



Pelvic & Sacrum Pain: Understanding and Managing Techniques

A comprehensive clinical guide to assessment, diagnosis, and evidence-based treatment strategies for pelvic and sacral pain management.

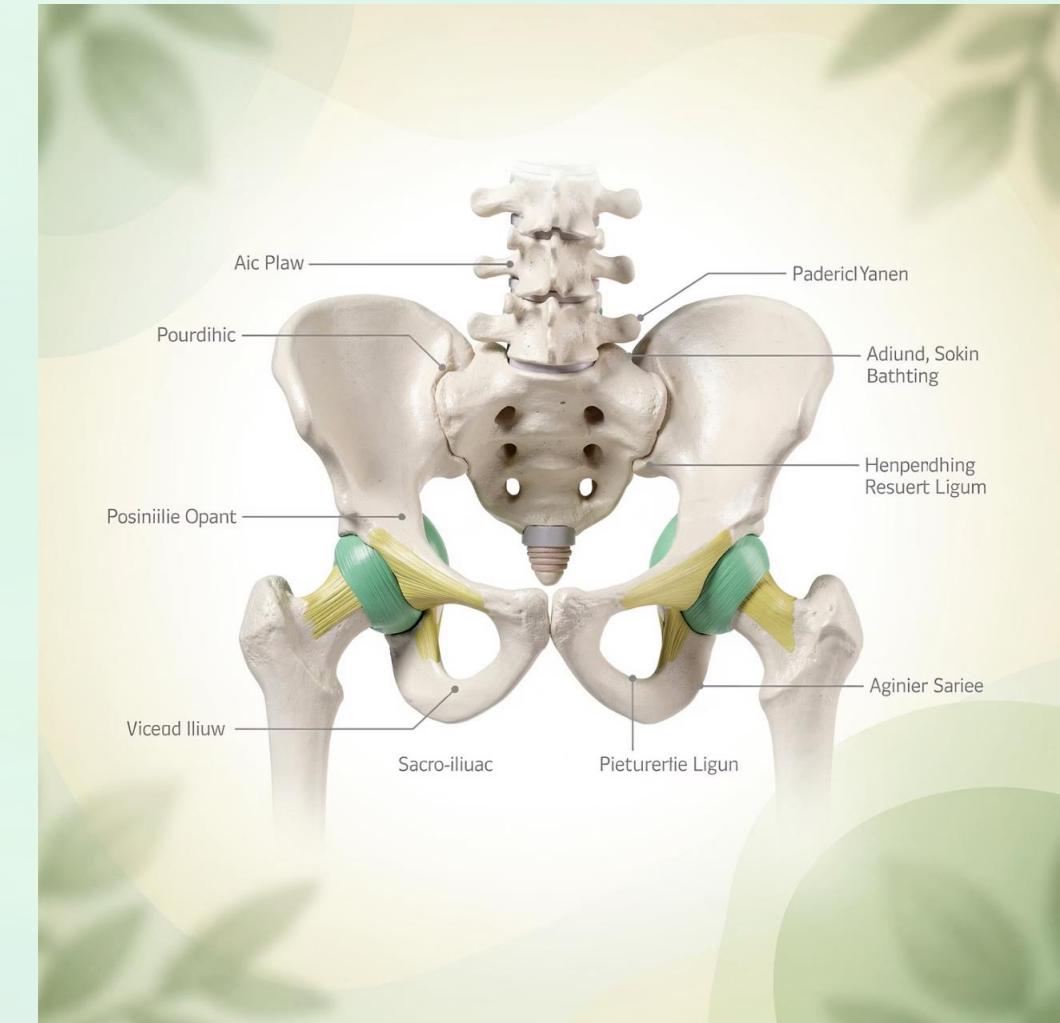
What is Pelvic & Sacral Pain?

Pelvic and sacral pain originates primarily from the sacroiliac (SI) joints, which connect the sacrum to the iliac bones of the pelvis. These joints are critical for transferring loads between the upper body and lower extremities.

Common Aetiologies

- Mechanical dysfunction and joint instability
- Inflammatory conditions (sacroiliitis)
- Pregnancy-related biomechanical changes
- Traumatic injury or repetitive microtrauma

This condition significantly affects mobility, posture, and quality of life, particularly in adults and pregnant women.





Key Symptoms & Clinical Presentation



Pain Localisation

Concentrated near the posterior superior iliac spine (PSIS), radiating to buttocks, hips, or lower back regions.



Pain Character

Sharp, stabbing, or shooting sensations that may radiate down the posterior thigh or into the groin area.



Aggravating Factors

Prolonged sitting or standing, walking long distances, bending forward, lifting objects, or rotational movements.



Functional Limitations

Difficulty climbing stairs, turning in bed, rising from seated position, or transitioning between positions.

Causes & Risk Factors

1

Mechanical Dysfunction

Hyper-mobility or hypo-mobility of the SI joint creates abnormal load transfer patterns, causing compensatory stress on surrounding structures and pain generation.

2

Pregnancy-Related Changes

The hormone relaxin causes ligamentous laxity, increasing joint instability and affecting approximately 50% of pregnant women during gestation and postpartum.

3

Degenerative & Inflammatory Conditions

Osteoarthritis, ankylosing spondylitis, psoriatic arthritis, and other inflammatory diseases compromise joint integrity and function.

4

Lifestyle & Biomechanical Factors

Poor postural habits, repetitive occupational stress, obesity, leg length discrepancy, and previous pelvic or spinal trauma.

Diagnosing Pelvic & Sacral Pain

Clinical Assessment

Comprehensive history-taking and physical examination form the foundation of diagnosis.

Provocation Tests

- **Fortin finger test:** Patient points to pain location with one finger
- **FABER test:** Flexion, abduction, external rotation
- **Gaenslen's test:** Hip hyperextension whilst contralateral hip flexed
- **Thigh thrust test:** Posterior shear stress applied

Three or more positive tests increase diagnostic accuracy significantly.

Diagnostic Imaging



Manual Therapy Techniques

01

Mulligan's Mobilisation with Movement (MWM)

The therapist applies a sustained joint glide whilst the patient actively moves through the painful range. This technique restores proper joint alignment, reduces pain, and improves functional movement patterns.

03

Joint Mobilisation & Manipulation

Graded oscillatory movements or high-velocity low-amplitude thrusts restore joint mobility, reduce muscle guarding, and stimulate mechanoreceptors for pain modulation.

Clinical benefits: Improved joint range of motion, reduced pain intensity, enhanced neuromuscular control, and faster functional recovery when combined with active rehabilitation.

02

Myofascial Release Techniques

Targeted soft tissue manipulation addresses trigger points in gluteal muscles, piriformis, quadratus lumborum, and iliopsoas to relieve chronic muscle tension and restore tissue mobility.



Therapeutic Exercises for Pelvic & Sacral Pain



Exercise Principles

Progressive loading, specificity, and consistency are essential for optimal outcomes.

Pelvic Tilts

Supine position with knees bent. Gently flatten lower back against floor, hold 5 seconds.
Improves pelvic mobility and motor control.

Bridges

Strengthen gluteus maximus and hamstrings.
Lift hips whilst maintaining neutral spine.
Progress to single-leg variations.

Clamshells

Side-lying hip abduction targets gluteus medius for lateral pelvic stability. Essential for controlling hip adduction during gait.

Bird-Dogs

Opposite arm and leg extension challenges core stability and trains coordinated lumbopelvic control patterns.

Stretching Programme

Hamstrings, piriformis, hip flexors, and quadratus lumborum. Hold 30 seconds, repeat 3 times daily to reduce muscle tension.

Consistent home exercise programmes are critical for lasting pain relief and prevention of recurrence.

Managing Pregnancy-Related SI Joint Pain

Pregnancy Support Belts

Sacroiliac belts provide external compression and stability, offloading joint stress during weight-bearing activities. Worn low around hips for optimal biomechanical support.

Gentle Mobility Exercises

Birthing ball exercises, pelvic rocks, and modified stretching improve comfort without overstressing relaxin-affected ligaments. Focus on controlled, pain-free movements.

Heat & Cold Therapy

Alternating modalities reduce inflammation and muscle tension. Cold packs for acute flare-ups (15 minutes), heat for chronic stiffness (20 minutes). Safe throughout pregnancy.

- ☐ **Clinical note:** Physical therapy tailored to pregnancy ensures maternal and foetal safety whilst addressing biomechanical changes. Avoid supine positions after 20 weeks gestation.

Interventional Pain Management Options

When conservative management provides insufficient relief, interventional procedures offer targeted pain control for moderate to severe cases.



Corticosteroid SI Joint Injections

Image-guided (fluoroscopy or ultrasound) intra-articular injections deliver potent anti-inflammatory medication directly to the pain source. Provides relief for 3-6 months in responsive patients.



Radiofrequency Ablation

Thermal lesioning of sensory nerves innervating the SI joint disrupts pain signal transmission. Reserved for refractory cases with confirmed diagnostic block response. Duration: 6-12 months.



Minimally Invasive SI Joint Fusion

Surgical stabilisation using triangular titanium implants for severe, persistent pain unresponsive to all conservative and interventional treatments. Long-term solution with high success rates.

Important: These interventions serve as adjuncts when physical therapy, exercise, and oral medications prove insufficient. Multidisciplinary approach yields best outcomes.