How do women manage pregnancy-related low back and/or pelvic pain? Descriptive findings from an online survey

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Abstract

Background. Low back pain is typically experienced by over 60% of pregnant women and pelvic pain by almost 20% (Pennick and Liddle, 2013). The treatment offered for this condition is mostly physiotherapy, however this is not always effective, or evaluated positively by women. Midwives accept that low back pain and/or pelvic pain (LBPP) is common during pregnancy and that treatment is conservative, often including paracetamol, alongside a variety of physiotherapeutic interventions. However, there is growing concern over the use of medication by pregnant women with LBPP. Therefore, an online survey was undertaken to explore women’s experiences of LBPP, treatments used and their perceived satisfaction and effectiveness.

Aim. To determine the treatments women use to manage LBPP in pregnancy, how helpful they find these treatments and how satisfied they are with them.

Method. An online UK survey was designed to investigate the incidence of LBPP among women who have recently given birth within the UK. The survey was developed and distributed using Qualtrics online software and contained 92 items piloted with 10 women who had given birth within the previous two years. The Doctoral Midwifery Research Society website hosted the survey and the popular mother and baby websites Netmums and Bounty advertised the study. Ethical and research governance approval was granted by the University of Ulster. The survey collected data on demographics, birth outcomes, body mass index (BMI), pain, treatments for LBPP in pregnancy, and physical activity levels. Women were eligible to complete the survey if they had given birth in the last two years, could understand and read English and were willing to take part.

Findings. A total of 331 women accessed the survey, 140 were currently pregnant and screened out. The remaining 191 were eligible and 176 questionnaires were fully completed. The mean age was 30.46 (SD 7.60) and 95% of women were white. The sample response was heavily weighted towards England (75%), with smaller proportions of respondents from Scotland (11%), Northern Ireland (8%) and Wales (6%). The average BMI of survey respondents before their most recent pregnancy was 26.

Most women reported being physically active on two days each week, with walking the most popular activity (81%). Mean low back pain intensity was 6.43 on a 0 to 10 sliding scale, mean frequency of low back pain was 7.16, mean pelvic pain was 7.62, and mean pelvic pain frequency was 8. Most women gave birth vaginally (66%), followed by emergency CS (12%), planned CS (8%), forceps (8%), and vacuum (6.29%). Most women (78%) gave birth at 36 to 42 weeks’ gestation. A large number of women (110/157) had suffered LBPP before their pregnancy, with many using over-the-counter painkillers. Painkillers were used by 96 women to manage LBPP, and the most frequently used was paracetamol, followed by codeine/co-codamol and non-steroidal anti-inflammatory drugs (NSAID). In total, 46% of women received treatment other than painkillers for LBPP in pregnancy. Qualitative data has revealed a disturbing picture of women’s pain and its impact on the quality of daily life.

Implications. Recommendations include the development of evidence-informed guidelines for practitioners and raising awareness of medication safety with mothers.

Key words: Low back pain in pregnancy, pelvic pain in pregnancy, medication in pregnancy, analgesia usage, online survey, evidence-based midwifery

Introduction

Low back pain and/or pelvic pain (LBPP) has been reported as a global phenomenon (Skaggs et al, 2007). It is one of the most frequently reported pregnancy complaints by women in the third trimester (Katonis et al, 2011; Zib et al, 1999) with an estimated time of occurrence between 18 and 25 weeks’ gestation. Treatment is complex, as there is a lack of data on the safety of medication usage in pregnancy due to the fact that being pregnant is an exclusion criterion for participation in drug trials. This often leads to inadequate pain management, evidenced in a recent study by Pierce et al (2012), which reported only 25% of women reporting LBPP actually received treatment.

The disability and distress caused by LBPP in pregnancy is increasingly being recognised as an issue that needs to be addressed. This is mainly due to the reporting of research
that demonstrates the impact on daily living for women; reports indicate disability at home and in the workplace, insomnia and increased risk of developing depression (van de Pol et al, 2007; Mens et al, 1996; Fast et al, 1987).

Recent evidence from a Cochrane systematic review reports that more than two-thirds of pregnant women experience low back pain during pregnancy (66%) and almost 20% experience pelvic pain (Pennick and Liddle, 2013). However, despite the frequent occurrence of LBPP during pregnancy and the significant impact it can have on pregnant women’s everyday life, at present there are no specific clinical guidelines available on how to manage this condition in the pregnant population. The absence of a clinical guideline has led to the use of a wide range of management strategies, some of which may pose a health risk to the mother and baby or fetus.

Management strategies for LBPP during pregnancy
Women with LBPP seek a range of interventions, including professional, self and complementary treatment in order to manage their symptoms. An Australian study by Stapleton et al (2002) reported that medications, physiotherapy and chiropractic care were among the most frequently used treatments to manage low back pain in pregnancy.

Medications
There is limited literature on the use of medications for LBPP during pregnancy (Vermani et al, 2009), however, there is no robust evidence to state that it is 100% safe. Recent research suggests that there may be links with paracetamol usage during pregnancy and the development of behavioural disorders, such as attention deficit hyperactivity disorder (ADHD), hyper kinetic disorder (HKD) and asthma in children (Liew et al, 2014; Eyers et al, 2011). Qualitative research data has reported cases where paracetamol has not been particularly effective for LBPP in pregnancy (Vermni et al, 2009; Wellock and Crichton, 2007).

Opiate-based drugs, such as codeine, morphine and tramadol, are category ‘C’ drugs, according to the Food and Drugs Administration (FDA) classification of pregnancy risk (FDA, 2004; 2002). Category ‘C’ incorporates drugs which have demonstrated a risk to fetal health in animal studies. However, despite the risk that using opiate-based drugs may pose on fetal wellbeing, the use of such drugs may be appropriate and necessary to manage severe pain during pregnancy (FDA, 1999).

A study by Bateman et al (2014) highlighted the frequent use of opiate-based drugs in pregnant women with back pain. This study reported 37% of women who were prescribed these during pregnancy had back pain and 61% of those women had taken the medication on three or more occasions. There is concern that the continuous use of opiate-based drugs, such as codeine, during pregnancy can lead to tolerance and dependence in the mother, which, in turn, can lead to neonatal withdrawal syndrome (Kennedy, 2011). The use of opiates in midwifery for pain relief is not common practice. However, there is published epidemiological research on the effect of opiates for pain medication by Broussard et al (2011). Their research reported 2.6% of 17,449 case mothers and 2.0% of 6701 control mothers used opiates between one month before pregnancy and the first trimester. Data analysis revealed that use significantly increased the risk of birth defects, such as spina bifida and gastrochisis.

Non-steroidal anti-inflammatory drugs (NSAIDs) are used to treat mild to moderate pain or fever (Kennedy, 2011). The NHS Choices (2014) website has a distinct message about the use of ibuprofen medication: ‘The Medicines and Healthcare products Regulatory Agency (MHRA) advises that all NSAIDs should not be used by pregnant women in the first two trimesters of pregnancy unless the potential benefit to the patient outweighs the potential risk to the fetus, and NSAIDs should not be used at all during the third trimester unless on the advice of a doctor.’

In addition, it includes a clear statement indicating that the use of ibuprofen in pregnant women, weeks one to 13, increases the risk of miscarriage and the baby could develop a heart defect or other abnormalities, such as defects in their abdominal wall (gastrochisis) or a cleft palate. There is a clear warning about the potential harm associated with taking ibuprofen after 28 weeks’ gestation and the risk of ‘heart problems in the baby and high blood pressure in the baby’s lungs, delay in labour and reduced amniotic fluid levels’ and women are advised only to take the medication on a doctor’s advice. More recently, Yates and Simon (2012) have indicated that use of NSAIDs after 30 weeks may increase the risk of premature closure of the ductus arteriosus and oligohydramnios.

Physiotherapy
Physiotherapy is the global standard treatment provided to women with LBPP in pregnancy and this may be due to its conservative and non-pharmacological nature. Physiotherapy for pregnancy-related LBPP often involves using a combination of home exercises, water-based exercise, use of a pillow, use of a support belt and encouraging women to keep physically active through walking or other gentle aerobic exercise (Stuge et al, 2003). In serious cases, where mobility is severely affected, physiotherapists may prescribe the use of walking aids or wheelchairs.

At present the evidence for the effectiveness of physiotherapy for pregnancy LBPP is conflicting. A systematic review by Stuge et al (2003) reported that there was no evidence of effectiveness for physiotherapy for managing LBPP. A systematic review by Richards et al (2012) reported that the evidence to support the use of physiotherapy was limited and this was supported in the Cochrane review by Pennick and Liddle (2013).

More recently, van Benten et al (2014) conducted a systematic review into the effectiveness of physiotherapy for LBPP in pregnancy and concluded that there was moderate quality evidence from nine trials to support the effectiveness of different forms of exercise for managing the condition. However, this review did not focus on interventions specifically delivered by physiotherapists, but rather interventions that...
may form part of physiotherapy treatment. Some of these interventions, such as complementary and alternative medicines (CAM), were delivered by other professionals.

Complementary and alternative medicine
CAM – which includes treatments such as reflexology, osteopathy, chiropractic care and acupuncture – has been used as a management strategy for LBPP. Research indicates that 25% to 30% of women use CAM to manage the condition, despite robust evidence of the effectiveness of CAM therapies for this pain (Sinclair et al, 2014; Wang et al, 2005). Furthermore, pregnant women have been shown to be very willing to use CAM for low back pain during pregnancy, with almost 62% of women in a survey by Wang et al (2005) reporting that they would be willing to try CAM for this pain. A recent systematic review by Close et al (2014), specifically focused on the effectiveness of CAM in the management of LBPP, has reported that there is evidence of the effectiveness of certain CAM therapies.

Most of the randomised controlled trials (RCTs) within this review focused on acupuncture, although there was one supporting the use of osteopathic treatment for LBPP in pregnancy and one RCT supporting the effectiveness of chiropractic treatment. However, Close et al (2014) highlighted that the quality of the evidence for CAM in the management of LBPP was very low and there was insufficient evidence for the development of evidence-informed guidelines for practitioners.

The evidence base for acupuncture is undoubtedly the largest. However, evidence of the effectiveness of other therapies, such as chiropractic treatment, is growing. A recent cohort study on the effectiveness of chiropractic treatment for LBPP in pregnancy by a Swiss team (Peterson et al, 2014) provided evidence of the effect of treatment on a sample of 115 women. Improvement at one week was reported for 52%; one month by 70%; three months by 85%; and 90% at six months. They followed up with the women one year after the birth and reported 88% retention of the effect (significant reductions in numerical rating scale for pain and Oswestry scores (p<0.0005)).

Pennick and Liddle (2013) investigated the effectiveness of all interventions for the prevention and management of LBPP and reported similar conclusions to Close et al (2014) in relation to the effectiveness of CAM therapies for managing LBPP during pregnancy. Both reviews found supporting evidence of effectiveness for a small number of CAM therapies for LBPP in pregnancy. It is important to note that CAM has been reported to be helpful for back pain in the general population (Eghbali et al, 2012; Quinn et al, 2008) and a reported strength of CAM therapies is their holistic approach to care that includes attention to the physiological, psychological and emotional wellbeing.

Within the UK, there continues to be a lack of clarity about which treatments women are actually using to manage LBPP and how they rate these treatments in terms of helpfulness and satisfaction. Therefore, we decided to undertake an online survey to explore these issues in more depth.

Aim
The aim of this study was to determine the treatments women use to manage LBPP in pregnancy, to investigate how useful women find the treatments and how satisfied they are with them.

Methods
An online survey was designed to investigate the incidence of LBPP among women who had recently given birth within the UK. It was called ‘The Healthy Back in Pregnancy Project’ and was designed by a small group of multiprofessional researchers from the University of Ulster, Northern Ireland, who have a special interest in effective and evidence-informed management of LBPP in pregnancy. The instrument included a total of 92 items and incorporated validated items to assess disability, pain management and exercise. The combined instrument was generated using Qualtrics software and piloted with 10 women. The Doctoral Midwifery Research Society (DMRS) website hosted the survey and the mother and baby website Netmums and Bounty were asked to support the survey by placing an information tab and a link to the DMRS website where women could complete the questionnaire. Ethical and research governance approval was granted by the University of Ulster.

The survey also collected data on demographics, birth outcomes, body mass index (BMI), pain, treatments for LBPP in pregnancy, and physical activity levels. Women were eligible to complete the survey if they had given birth in the last two years, could understand and read English and were willing to take part.

Descriptive findings
A total of 331 women accessed the survey, 140 were pregnant and screened out. The remaining 191 were eligible and 176 questionnaires were fully completed. The mean age was 30.46 (SD 7.60) and 95% of women were white. The sample response was heavily weighted towards England (75%), with smaller proportions of respondents from Scotland (11%), Northern Ireland (8%) and Wales (6%). The average BMI of survey respondents before their most recent pregnancy was 26. Most women reported being active on two days each week and walking was the most popular activity (81%).

Of those women who reported having experienced LBPP (n=157), 70% (110/157) had experienced it prior to becoming pregnant. Mean low back pain intensity reached 6.43 on a 0 to 10 sliding scale, mean frequency of low back pain reached 7.16, mean pelvic pain reached 7.62, and mean pelvic pain frequency reached 8 (pain was measured using the visual analogue scale for pain with 0 meaning ‘no pain’ and 10 meaning ‘the worst pain possible’).

Most women gave birth vaginally (66%), followed by emergency CS (12%), planned CS (8%), forceps (8%), and vacuum (6.29%). Most women (78%) gave birth at 36 to 42 weeks’ gestation.

Treatments used for LBPP in pregnancy
Of those women who sought treatment for their LBPP symptoms, most (64%) took painkillers (see Figure 1).
These were mainly prescribed by the GP (40%), self-prescribed or purchased over the counter (OTC) (39%) (see Table 1). Paracetamol was the most popular painkiller used by women, followed by codeine/co-codamol and then NSAIDs). Physiotherapy (n=58) and GP care (n=31) were the most popular treatments received. Women also reported using CAM therapies. Osteopathy, reflexology and chiropractic treatment were the CAM therapies used most frequently (see Table 2).

Satisfaction and helpfulness of treatments for managing LBPP in pregnancy

In total, 36 responded to an open-ended question at the end of the survey asking if there was any further information they would like to share. Many of these responses focused on the standard care treatment women received for managing LBPP in pregnancy and four themes have been identified.

Normal for them but not for me

Many women commented in depth about the way in which back pain was considered ‘normal’ by staff but their experience was not normal:

“Didn’t think back pain was taken seriously I was just another mum-to-be with a bit of back ache – it was agony some days” (number 94).

“I complained a number of times about back pain in pregnancy and was told it is normal and was not offered any advice on how to cope with it” (number 112).

“This was never taken seriously by my midwife or doctor and I was told that I would have to live with it because it was all part of a normal pregnancy” (number 21).

Pain worsened with treatment

Women described their disappointment with a range of treatments provided by the hospital and their detrimental effect on their pain:

“I have had symphysis pubis dysfunction/pelvic girdle pain (SPD/PGP) for four years now and feel the treatment that the NHS offered is abysmal” (number 21).

“Having physio caused me more pain during pregnancy than I was already experiencing” (number 32).

“Belt provided by physio caused increased pelvic pain” (number 10).

Pain is crippling

Women described their LBPP as being something that has everyday impact and stops them from moving:

“My pelvic pain was excruciating in the third trimester” (number 21).

“I was in so much agony while pregnant – it has put me off having more children” (number 15).

“I suffered from horrible SPD which left me on crutches and housebound for the last 10 weeks” (number 11).

Midwife support was invisible

Women expressed their disappointment and, more importantly, their acceptance of the lack of midwife support:

“Lack of help from the midwife is an inevitable part of pregnancy” (number 17).

“… generally lack of help or support from NHS staff” (number 44).

“I found the lack of information and support very bad… I had never heard of this before [SPD] and was left to do my own research” (number 11).

Discussion

This descriptive account of the survey findings highlighted many issues but it is important to focus on those that are most prominent and of most concern. The use of

| Table 1. Prescribed and non-prescribed medication used for LBPP in pregnancy |
|-----------------------------|------------------|-------------|
| Answer | Response | % |
| Yes, by my general practitioner (GP) | 37 | 40% |
| No, I decided to take it myself | 36 | 39% |
| Yes, by my gynaecologist or specialist | 11 | 12% |
| Yes, by another healthcare professional (please specify) | 5 | 5% |
| Other* (please specify) | 4 | 4% |
| Total | 93 | 100% |

<table>
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<th>Yes, by another health professional (please specify)</th>
<th>Other* (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife</td>
<td>Told by a midwife I could take them</td>
</tr>
<tr>
<td>Physio</td>
<td>Not prescribed but recommended by consultant and physiotherapist</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>I took them on advice of my GP and midwife</td>
</tr>
<tr>
<td>Midwife</td>
<td>The codeine and paracetamol were, but not the ibuprofen lysine</td>
</tr>
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painkillers for managing LBPP in pregnancy is increasing and the data from this survey demonstrates that women are self-medicating by buying OTC painkillers (see Table 1). Henry and Crowther (2000) reported that 50% of women use painkillers during pregnancy. However, in this survey of women with LBPP, the use of painkillers was substantially higher (64%). This requires further exploration and research as no medication is considered 100% safe and women are encouraged to avoid medication use during pregnancy (NHS Choices, 2013).

The type of medications used by some women was also an issue, as codeine-based drugs were used by many women – such drugs carry the risk of neonatal withdrawal symptoms and women are more at risk of building up a tolerance and dependence to opiate-based drugs with frequent use (Kennedy, 2011). Research has also shown that this type of drug may increase the risk of birth defects (Broussard et al, 2011). In addition, the side effects of codeine-based drugs, such as constipation, could increase the need for further medication to be taken. The high usage of paracetamol is also concerning, especially in light of the emerging data linking the drug to ADHD, HKD and asthma (Liew et al, 2014; Eyers et al, 2011).

Self-medication and OTC purchasing of medications by pregnant women with LBPP was evident in this study and this is another required area for investigation with the possibility of securing national guidelines for providers and prescribers. This result has previously been reported and research has demonstrated that some pregnant women with LBPP may take more than the recommended dosage of pain medications (Wellock and Crichton, 2007). The findings from this survey are sufficiently convincing to demonstrate the need for much more focused attention and collaborative planning to tackle this issue at the micro, mesa and macro levels.

In those women who report using medications for LBPP during pregnancy, health professionals need to give clear advice on safety and, where possible, offer or suggest an evidence-based non-pharmacological method for managing LBPP. For women who are prescribed medications, full records need to be kept and reviewed on a regular basis at each antenatal appointment.

This survey provided evidence about the frequency of use of physiotherapy and women’s perceptions of its usefulness. We know from previous literature that physiotherapy is the most popular form of treatment for LBPP (Stapleton et al, 2002) and, as there is no medication, it is deemed to be ‘safe’. Many women (n=23/58) found physiotherapy either useful or very useful for managing their LBPP, however, 10 women did indicate that it was useless (see Table 2).

Physiotherapy may work best as part of a multimodal intervention or a menu of choices that include relaxation therapy, pilates, yoga, exercise in water, CAM and online support. Such multimodal interventions are advocated for treating low back pain in the general population, due to their improved outcomes and an emerging body of evidence suggests that such approaches to LBPP in the pregnant population may yield better results than interventions which focus solely on the physical elements of pain (George et al, 2013; NICE, 2009). Some women sought CAM therapies for their LBPP and found this very helpful, in comparison with those who found physiotherapy to be ‘useless’.

While it was evident that women were more dissatisfied with physiotherapy in comparison, it is important to take into account the fact that physiotherapy has been around for many years and women simply may not have the same enthusiasm for this treatment, not to mention the fact that physiotherapy requires the woman to actually self-manage her LBPP in terms of keeping active and doing home exercises. Some women may like a more passive role, such as using CAM, where the pain is treated by the therapist with the woman needing to take little responsibility.

The fact that CAM, when

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Table 2. Women’s perceptions of the treatments received for LBPP

<table>
<thead>
<tr>
<th>Question</th>
<th>Very useful</th>
<th>Useful</th>
<th>Neither</th>
<th>Not that useful</th>
<th>Useless</th>
<th>Total responses</th>
<th>Mean</th>
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<td>3</td>
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<td>6</td>
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<td>1</td>
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<td>0</td>
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<td>3</td>
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<td>6</td>
<td>17</td>
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<td>0</td>
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<td>0</td>
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<td>0</td>
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</table>

used, was deemed to be useful for LBPP, is a key finding, particularly as women most likely funded these treatments themselves, indicating a willingness to pay for pain relief and their pressing need to access treatment which would alleviate their pain. Only 10% of CAM therapies are provided on the NHS (Thomas et al, 2001). The expectation was that women would have been more critical of CAM and its value for money was not realised. CAM is commonly dismissed by healthcare professionals due to a presumed lack of scientific evidence and thus, effectiveness. However, reduction in known stress parameters in response to reflexology, highlighted by McCullough et al (2014), demonstrates that such treatments may have more to offer patients biochemically and psychologically.

The precise reasons for the reported helpfulness and satisfaction with CAM for LBPP during pregnancy were not explored within this survey, but evidence would suggest that pregnant women find the non-pharmacological and holistic nature of CAM appealing (Warriner et al, 2014; Hastings-Tolsma and Vincent, 2013).

The open-ended question towards the end of the survey provided women with an opportunity to provide additional comments. Many of the responses to this question highlight women’s general dissatisfaction around the standard of care received and advice provided by NHS staff, including midwives, for management of LBPP and has previously been reported by Pierce et al (2012). There may be many reasons as to why health professionals may not offer advice or treatment for LBPP during pregnancy. Studies have shown that some doubt the presence of it in pregnancy, that they frequently only have self-acquired knowledge of LBPP in pregnancy and they often lack knowledge of available treatments (Pierce et al, 2012; Candelier et al, 2011; Mogren et al, 2010).

The literature, combined with the data from this survey, points to a need for further training to improve the standard and quality of care currently provided to women experiencing this common and often debilitating problem. There is a need to conduct further research into the best way physiotherapy can be delivered at a clinical level. While there is evidence from RCTs supporting the effectiveness of components of physiotherapy, such as different forms of exercise, it would be worthwhile exploring if such interventions are available to pregnant women from physiotherapists and how these interventions are being provided. Furthermore, some women may suffer more pain following the use of interventions which form part of physiotherapy treatment for LBPP in pregnancy, such as support garments, and this has the potential to increase their use of stronger analgesia with higher risk of harm.

Limitations
It is known from recent evidence reported by Hall and Jolly (2014) and Warriner et al (2014) that many women fail to tell their health professionals about their pain and the authors acknowledge this to be a key question for any future research into back pain in pregnancy.

Conclusion
Women with LBPP during pregnancy need to be listened to and supported appropriately to manage their back pain. Their treatment plan needs to be holistic and woman-centred and women need evidence-based information about medication use in pregnancy to enable them to make choices.

A full history of the pain experienced, including symptoms, such as incontinence, the treatments used, daily impact and the social support provided, as well as the psychological wellbeing of the woman, need to be documented. It is essential to ensure that a full examination by a physiotherapist is undertaken to rule out any pathology when any woman complains of severe LBPP. We need guidelines with appropriate evidence to inform safe and effective management of this under-researched and under-estimated problem. Health professionals are currently in a vulnerable position having limited ability to confidently provide evidence-informed care pathways for women suffering from LBPP.

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