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17 February 2020

Musculoskeletal

Changing the narrative of sacroiliac pain

How sure can we be when identifying sacroiliac movement disorders?

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Sacroiliac joint (SIJ) movements are imperceptibly small and there is no evidence to support the use of clinical tests of SIJ movement dysfunction. Nevertheless, the presence of pathoanatomical processes in the SIJ is not denied; they may very well contribute partly to the pain experience.

A paradigm shift in clinical reasoning is needed, towards modifying clinicians' perceptions, correcting beliefs about structural fragility, and implementing evidence-based treatment rationales. These are conclusions by an international group of scientists who conducted a review on this topic.

A total of 16-35% of low back pain cases is thought to involve the SIJ complex. Although the biological plausibility of identifying SIJ movement dysfunctions based on movement evaluation and palpation of the SIJ has been questioned for over a decade, it is still widely taught and practiced. In fact, a previous study showed that 89% of patients with persisting spinal pain viewed their pain as originating from "physically defective" structures and had this information given by health professionals.

Although pain provocation tests can diagnose

the SIJ as a source of local sensitivity (differentiating it from the back and hip), they cannot identify why these structures are sensitive or differentiate in SIJ movement. Current evidence shows two factors which undermine the accuracy of these tests:

1. The biological plausibility is questioned given the movement of the SIJ being so small that detection by manual methods is virtually impossible. For example, SIJ rotation and posterior superior iliac spine displacement in the Gillet test have been found to be 0.2 degrees and less than 0.2 mm.
2. Interexaminer agreement of anatomical landmark identification has been shown to range from slight to fair (Cohen ? of 0.24 and 0.08 for the anterior and posterior superior iliac spines, respectively).

The following recommendations are made based on the discrepancy between what is commonly seen in clinical practice and what current evidence tells us:

- Explain pain mechanisms considering the individual presentation with a biopsychosocial model;
- Constructively address unhelpful/ aberrant health beliefs;
- Provide reassurance regarding structural integrity of the pelvis/ SIJ;
- Design and discuss a management plan considering the previous points.

Expert opinion

It has always confused me how anyone can detect hyper/ hypomobility of a joint that moves (taking into consideration the reviewed studies in this article) less than 2 degrees in any axis.

As the authors say, this review is not meant to promote or discourage any kind of treatment. Instead, it offers us insight on two major areas: first, how we should explain treatment mechanisms or effects to patients so misguided beliefs and external control patterns are corrected; and second, how to educate patients regarding the importance of movement to break fear-avoidance cycles.

The full article is definitely worth a more thorough read (a free full text version is available here) as it provides a challenge to common views which must be approached with an open mind.

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