is not intended to be either inclusive or exclusive of appropriate interventions.
 1. Patient and Family Education (mobility techniques, activity modification and progression, safety, pain management, infant care)
 2. Fit with abdominal binder or SI belt (usually circumferential measurement just proximal to greater trochanters—see instructions attached)
 3. Ice/cold pack to pubic symphysis/groin area
 4. Positioning—patients usually prefer supine for comfort; however, use pillow between knees if they can tolerate sidelying.
 5. Bed mobility and transfer training
 - a. Very few patients can tolerate log roll technique
 - b. Easiest method may be to push up to long sitting and then try to bring legs to side of bed.
 - c. Leg lifter may be beneficial
 - d. Patients can usually bridge.
 6. Ambulation/Gait training
 - a. Major problem is lifting swing phase foot off floor—no stability in pelvis to allow unloading for swing phase. Patient may slide foot along floor; if unable to move forward, may be able to walk backward less painfully.
 - b. Pattern of gait will be per patient tolerance—either leg is equally painful. Function is more important than normalcy of gait pattern at this point.
 - c. Attempt stairs only if patient’s gait is acceptable—often descending stairs backward is least painful.
 - d. Do not recommend sit method (on stairs) due to perineal sutures, edema, and the potential for further pelvic trauma.
 7. Support patient and family in adjustment to level of disability and in problem-solving to allow maximum patient independence.
 8. Infant care instruction
 - a. Patient should not attempt to carry infant until independent with mobility, preferably without assistive device. If still using assistive device, may use front sling to carry infant if assistance is not available.
 - b. Encourage use of dressing table or bureau for changing/other infant care.
 - c. Breast-feeding in sitting.
 - d. Limit necessity of stair climbing by stocking baby supplies both upstairs/downstairs (if applicable).
 9. Evaluation for discharge needs, including equipment and services.

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- Frequency & Duration
 1. Patient will be seen once a day for 1-4 days or until goals met or d/c from hospital.
 2. Coordinate activity schedule with patient to avoid conflicts with infant care/education, and with patient's pain medication schedule.
- Patient / family education
 1. Role of physical therapy
 2. Limitations in activity (as outlined in Intervention section)
 3. Treatment goals and anticipated outcomes
 4. Discharge needs
- Recommendations and referrals to other providers.
 1. Anticipate impending discharge—usual length of stay for vaginal post-partum is 48 hours. You can usually only extend LOS 1-2 extra days.
 2. Consider early recommendation for discharge by ambulance if negotiating stairs is main issue preventing discharge and follow up with Home PT.
 3. Early notification of continuing care coordination will facilitate coordinated planning.
 4. Consider occupational therapy referral for assistive devices if functional deficit is severe.
 5. Consider use of rental wheelchair until pain decreases if unable to ambulate with walker.

Re-evaluation / assessment

- Standard Time Frame: Most patients will be discharged from the hospital by no later than 5 days post delivery; however, re-evaluation of this patient would be indicated if the patient's length of stay exceeds 7-10 days
- Other Possible Triggers: Re-evaluation is indicated if there is a significant change in medical status.

Discharge Planning

- Commonly expected outcomes at discharge: The outcome goal at time of discharge from the hospital is that the patient will have achieved complete or modified independence (with/without assistive device) with basic mobility tasks (bed mobility, transfers, and ambulation on level surfaces). They may still require assistance with negotiating stairs. Until weaned from using assistive device, they will require assistance with infant care and transportation. Goals are directly dependent on the patient's social support system and assistance available upon discharge.

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- Transfer of Care: Occasionally, referral to local service agency (VNA) for evaluation and treatment is indicated. Recommend Home PT for home safety evaluation, progression of stair training. Home health aide if needed for infant care, assist with patient self-care ADL's.
- Patient's discharge instructions
 1. Reinforce need for rest, limitation of household activities, and emphasize performance of continued infant care.
 2. Provide patient with individualized written home instructions as needed for functional activities. Hip exercises are not recommended.
 3. Follow up with Obstetrician—if patient continues symptomatic by the 4-6 weeks visit, encourage her to request further PT follow-up.

Bibliography / Reference List

- Stephenson R and O'Connor L. Obstetric and Gynecologic Care in Physical Therapy. Slack Incorporated, 2000.
- Guide to Physical Therapist Practice. Phys Ther:2001;81:1-768.

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