

Sacral Pain During Pregnancy With Endometriosis History

Nancy Martin-Molina, DC, QME, MBA, CCSP

This case describes the chiropractic care of a woman with a history of infertility and miscarriage. A retrospective case study is presented. The approach to chiropractic care was based on the premise that discarthrosis of the lower lumbar spine and pelvis is attended by a restriction of the intervertebral and sacroiliac ligamentous movement, and that amplitude of the intervertebral and pelvic joint movements is increased after manipulative therapy. Can reproductive implantation be successful with a more flexible lumbar spine and pelvis?

Introduction

The patient is a 32-year-old Caucasian female who presented with a chief complaint of low sacral backache. Associated symptoms include [dyspareunia](#) (painful sexual intercourse) for three years with worsening progression, [dyschezia](#) (painful defecation), [dysmenorrhea](#) and [dysuria](#) (painful urination) with hematuria. The patient has been unable to achieve pregnancy. Past medical history reveals appendectomy, ovariectomy (removal of right ovarian cyst) and recent laparoscopy for acute abdominal pain. Menses onset was at age 12 with regular cycles, if not heavier flow than normal.

There is bilateral palpable tenderness in the iliac fossa region on abdominal examination, yet no masses. Pelvic examination was recent with her OB/GYN, and deferred with records requested. Record review indicated this doctor's pelvic examination yielded slight pelvic discharge and some rectal pain without palpable tenderness or active bleeding. The OB/GYN diagnosis discussed [endometriosis](#). This patient came to chiropractic on a friend's referral, citing infertility issues and a request for pain alleviation. Her OB/GYN said she would never carry a fetus to term unless she considered fertility drugs.

Discussion

The patient's age alone provided a clue to the etiology of the chief complaint and associated symptoms. The patient is of a reproductive age at which causes of hematuria or generally abnormal uterine bleeding may be linked to organic lesions (adenomyosis, polyps, endometrial hyperplasia or cancer). Fortunately, her OB/GYN ruled out malignancy upon record review. Infertility was suspected. Infertility is [defined as](#) the inability to achieve pregnancy or conception after one year of unprotected intercourse.

The patient's low back pain was sacral and the associated signs and symptoms did not present with radicular (nerve root) pain, acute duration or nocturnal pain, and was not exacerbated by joint/spinal motion. Pain did not disappear or diminish upon onset of menses. A back-pain referral pattern was strongly suspected, from either the abdomen or pelvic region. With this pattern of low back pain, the etiological factors now included peptic ulcer, pancreatitis, endometriosis or retroperitoneal tumor. The first two were eliminated on the basis of the pain association with menses and the absence of palliative or provocative signs.

The sacral pain is classically referred from the rectum. The symptomatology of referred pain is such that it is felt in more distant sites that are innervated at approximately the same spinal levels as the disordered structures. Dyschezia supports this explanation of sacral pain origin, which indicates rectal-wall involvement. Dysuria, however, indicates movement of the serosa of the bladder. Pain on urination typically accompanies inflammation or irritation of either the bladder or the urethra, and is usually felt as a burning sensation.

There are three main types of pelvic pain in the gynecological context: dysmenorrhea, ovulation pain and dyspareunia. *Dysmenorrhea* is congestive, beginning up to one week before the onset of menses and resolving with menses. It is felt in the pelvis and low back. *Dyspareunia* is generally felt deep in the pelvis and is due to pressure on the ovaries and rectovaginal septum. Palpable iliac fossa tenderness is the usual symptom seen in endometriosis. For example, pain in the flank and iliac fossa is secondary to endometriosis involvement of the ureters. This symptom is usually due to involvement of the rectovaginal septum by endometriosis, and is often associated with a fixed retroverted uterus and endometriosis nodules on uterosacral ligaments.

Endometriosis is defined as the presence of [endometrial tissue outside the uterus](#). A diagnosis of endometriosis can be made from the patient's presentation, but must be confirmed by laparoscopy. It is frequently diagnosed in the third and fourth decades of life, but rarely in postmenopausal women. Endometriosis is a common cause of abnormal bleeding and dysmenorrhea. During a woman's menstrual cycle, cells from the endometrial and stroma of the uterus migrate retrograde into the pelvic cavity. These cells then implant themselves into such structures as the posterior uterus. As the cycle continues, increased levels of estrogen stimulate the endometrial cells to proliferate. When a woman reaches the secretory phase of her cycle, progesterone is released. Progesterone enhances the proliferation, and inflammation occurs.

Treatment

The main goal in conventional medicine is to preserve the fertility of the woman. Since endometrial cell growth is hormone-dependent, the main treatment is to regulate spikes in hormone levels, preventing cyclic stimulation of the implants and reducing their size. Birth-control hormones are generally an inexpensive remedy. If a patient is over age 35, disabled by pain and has bilateral involvement of the ovaries, a [bilateral salpingo-oophorectomy](#) and hysterectomy are performed.

Research at our facility with similar cases had demonstrated good responses in patients with low-back and/or leg pain, compounded by endometriosis that was confirmed by a gynecologist. These patients are generally treated due to a subluxation at or above L3, and pelvic fixations are addressed.

For this patient, adjustments were applied with a diversified technique. The initial schedule was twice weekly for 90 days and then one follow-up. Other therapies included myofascial release and percussion therapy addressing the iliolumbar and sacroiliac ligaments (common sites of ligamentous shortening). After 90 days of care, the patient became pregnant and carried to full term. Within eight months postpartum, she became pregnant again, completing her family with both a boy and a girl.

Conclusion

While previously infertile for five years, this woman conceived and sustained a successful pregnancy. Further research is suggested that examines the application of chiropractic care in infertility issues and the potential for positive outcomes.

