

Pregnancy-Related Pelvic Pain: A Neglected Field in Developing Countries

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Inadequate access to antenatal care is still a major concern in many developing countries, and reducing pregnancy-related mortality is the main goal of national and international organizations of maternal health (1, 2). Despite the significant gap to reach the millennium development goal 5 (MDG5) to put an end to all the preventable causes of maternal deaths, the importance of other apparently benign pregnancy-related disorders should not be underestimated (3). In other words, besides considering the warning signs of major causes of maternal morbidity and mortality during the antenatal visits, including hemorrhagic or hypertensive disorders, some other measures should be taken to make the gestational and puerperal period as tolerable and satisfying as possible both for mother and her family, especially in the developing countries (3, 4). Nearly, half of the pregnant females experience pelvic girdle pain (PGP), at least to some extent (5). Although this musculoskeletal pain within the pelvic area is not harmful to females or their fetuses, it is indeed disabling interferes with their motherhood, familial relationships and their profession (5, 6).

Unfortunately, among the discomforts experienced by females during pregnancy, musculoskeletal complaints like PGP are not taken serious by the majority of clinicians. In a study by Pierce et al. the mean pain intensity score reported for low back or pelvic girdle pain was six out of ten and in 80% of females these rate had negative impact on their lifestyles (7). In another study by Malmqvist et al. PGP was the main cause of sick leave in Norwegian pregnant females with a mean duration of 11 weeks (8). In the same study, the principal reason not to take a leave from work was the subjects' higher educational level besides job satisfaction and not to perceive less pain, which actually did exist (8). The pain which tends to begin as early as 18 weeks of pregnancy may persist in the postpartum period for as long as 15 months (9, 10).

A number of mechanical and hormonal factors are blamed for the development of this disorder: 1) the in-

creasing load of the gravid uterus on spine and pelvis, 2) softening of the pubic symphysis, 3) laxity of the pelvic ligaments and 4) shifting of the uterus and a change in the pelvic orientation, which result in pelvic instability (10-13).

Females may have a wide range of complaints. Simply, everyday activities like getting up, turning over in bed, sitting down or walking may become painful (14, 15). The most common pain characteristics reported were dull, stabbing or cutting pain types within the pelvic area radiating to back or thighs (15). Many other aspects of a females' life can also be greatly deteriorated (14-16). With regard to the pain management, no single medical treatment has proved to be effective till now (14-18). While, non-steroidal anti-inflammatory drugs (NSAIDs) are contraindicated in the third trimester of pregnancy and opioids are not considered safe, paracetamol is not associated with satisfactory results (14). Opioids are not generally considered harmless; however, tramadol, with weaker tendency for opioid receptors, is safely used during pregnancy without maternal or neonatal toxicity (19). Combined treatment of opioids with N-methyl-D-aspartic acid (NMDA) antagonist like ketamine seems to have better analgesic effects; though, not proved by all studies (20). Compartment block with local anesthetics is another modality to decrease opioid consumption; nonetheless, its efficacy is not established yet (16, 21). Other proposed interventions include using pelvic belts, regular exercise, physical therapy, transcutaneous nerve stimulation and acupuncture which are costly and not everyone can afford especially in the developing countries. Therefore, what seems to be practical and cost-benefit, at least at the present time, is the role of appropriate support and adequate education from health care providers to recognize the risk factors and the ways to minimize the symptoms (16). Since there seems to be a lack of knowledge and awareness about the existence of such a disability among the caregivers themselves,

further investigation is required in this field (6, 16). According to recent studies, physical exercise could have alleviating effects (17, 18). However, in a systematic review by Gutke et al. among different treatment modalities for lumbopelvic pain during pregnancy, it was reported that acupuncture and pelvic belts had the strongest effect and exercise had a weak effect (22).

In conclusion, it can be stated that pregnancy-related chronic pains, including pelvic girdle pain, are really disabling throughout many females' lives, though not detrimental. While there are still many gaps in detection and appropriate management of this disorder, PGP should be considered as a major health concern in the society which deserves much more attention and support.

Footnote

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