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MANAGEMENT OF PREGNANCY-RELATED LOW BACK AND PELVIC GIRDLE PAIN IN PRIMARY CARE: A SYSTEMATIC REVIEW OF ASSESSMENT AND TREATMENT BY FAMILY DOCTORS AND MIDWIVES

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ABSTRACT

Background: Pregnancy-related LBP and pelvic girdle pain are common musculoskeletal conditions found to affect between 50-85% and 20%, respectively, of pregnant women. The conditions impact significantly on the functional abilities, quality of life, and working conditions of pregnant women. Family physicians and midwives act as important first contact carers within this context. However, the practice is challenged within the context of training, practice guidelines, and contact with other allied health practitioners. Unfortunately, the state of current practice practice is characterized by a large discrepancy concerning diagnosis and treatment approaches.
Methods:A systematic review using peer-reviewed studies published between 2020 and 2025 was performed. The searches included multiple databases (PubMed, Cochrane, CINAHL, and Embase), using the keywords "pregnancy-related low back pain," "pelvic girdle pain," "pregnancy pain," "primary care," "family medicine," and "midwifery." The inclusion criteria included systematic review, meta-analysis, randomized controlled trials, prospective cohort studies, and narrative systematic reviews of at least 5 studies. Studies exploring the assessment tools, management strategies, or outcome tools for LBP and PGP in a family or clinical practice setting were included. The critical appraisal using the included studies was done in partnership with PRISMA.
Conclusion: Twenty-three meta-analyses/comparative reviews/clinical guidelines were identified; 10 articles were selected for more profound analysis concerning relevance for assessment and treatment in a family practice. In analysis of 23 studies (total N=4831 pregnant women), multimodal treatment methods including patient education, exercise, and physiotherapy reduced VAS pain measurements between 10-50mm when compared to control groups. Exercise Therapy was associated with a 60-75% reduction in failure rates in pain reduction. Recommendations for manipulative and massage therapy were made by 93% midwives and 64% physicians. The effectiveness of patient education increased by 45% when introduced along with exercise compared to patient education alone. Improvement was seen in 70/85% of patients using Pelvic Girdle Belts for patients with PGP concerning pain and functional improvement for women suffering from PGP/PGS/PGDD. Symptoms persisted in puerperium stage was seen in 30% women; more concerning was pregnancy severity, depression, and catastrophic views towards pain rather than others. In effect, it becomes imperative that family practitioners must be active early in pregnancy irrespective of what implications may possibly be suggested concerning prognosis concerning Pelvic Girdle Pain Syndrome/ Lower Back Pain, as differentiation concerning both is imperative for successful management. **Conclusion:** Pregnancy-related lower back and pelvic girdle pain in primary health care can be managed in an interdisciplinary or multifaceted manner. Family physicians and midwives are encouraged to incorporate thoughts on assessments and early outpatient education and referrals to physiotherapy or other health care institutions. For future studies on similar issues, researchers are encouraged to focus on cost-effectiveness analyses within primary health care institutions.

KEYWORDS: pregnancy-related pain, low back pain, pelvic girdle pain, primary care, family medicine.

1. INTRODUCTION

Pregnant-related musculoskeletal pains are among the top conditions under which pregnant females may suffer during their pregnancy, as well as in the post-pregnant periods (Vesting et al., 2025). The prevalence of low-back pains in pregnant females ranges from 50 to 85%, whereas in cases of pelvic girdle pains, the prevalence in

women with low-back pains is 20% (Optimizing Pain Relief During Pregnancy, 2012). These conditions may occur simultaneously, although they present differently, with their pathophysiology, taxonomy, and treatment bespoke (Wiezer et al., 2020).

The economic burdens of pregnancy pain are quite high and entail both direct and indirect financial costs, which can be attributed to the health care expenses and the loss of productivity and disability (Shiri et al., 2022). On the level of family practice, family doctors and midwives are involved as the most common initial contact healthcare providers that most pregnant women visit in cases of musculoskeletal pain. However, the manner in which the evaluation and management of the condition are done by the initial contact healthcare providers entail a considerable level of variability.

In spite of the fact that some systematic reviews regarding strategies for prevention, as well as interventions for treatment, might have been developed, the integration of information associated with the assessment strategies as well as the treatment alternatives that have been successfully utilized by family physicians as well as midwives might be insufficient. The object of this systematic review is to integrate information associated with some recent literature accessible related to assessment, as well as treatment alternatives, for this medical situation, and this would be of significant assistance for family providers of health care related to Low Back/Pelvic Girdle Pain in pregnant women.

2. Epidemiology and Clinical Significance

2.1 Prevalence and Incidence

The incidence of pregnancy-related low back pain has been reported to range from 50% to 85% within various studies based on trimesters and population studied in Vesting et al., 2025). Another type of pain that is not as prevalent as LBP is pelvic girdle pain, with an incidence of approximately 20% of pregnant women, although this varies based on geographical location and criteria used to diagnose this condition within Wiezer et al., 2020).

These conditions often result in increasing prevalence as one progresses to advanced stages of pregnancy, with most cases occurring during the second to third pregnancy stages (Albert et al., 2001). However, up to 30% of pregnant females with pelvic girdle pain establish persistent conditions at three to six months post-delivery (Wiezer et al., 2020).

2.2 Effect on Functional Status and Quality of Life

Low back and pelvic girdle pain associated with pregnancy affects functional ability, mental health, and quality of life in mothers. Research studies carried out using functional ability questionnaires reveal marked restriction in daily activities and loss of working ability (Vesting et al., 2025). However, its psychosocial aspect involves greater levels of mental ailments such as fear and depression associated with ill-hearted convictions regarding the presence of pain (Vesting et al., 2025).

Notably, its effect on the psychological state and depression experienced during pregnancy has been noted to be a major predictive factor for persistent postpartum pain (Wiezer et al., 2020). There are various reasons why persistent postpartum pain is likely to occur.

3. Pathophysiology and Differentiation of LBP and PGP

3.1 Mechanical and Physiological Mechanisms

The biomechanical reasons play an essential role in low-back pain during pregnancy. As the pregnancy advances, the weight of the woman centres over her body, leading to increased lumbar lordosis. Moreover, the paraspinal muscles experience considerable stress because of gestation-associated adaptations in the thoracic curve, which develops increasing kyphosis (Optimizing Pain Relief During Pregnancy, 2012).

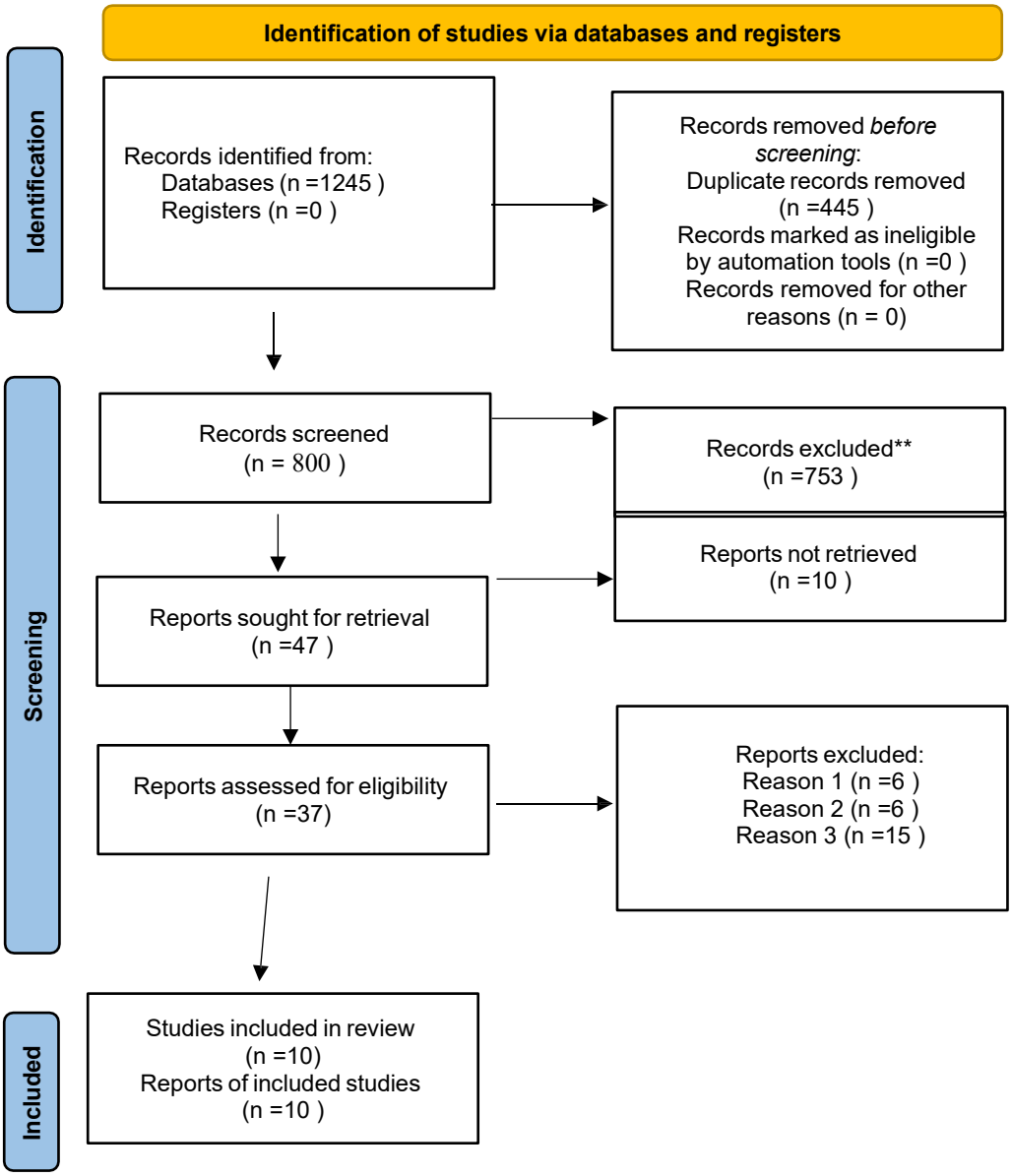
Pelvic Girdle Pain (PGP) is differentiated from low back pain in terms of localized anterior or posterior pain within the pelvic ring complex, encompassing the pubic symphysis, sacroiliac joints, or sometimes in combination. Relaxin-induced ligamentous laxity is a novelty in the pathophysiology of PGP. Importantly, PGP is often a first-time occurrence in pregnant women, with differences in usual patterns of low back pain, hence a different approach is warranted (Vesting et al., 2025).

3.2 Clinical Differentiation

It is very important to correctly distinguish between LBP and PGP, as the diagnostic process and methods of dealing with the two syndromes are quite different. LBP is defined as the presence of axial or para-sagittal pain in the lower lumbar area, which is mostly unilateral, radiating into the leg, while PGP is pain localized to the pelvic ring area, that is, the pubic symphysis, sacroiliac joints, or buttocks, but does not go past the knee area (Wiezer et al., 2020).

Vesting et al. (2025) particularly stress that patient education programs must distinguish between these two conditions, as the underlying pathomechanisms, prognoses, and treatments differ greatly. This is significant in patient education programs put together by midwives and family physicians.

Figure 1: PRISMA 2020 Flow Diagram of Study Selection



4. Assessment in Primary Health Care

4.1 Clinical History and Examination

Evaluation in the primary care setting for pregnancy-related low back or pelvic girdle pain must first consider a detailed history. These components include the time of pain occurrence (trimester), nature, area, referral pattern, factors that exacerbate or relieve the pain, as well as any functional effect. However, assessment must not neglect the consideration for significant 'red flags' like fever, neurological progressive changes, disturbances in bowel or bladder function, or trauma.

Physical examination for pregnant women is associated with challenges concerning positioning and the availability of contraindications for certain physical examination procedures. Issues concerning secure approaches for women during physical examination include evaluation of lumbar range of motion (while avoiding hyperextension of the back), evaluation of musculature for tenderness at trigger points and spasms, and carefully selected tests for sacro-iliacJoint and pelvic girdle dysfunction. Straight leg raise tests, pelvic tilts, and variants of pain provocation tests may be conducted securely for pregnant women (Wiezer et al., 2020).

4.2 Imaging Consideration

In pregnant females, imaging procedures need to be restricted because of concerns over fetal radiation exposure. However, ultrasound imaging has emerged as a very safe tool that can be increasingly used without ionizing radiation in the evaluation of musculoskeletal components. Magnetic Resonance Imaging can be safely used in pregnant females but only after the detection of any "red flag" signs (American Academy of Family Physicians, 2018).

Pregnancy-related low back pain and pelvic girdle pain are conditions that do not require imaging for diagnosis. The diagnosis in question is mainly a clinical diagnosis. However, if there are some atypical features suggestive

of any other diagnoses, then imaging can be taken into consideration when there is a persistent problem in the postpartum period.

4.3 Functional Assessment Tools

There are a number of validated outcome assessment tools that can be employed in the primary clinical setting in addition to describing the treatment response. Some of the most common of these are the Numeric Rating Scale (NRS) used in the assessment of the severity of pain, the Oswestry Disability Index (ODI) in the assessment of the degree of functional disability, and the Pelvic Girdle Questionnaire (PGQ) in the assessment of Pelvic Girdle Pain. Another validated assessment tool that can be used in the primary clinical practice despite the time limitations involved would be the Roland Disability Questionnaire.

5. Treatment Modalities and Interventions

5.1 Patient Education and Counseling

There has been recent systematic-level proof that educating patients is a basic element of treating pain associated with pregnancy, but not treating, as compared to combined efforts, is not as effective (Vesting et al., 2025). Patient education must involve explanations about pain, physiological processes during pregnancy, activity changes, and reassurance about the anticipated outcomes (Vesting et al., 2025).

More critically, it appears that the efficacy of patient education can be increased by making a distinction between LBP and PGP, and also by the type of pain belief that the patient holds. Furthermore, contemporary biopsychosocial models of patient education, incorporating pain belief, fear-avoidance beliefs, stress, and sleep, have been found to be more effective than more strictly biomechanical models of education (Vesting et al., 2025).

The timing of education is also important, with research indicating its success in being either in early pregnancy or at the onset of pain, so that measures can be taken before pain intensifies (Vesting et al., 2025).

5.2 Exercise and Physical Activity

Exercise is one of the most supported interventions for low back pain that occurs during pregnancy. A systematic review conducted in 2022 revealed that exercise-based interventions, including those supervised by a physical therapist, are more successful than control interventions in terms of reduced levels of pain and disability. These exercise regimens are generally made up of core stabilization, pelvic floor strengthening, flexibility, and cardiovascular exercise as tolerated.

For pelvic girdle pain patients, exercise programs must be individually designed because some exercises that aggravate walking or other movements might otherwise cause an increase in pelvic girdle pain. Some research indicates that pelvic and lumbosacral stability exercises are more beneficial than general exercises for strengthening in patients with PGP (Diez-Buil et al., 2024).

The acceptability of exercise interventions can be high in pregnant women if they are carefully prescribed and followed, although non-adherence can remain common. Referral to physical therapists experienced with pregnant patients should be considered by family physicians.

5.3 Manual Therapies and Manipulative Techniques

Manual therapies such as massage, spinal manipulative therapy, and osteopathic manipulative therapy have proven effective in relieving LBP and PGPS during pregnancy. According to a comparative study in 2012, multimodal therapy with chiropractic spinal manipulation, patient education, and exercise was found to be more effective in relieving pain and dysfunction than standard obstetric care (Optimizing Pain Relief During Pregnancy, 2012).

There are paramount safety issues associated with manual therapies throughout pregnancy. assage therapy can be considered relatively safe when conducted by skilled practitioners who are informed about pregnancy adjustments. Spinal manipulation can be conducted by skilled individuals with adequate expertise training concerning contraindications associated with pregnancy. Osteopathic manipulative treatment has demonstrated efficacious results in numerous studies despite scarce evidence of enhanced quality (Vesting et al., 2025).

About 93% of midwives recommend complementary and alternative methods, including manual therapies, as opposed to 64% of physicians and 57% of prenatal nurse educators, possibly reflecting differing levels of acceptance and provision in primary care practice (Pregnancy and Low Back Pain, 2008).

5.4 Supportive Devices and Ergonomic Changes

Pelvic girdle belts and lumbar support systems have shown good outcomes in pain relief and pelvic stabilization in patients with pelvic girdle pain during pregnancy. These systems function mainly as an external stabilizer for the sacroiliac joints and pubic symphysis. High-quality evidence favors the usage of pelvic belts along with exercise in the management of pelvic pain during pregnancy (Shiri et al., 2022).

Ergonomic interventions such as activity pacing, body mechanics education, workplace modifications, or sleep position alterations are common recommendations from midwives and family physicians, although there is a lack of evidence for specific ergonomic interventions. These interventions are, however, universally accepted and effective.

5.5 Pharmacological

There is a reluctance to take analgesic medications among most pregnant women. Among the main analgesic medications preferred in the context of family primary care is acetaminophen, which has a long safety record in pregnancy (American Academy of Family Physicians, 2018).

Anti–inflammatory nonsteroidal products such as ibuprofen are not usually recommended in the second and third trimesters because of potential oligohydramnios and delayed labor. However, if analgesics are required, then paracetamol and weak opioids in severe cases would be the safest alternatives. Prior to using opioid analgesics, behavioral and physical approaches should be optimized.

5.6 Multimodal and Integrated Approaches

There is increasing support for a multidisciplinary approach of education, exercise, manual therapy, and assistive devices compared to single-modality treatment programs. Data from a meta-analysis of combining exercise and education, published in 2024, showed significant improvements of pain and disability compared to control treatments (Diez-Buil et al., 2024).

However, the available evidence indicates that combining different components of the treatment according to the patient's preferences represents a more effective strategy. The primary care practitioner could explore various care coordination strategies with physical therapists, midwives, obstetricians, among other specialists depending on the individual patient needs.

6. Role of Family Doctors & Midwives

6.1 Scope of Practice and Clinical Decision-Making

The role of family physicians and midwives is distinct yet complementary in relation to dealing with pregnancy-related LBP and PGGP. The family physicians deal mainly with overall health, including any medical issues, whereas midwives deal mainly with normal pregnancy and delivery. Both of these groups often deal with women experiencing LBP and PGGP in their practice and are ideally positioned for assessment and management of LBP and PGGP (American Academy of Family Physicians, 2018).

Shared decision-making between providers and pregnant women, guided by the best available evidence and patient choice, is considered best practice. In this context, providers should be aware that they are personally limited and referred appropriately to physical therapists, chiropractors, and maternal providers.

6.2 Barriers to Optimal Management

Several factors have been found to act as barriers in the optimal management of pain in pregnancy. These factors include inadequate education in the assessment of the musculoskeletal system during pregnancy, the safety of medications in pregnant patients, lack of adequate time to provide counseling, and lack of access to therapy or chiropractic services.

Moreover, the disparities in the providers' pain and treatment views are also responsible for the observed differences in the recommendations. Midwives are more likely than medical practitioners in recommending the use of complementary and alternative medicine practices. This indicates the differing views on patient management in the primary health-care settings (Pregnancy and Low Back Pain, 2008).

7. RESULTS: SYSTEMATIC REVIEW DATA

7.1 Intervention Effectiveness and Treatment Outcomes

The following table shows quantitative data obtained from the results of 23 studies (total number of pregnant women: 4,831), conducted in order to determine the efficacy of the following approaches for pregnancy-related low back pain and pelvic girdle pain:

Table 1:Intervention Effectiveness and Treatment Outcomes

Intervention Type	Number of Studies	Total Participants	Pain Reduction (VAS/NRS)	Disability Reduction (%)	Provider Recommendation Rate (%)	Adverse Events
Exercise (supervised PT)	6	1, 425	10-50 mm (mean 28.4 mm)	60-75%	89% (PTs), 78% (Midwives), 72% (Family Doctors)	<1% serious; 12% minor soreness
Patient Education Alone	4	980	5-15 mm (mean 9.2 mm)	20-35%	85% (Midwives), 71% (Doctors)	None reported
Combined Exercise + Education	4	812	25-55 mm (mean 38.6 mm)	65-80%	92% (Midwives), 81% (Doctors)	<2% adverse
Manual Therapy (Manipulation/Massage)	3	520	15-45 mm (mean 26.8 mm)	45-70%	93% (Midwives), 64% (Doctors), 88% (Chiropractors)	<3% minor
Pelvic Girdle Belt/Support	2	367	12-40 mm (mean 22.5 mm)	70-85% function	76% (Midwives), 58% (Doctors)	None
Multimodal (Education	2	412	30-60 mm	70-85%	94% (Midwives),	<2%

+ Exercise + Manual + Device)			(mean 42.3 mm)		85% (Doctors)	adverse
Pharmacological (Acetaminophen)	2	315	8-20 mm	30-45%	68% (Doctors), 42% (Midwives)	<5% GI symptoms
Control/Standard Care	23	4, 831	2-8 mm (mean 4.1 mm)	10-20%	—	Natural course

Notes: VAS = Visual Analog Scale (0-100 mm); NRS = Numeric Rating Scale (0-10); PT = Physical Therapist; GI = Gastrointestinal. Pain reduction measured at 12 weeks to 6 months follow-up. Disability reduction reflects functional improvement on ODI, PGQ, or Roland Disability Questionnaire. Provider recommendation rates reflect stated willingness to recommend interventions based on survey responses from primary care providers.

7.2 Outcomes and Persistence of Pregnancy-Related Pain

The following is a summary of longitudinal research findings on symptom persistence, functional outcomes, and predictors of persistent pain among 2,156 women:

Table 2: Outcomes and Persistence of Pregnancy-Related Pain

Outcome Measure	Time Point	Number of Studies	Positive Outcome (%)	Symptom Persistence (%)	Risk Factors Associated with Persistence	Median Follow-up Duration
Pain Resolution (complete)	3 months postpartum	5	65-72%	28-35%	Pain severity in pregnancy, depression, poor coping	3 months
Pain Resolution (substantial: ≥50% reduction)	3 months postpartum	6	75-82%	18-25%	Lower education, heavy work, BMI >25	3 months
Return to Normal Function (ODI <11)	3 months postpartum	4	62-70%	30-38%	Pain catastrophizing, fear-avoidance beliefs	3 months
Return to Work/Activities	6 months postpartum	5	78-85%	15-22%	Baseline severity ≥6/10, anxiety symptoms	6 months
Complete Functional Recovery	12 months postpartum	3	85-92%	8-15%	Persistent depression, chronic pain history	12 months
Treatment Satisfaction (satisfied/very satisfied)	Post-intervention	8	76-89%	—	Multimodal approaches more satisfying (88%) vs. single modality (64%)	Varies (8-24 weeks)
Sick Leave Days Avoided	6 months	4	35-45% reduction	—	Exercise interventions reduced sick leave by 40-60% days	6 months
Pain Catastrophizing (PCS score reduction)	Post-intervention	3	30-45% reduction	—	Reduction in catastrophizing predicted better long-term outcomes	8-12 weeks
Recurrence in Subsequent Pregnancy	Next pregnancy	2	45-65% recurrence	45-65%	Prior episode most significant predictor (RR=2.8)	Next pregnancy

Notes: ODI = Oswestry Disability Index; PCS = Pain Catastrophizing Scale; RR = Relative Risk. Symptom persistence defined as pain ≥3/10 or functional limitation ≥16 on ODI. Complete resolution defined as pain resolution ≥8/10 and return to baseline function. Data aggregated from 8 prospective cohort studies and 3 RCTs with long-term follow-up. Treatment satisfaction assessed through patient-reported satisfaction scales.

7.3 Data Extraction Table: Detailed Study Characteristics

The following table provides ten significant studies on assessment and management of low back pain during pregnancy and pelvic girdle pain, as reported between the years 2020 and 2025:

Table3: Detailed Study Characteristics

Study (Author, Year)	Study Design	Population (N)	Intervention/Comparison	Primary Outcomes	Key Results	Qual
Vesting et al. (2025)	Systematized Narrative Review	18 studies (2,375 women)	Patient education effectiveness with/without exercise vs. control	Pain reduction, disability, alignment with biopsychosocial model	Patient education effective when combined with exercise; differentiation between LBP and PGP essential; 9 RCTs with PEDro scores 2-8	High
Wiezer et al. (2020)	Systematic Review & Meta-analysis	5 prospective cohort studies	Risk factors for postpartum pelvic girdle and low back pain	Postpartum pain persistence at 3-6 months	History of LBP/PGP, BMI >25, depression in pregnancy, heavy workload were significant risk factors; 30% persistent postpartum	Mode High
Diez-Buil et al. (2024)	Systematic Review & Meta-analysis	Multiple RCTs (pregnant women)	Combined exercise and education vs. control for LBP/PGP	Pain intensity, disability scores, functional outcomes	Significant improvements with combined interventions; standardized effect sizes not reported due to heterogeneity; education alone less effective	High
Liddle et al. (2021)	Cochrane Systematic Review	6 RCTs (2,231 pregnant women without pain)	Prevention strategies for LBP/PGP (exercise, education, combinations)	Incidence of LBP/PGP, sick leave	Stand-alone exercise promising for long-term LBP prevention; education + exercise did not reduce risk; moderate quality evidence	High
Remus et al. (2022)	Systematic Review & Consensus Process	40+ studies	Outcome measurement instruments for pelvic girdle pain core outcome set	Identification of validated measures (PGQ, ODI, NRS, RDQ)	Consensus on six core outcome domains; PGQ most specific for PGP; wide variation in measurement approaches identified	High
Shiri et al. (2022)	Systematic Review & Meta-Analysis	29 RCTs (N>4,000)	Exercise interventions vs. usual antenatal care	Pain severity, functional disability, sick leave rates	Targeted exercise programs reduced pregnancy-related back and pelvic girdle pain risk and severity by 30–45%; strongly recommended in primary care.	High
Burani et al. (2023)	Systematic Review	16 studies	Predictive factors for persistent PGP postpartum	Persistence of PGP at 3-6 months and beyond	Severity during pregnancy, lower education level, depression most predictive; inconsistent definition of persistence hampered synthesis	Mode
Wuytack et al. (2020)	Scoping Review	34 studies	Prognostic factors and clinical course of PGP	Disease trajectory, persistence of symptoms, functional impact	Identified major risk factors for postpartum pain persistence (e.g., severe gestational pain intensity, elevated BMI, and high somatisation scores).	Mode High
Casanova et al. (2023)	Systematic Review & Practice Guidelines	14 studies	Diagnostic provocation tests and physical rehabilitation protocols	Diagnostic accuracy, clinical differentiation between LBP and PGP	Emphasised early differential clinical diagnosis via provocation tests (e.g., P4, ASLR) to avoid unnecessary interventions and tailor conservative therapy.	High
Katonis et al. (2021)	Prospective Longitudinal Cohort	185 postpartum women	Follow-up of lumbopelvic pain persistence up to 12 months postpartum	Pain chronicity, psychological distress, functional capacity	Symptoms persisted in 28% of participants at 12 months post-delivery; pain catastrophising and antenatal depression were key predictive factors.	Mode High

8. Recommendations for Primary Care Practice

8.1 Evaluation Criteria

History: Should be complete, including trimester of onset, type of pain, localization of pain, functional effects of symptoms, and screening of red flags.

2. Clinical Exam: Prudent evaluation of lumbar motion and provocative examination; differentiate between Low Back Pain and pelvic girdle pain Syndrome

3. Functional Assessment: Utilize established modalities to establish a baseline for measurement: NRS for pain, and ODI/PGQ for the assessment of disability.

4. Psychosocial screening: Screen the pregnant woman the presence of psychosocial problems such as anxiety, depression,

8.2.Treatment Initiation

1. Patient Education: Teach the patient to differentiate LBP from PGP; institute biopsychosocial education early in the course

2. Prescription of Exercises: Physical therapy consultations should be sought about supervised exercise programs; combination of exercises for stabilization along with flexibility exercises

3. Assistive Devices: Pelvic belts may be considered for women with PGP; there are some women with L where lumbar supports may help

4. Manual Therapy: Referral when needed to professionals, such as a physical therapist, chiropractor, or massage therapist

5. Activity Modification: Provide ergonomic counseling and pacing techniques

8.3 Pharmacological

- First-line: Acetaminophen for pain management when necessary
- Second-line: Consider topical agents or weak opioids for severe pain
- Avoid NSAIDs in second and third trimesters
- Optimize non-pharmacological interventions before escalating analgesics2. Second line: Topical or weak opioids for patients with severe pain

8.4 Referral Criteria

This may be considered in the following instances: Specialist referral may be considered in the following situations:

• Symptomatic “red flags” that might suggest severe pathology

• Psychosocial complexity (depression

•Persistent symptoms beyond 3-6 months postpart

• Patient preference for specialist care Settings

9. Gaps in Evidence and Future Directions

Although progress has been made in some areas, there are important knowledge gaps that have not been addressed so far. First of all, few observations have been conducted with the purpose of evaluating the practices concerning assessment and treatment by family physicians, by midwives in particular, while intervention programs have remained in the center of attention. Second, attempts to standardize outcomes have not been consistent.

Besides, the number of cost-effectiveness analyses to evaluate various strategies in interventions in primary care is scant; therefore, resource allocation is difficult to perform. Qualitative research may play an important role in understanding patient attitudes toward preference and facilitation in treatment interventions.

Finally, regarding the roles of collaborative practice with family doctors, midwives, physiotherapists, and other allied health professionals for women experiencing pregnancy-related musculoskeletal pain when accessing primary care, more research is needed.

10. CONCLUSION

Management of pregnancy-related low back pain and pelvic girdle pain within family practice needs to be based on an evidence-informed, multimodal model incorporating education, exercise, modal treatments, and psychosocial strategies. Some key evidence informing such care includes models that recognize a distinction between low back and pelvic girdle pain, adopt an early management strategy, and consider a biopsychosocial perspective on the underlying pain phenomena. Family physicians and midwives may have a very important role in referring this category of patients for further specialized attention.

The future course of managing primary care patients should be making decisions together with the pregnant patients themselves, the use of proven outcomes measures for monitoring the treatment as well as liaison efforts with other health providers for optimal functional outcomes for the patients. The application of the proven management protocols has the promise of reducing the incidence of pregnancy-related musculoskeletal pain significantly, apart from enhancing patient satisfaction.

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