

POST-PARTUM BACKPAIN AND REGIONAL ANESTHESIA: CASE REPORT

INTRODUCTION

Post partum back pain is a common complication of childbirth. Symphysis pubis diastasis commonly presents as post-partum back pain. It is sometimes difficult to differentiate pubis symphysis separation from severe neurological complications in women who received neuroaxial analgesia. We present a case of symphysis pubis separation that manifested as back pain and motor weakness of lower extremities.

CASE REPORT

A 33-year-old G5P1 female with no previous medical history delivered a baby weighing 4145 g with Apgars 9/9. Delivery was complicated by mild left shoulder dystocia. Patient did not require an episiotomy and did not sustain any lacerations. Combined spinal epidural anesthesia was used to provide labor analgesia. Shortly after delivery, the anesthesia team was called to evaluate the patient for back pain. Patient complained of back pain at the site of the epidural, bilateral hip and groin pain and leg weakness. On physical exam, the patient had suprapubic tenderness on palpation and decreased range of motion of both lower extremities due to pain. No urinary or bowel incontinence was present. The patient was under the impression that her problems were caused by the epidural. Pelvic X-ray was obtained and showed a widened symphysis pubis, measuring 5.5 cm. Orthopedic surgery was consulted, recommended a pelvic binder, physical medicine consult and pain control. Patient was discharged home 3 days later with slight improvement of her condition.

At 3 month follow-up, the patient was still complaining of back and hip pain, which has been improving with physical therapy. Repeat X-ray showed improvement in symphysis pubis separation, now measuring 3.2 cm.

Immediately Post Partum



3 Month Follow-up



Note difference in size of gag between pubic bones.

DISCUSSION

An average gap between the pelvic bones in a non-pregnant woman is 4-5 mm. During pregnancy this gap may widen by 2-3 mm. If the gap is wider than 10mm, diastasis symphysis pubis is diagnosed.¹ Symptoms include suprapubic pain radiating to the lower extremities, hips and back. Pain is potentiated by weight bearing, walking, climbing stairs, lifting, getting up from a chair. Severe cases may present with urinary incontinence and inability to walk. Risk factors include fetal macrosomia, precipitous labor, rapid second stage labor, intense uterine contractions, previous pelvic pathology, and trauma to the pelvic ring, multiparity, forceps delivery. Treatment includes bed rest in the lateral decubitus position, pelvic support with brace or girdle, ambulation with walker or crutches and graded exercise protocol. Pain can be managed with NSAIDs, opiates and intrasymphyseal injections. Recovery from pelvic girdle syndrome can take up to 2 years and symptoms may recur in subsequent pregnancies.² Surgery can be done to fuse, wire or plate the symphysis pubis.

CONCLUSION

Neurological complications associated with labor analgesia are rare. However, due to the patient's fear of paralysis, any subsequent neurological deficit is usually blamed on the neuraxial block. Differentiating the side effects of labor from complications of neuraxial anesthesia is important, as anesthesiologists are the first consultants to evaluate these patients. Anesthesiologists and obstetricians must be familiar with potential complications of regional anesthesia in order to provide the treatment, information and reassurance each patient needs.

REFERENCES

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