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Pelvic Girdle in Pregnancy - Ref 146ED

with Elisabeth Davidson

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TRANSCRIPT

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Steven Bruce
Today I'm talking to Elisabeth Davidson. Now, Elisabeth, we promoted her earlier on, we said she was the Director of Academic Affairs at the Royal College. She's actually responsible for academic affairs for the paediatric faculty. So, apologies, we misled you slightly there. We've got her on to talk about pelvic pain in pregnancy. It's a popular topic. We've done lots on pregnancy in the past. And I know that all of us see lots of patients who are pregnant in clinic and we always, not always, quite often we struggle. Elisabeth, welcome.

Elisabeth Davidson
Thank you very much.

Steven Bruce
Very kind of you to join us. And yeah, that's a fantastic alpine background that you have there suggests that you aren't actually in Scotland, but I know you are. You're up in Inverurie.

Elisabeth Davidson
I am. Yeah.

Steven Bruce
Yeah, well, it's a nice backdrop. You said, when I spoke to you earlier this week, that there's a reasonable amount of new information coming out through research and so on, and some of which you're involved in yourself, do you want to tell us about what you can?

Elisabeth Davidson
Yeah, absolutely. I was asked almost two years ago to take part in a Delphi process on best practice of care of pregnant women, which is a sort of multi-international collaboration between some of the big researchers, particularly in America, but they've asked a lot of people to take part in it. So I saw hopefully the final paper last year, but these things always take a long time to get published. So I'm hoping that that will be a landmark paper that we will be able to refer to very soon.

Steven Bruce
Are you able to tell us anything about its conclusions or is it too early?

Elisabeth Davidson
I can't really until it's published. But it's basically setting out what is best practice in terms of examination, in terms of treatment, in terms of investigations for the care of pregnant women from a musculoskeletal point of view.

Steven Bruce
I have to say, I find it astonishing that here we are on the 21st century and it takes years for research to actually get published. And therefore, not surprisingly, if you want to change clinical practice in say, the

NHS or another official body like that, it takes a long time to do that, even longer. Except in the case of emergency medicine, the COVID stuff has gone through very, very quickly. But so, what can you tell us then about treating pregnant women?

Elisabeth Davidson
Well, I actually was very lucky, I've been in practice 26 years and I ended up seeing lots of pregnant women right from the beginning. And I didn't really feel I had any particular qualifications in it, but I just did the best I could. And then I went back to university after 10 years to do a master's degree in paediatric and pregnancy care and then discovered that there was no real research. Back when I graduated, evidence-based medicine wasn't even invented yet. And so, it was just a case of try your best. But now, of course, we really have to try and inform our practice with evidence as best as we can. So, I decided to look at the evidence. And yeah, so I did my master's degree back in 2007 and back then there was none, none really at all. But I do the best I can. And when you treat pregnant women, you obviously have to modify your techniques, you have to use low force techniques, you have to usually take longer, particularly the further along in the pregnancy they are. And there's a whole list of complications, particularly red flags that you must be aware of. And it's very good if you can work with a local maternity care community, but that can be a challenge in itself.

Steven Bruce
Yeah, we said we were going to talk about pelvic pain, by which I have assumed we're going to talk about pubic symphysis and sacroiliac joints, is that right?

Elisabeth Davidson
Yeah, I mean, pelvic girdle pain used to be known as pubic symphysis pain, but it actually encompasses sacroiliac and pubic symphysis and anything between the iliac crest and the ischial tuberosities anteriorly and posteriorly, with or without radiculopathy, and you can have pelvic girdle pain out with pregnancy, but it's extremely common. I saw a paper yesterday that quoted 81% of women today report pelvic girdle pain during pregnancy, which is astonishing. And it's common. It's not normal, but it's common.

Steven Bruce
Right. And, you know, you said you have to modify techniques. Presumably, again, we're talking about, you know, the lack of stability as a result of ligaments which have softened up and so on. And you've talked about red flags. So, do you want to elaborate on those?

Elisabeth Davidson
Yeah, well, you have to be aware of all the things that can go wrong, in pregnancy anyway, things like preeclampsia, gestational diabetes, there can be things wrong with a mother, there can be things wrong with the baby. Pelvic girdle pain in itself isn't a red flag. But if it's combined with other things like headaches or swelling or neuralgia, pins and needles, things like that, then it could potentially be an issue that needs medical attention. So, you need to really make sure that you monitor a pregnant woman very carefully throughout your treatment over. Sorry, I forgot part of your question. What was your question again?

Steven Bruce
I forgot what the question was.

Elisabeth Davidson
Oh, red flags. Yeah, so those are probably the main ones to be aware of. But there are loads that, you know, that could go wrong.

Steven Bruce
So how are we going to recognise preeclampsia?

Elisabeth Davidson
The main thing is sudden onset of severe headaches, hypertension, and oedema, facial oedema, but also oedema of the extremities, so particularly the feet and the hands. I mean, a lot of women get carpal tunnel syndrome, for instance, and get a little bit of swelling in the hands. That's not in itself a big problem. But if combined with the headaches and the proteinuria. So, it's a good idea to invest in the urine analysis sample to have in your clinic to check when she comes in.

Steven Bruce
You just use urine strips.

Elisabeth Davidson
Yes, I do. Yeah. And then I always check blood pressure every single time I see a pregnant woman. I think that's essential.

Steven Bruce
This is a bit of a refresher, what's going on in preeclampsia?

Elisabeth Davidson
So basically, it's a vascular issue where the mother and the foetus is at great risk. And mom can actually end up dying and then so can the foetus. If it develops into what's known as full blown eclampsia. And you start getting, as I say, such elevated blood pressure that you can stroke out on the venous side. So, it's most common in first pregnancies. It's quite rare to have in second pregnancies unless it's a different father. But it's something that you need to be aware of.

Steven Bruce
That's curious, so a different father could provoke it in second pregnancy?

Elisabeth Davidson
I'm not sure, I was told that by several midwives. So I'm not sure what the reason for that is.

Steven Bruce
Right. Okay. Do we know, I mean, what are the risk factors for preeclampsia? Who should we be more cautious about?

Elisabeth Davidson
First time moms is the main one, older moms, very young teenage girls can also be drawn to it. If you're a smoker, if you're known as a mature mother or geriatric mother, I think the term is. They are more prone to, if you are, well, if there's a genetic history, so for instance, if the mother's own mother potentially had it, that's also one of the risk factors.

Steven Bruce
Okay. So, let's get on to, well, I don't want to sort of lead you down any particular routes, but I mean, what about your treatment and case history taking protocols? How do they differ for pregnant women?

Elisabeth Davidson
Well, first of all, you have to take a very specific case history. Looking at, obviously, you have to do all your normal neurological and musculoskeletal examinations, your blood pressure, you know, you do a full examination, but then you also need to look at things like the pregnant abdomen, and you have to understand the different stages of pregnancy, what happens in the pelvis, you should really be able to understand what the foetus is doing at different stages during pregnancy, things like pelvic girdle pain for instance, let's just go back to that, tends to occur around about halfway through the pregnancy, but it can be earlier, and it can be later on, 20 to 25 weeks is a normal onset. Pelvic girdle pain also tends to be an earlier onset in subsequent pregnancies. And it can get worse in subsequent pregnancies, particularly if it wasn't treated. In my own experience, women that have had regular chiropractic care, or osteopathy care for that matter, don't tend to develop it as early as women who have never had care before but present to you as a first-time patient with them, which suggests that there is definitely a huge musculoskeletal component to it. It used to be thought that it was mainly hormonal, but we now think that it's not, that is not as big an influence on it. It's not just about the relaxin and the oestrogen and progesterone levels, it is multifactorial.

Steven Bruce
I'm going to guess here that you're not going to cure their pelvic girdle pain through treatments. So, we are in the business of maintenance care for a lot of these ladies.

Elisabeth Davidson
Yeah, I mean, it very much depends. Some women, you can manage to see them, you know, once a month or every couple of weeks throughout pregnancy, and I've had women that drag themselves into the clinic every day for the last couple of weeks, because they felt it was the only way that they can keep going until they have the baby. The doctors tend to say that it is self-limiting, as in, you know, having the baby through the pelvic girdle pain.

Steven Bruce

It's not much consolation, is it when you got 40 weeks of pregnancy ahead of you?

Elisabeth Davidson
Yeah, because we know that if it's not treated properly, it can lead to things like prenatal, antenatal and perinatal depression, which obviously can have a huge long-term impact on the mother's relationship to the baby. We also know that there's a small subset of women, it's about 10% of those who suffer with pelvic girdle pain that have chronic severe long term, pelvic girdle pain that doesn't resolve after birth. And those are the ones that we need to maybe look after a little bit more and try and recognise, so that we can give them a little bit more.

Steven Bruce
We've had some interesting talks about chronic pain recently. I mean, what are your thoughts on women who have got this chronic problem after the baby has been delivered?

Elisabeth Davidson
Well, there's several factors that are influencing. If they've had pre-pregnancy trauma, if they have a job where they do a lot of heavy manual labour, if they have a job that's very sedentary, and they're not particularly fit, or if they're obese pre-pregnancy, those are other factors that can predispose to long term pelvic girdle pain. But there is one other major factor that I think has been overlooked. And that's hypermobility. Because that is something that, I mean, I always used to say that every woman is by definition hypermobile when she's pregnant. And if you are already of the hypermobile condition, then it can make it much much worse during pregnancy to the point where some women end up on crutches or in bed because the pelvis is just not coping at all with the increased loads.

Steven Bruce
Yeah. Tell me, I've actually had a question about it. It's commonly thought that we shouldn't treat people in the first 12 weeks of pregnancy because it's a risky period. I'm a little bit skeptical about that sort of guidance, not least because we had Stephen Sandler who's a very experienced obstetric osteopath on the show. And he said, actually, there are some specific times during pregnancy when a woman is likely to miscarry. It's not just the first 12 weeks, I think 30 weeks is the most risky period I think he said.

Elisabeth Davidson
That's right. I agree. If you look at the research, there's actually nothing at all that suggests that it's dangerous to have manual therapy in pregnancy, in terms of miscarriage, there's was one old reference, I think, from the early 70s that suggests that in women who have repeated miscarriages, it's probably not a good idea. And I think the main reason is that should that woman have a miscarriage after having seen a manual therapist the manual therapist is likely to get blamed. There's no evidence to say that it's the cause of it. It's often just a time link, basically.

Steven Bruce

Yeah. So often the case throughout medicine, isn't it, we base too much on association rather than cause. Salame Olivia has sent in a question asking why diabetes persists after delivery and why the mother might become a type one diabetic.

Elisabeth Davidson
I think that has a lot to do with lifestyle, unfortunately. I think women on the whole in the Western world don't necessarily have a good lifestyle, they may think that they do. But when you actually go in and do a nutritional profile and say, well, what do you actually eat? A lot of them tend to have processed foods, high in sugar. And yeah, you don't always have time to cook a proper meal when you're having a new baby and you've just given birth. Part of the problem is modern lifestyles, basically, more than anything.

Steven Bruce
Interesting. I mean, I'd refer Salame Olivia back to the talk that I did with Gary Taubes, because he talked a lot about the effect of carbohydrates and sugar on insulin levels. And we don't tend to think of what insulin does other than control blood glucose, but it does do other things. And the evidence which he has come across and he's done a lot of research is that if you eat a keto diet, then you are likely to bring your diabetes under control, if not get rid of it and improve your lifestyle in many other ways as well.

Elisabeth Davidson
That I think, is what the research is showing now because we know that women of a lower socioeconomic standing if you like, are more likely to not have as good a diet and also are more associated with both post baby gestional or gestational diabetes and having it afterwards. So whereas women of a higher socioeconomic standing are more likely to have a good diet. So yeah, I would agree with that.

Steven Bruce
Yeah. So, do you use high velocity techniques during pregnancy?

Elisabeth Davidson
No, I don't. I actually don't do any side posture adjustments after 20 weeks at all, you have a massive surge in relaxing around about 20 weeks, where the pelvis can become quite unstable. But personally, I don't really use high velocity techniques anyway, because I myself I'm hypermobile, I have ehlers-danlos syndrome. So. I veered away from that type of adjustments, and really use low force techniques more or less all the way through pregnancy, there's so many good low force techniques that can be applied very successfully. But what the research says is that we should not use high velocity type adjustments in the upper cervical spine in any pregnant woman, simply because of the increase in vascularity, you have almost 40% increase in vascularity in pregnancy, and therefore the risk of having a vascular event also increases greatly. So, that's not to say you can't do thoracic adjustments or lumbar adjustments in different ways, but we should not use them in the upper cervical spine in pregnancy.

Steven Bruce

Okay. Hannah has sent in a question saying that she tends to understand pelvic girdle pain as a woman who's had underlying issues that the body is managing to compensate for, but then changes, physical and emotional during pregnancy, tip them over the point that the body can compensate, which results in pain? What do you think about that?

Elisabeth Davidson
So, what's the question?

Steven Bruce
She's basically saying that pelvic girdle pain is peculiar to women who are managing it perfectly well before their pregnancy. But with all the changes both emotional and physical during pregnancy, it then brings that pelvic problem to the fore. So she's saying the problem was there already.

Elisabeth Davidson
Well, that certainly makes it worse if there was already an underlying problem. But it also depends very much on several factors. It depends on her emotional support, whether she has people around her that can help her. I think part of the problem is a lot of women today think they have to be superwoman. And they have to be able to work right up until they give birth, they have to, not run a marathon, but at least go and do all the things that is trendy. And actually, you don't need to be superwoman, you need help, especially if you have a lot of pain, or especially if it's your second or third pregnancy. And that's not possible for everybody, especially at the moment. I mean, I've seen a massive increase in women with emotional issues in the last year because of COVID because of isolation, and not only in pelvic girdle pain, but in headaches and tension, you know, they come in absolutely rigid. So, I think that's a big part of it. It also depends on how fit you are pre-pregnancy and how fit you try and keep yourself during pregnancy, which is often easier in the first pregnancy. But if you have a toddler or two, then trying to stay fit is not easy.

Steven Bruce
No, I can imagine. Zoe's asked for clarification about diabetes. She says do we mean type two diabetes following pregnancy? Because type one is not lifestyle related?

Elisabeth Davidson
Yes, I would imagine that was a question. Yeah.

Steven Bruce
I think there's a yes and a no answer to that Zoey, because type two can develop into type one diabetes, it can become insulin dependent in some people. Yeah. So, in terms of your examination protocol, then Elisabeth, how would you go about it? Someone comes in with pelvic girdle pain?

Elisabeth Davidson
Well, you have to, I've developed this protocol over the years that is partly based on the European guidelines for pelvic girdle pain, which is a massive 120-page document that was published in the early

2000s. And they named some specific tests that you should do, pelvic provocation pain tests, active SLR, which I actually think is really cruel. If someone has acute pelvic girdle pain, an active SLR, is very harsh to do but that's one of the tests they suggest. And they look at Trendelenburg test that also suggest that you do palpation of the long dorsal ligament and the pelvic ligaments. But I tend to do all my standing and walking test first and then I have the mom sit down and I do a lot of the upper body, musculoskeletal tests. Then I have her prone on a pregnancy pillow. And then finally I turn her over in supine because you don't really want to have a pregnant woman move too much if she's in pain anyway. So this is the specific protocol that I do, and I've learned lots of different techniques over the years that I find for me works really well. I've actually designed a form that hopefully we can get published soon, which is partly based on the new best practice guidelines coming out, which incorporates everything that you should be doing if you're seeing a pregnant woman.

Steven Bruce
I would want to share that with our viewers, but I can't until it's published. Oh, I can?

Elisabeth Davidson
Yeah, absolutely. Yeah.

Steven Bruce
Excellent. Brilliant. I'll send that out after the broadcast if you let me have it. Thank you. Super, that'd be really kind. Somebody who's chosen not to give us their name says what do you think about women who practice a lot of yoga? And is there any truth in the rumour that the cord can unravel and end up around the baby's neck during some postures?

Elisabeth Davidson
That's a good question. I think that very much depends on what type of yoga you do. I've seen some that do this sort of acrobatic type yoga where you go upside down, I probably wouldn't recommend that in pregnancy. But I always recommend pregnancy yoga for women, because I think, in the last 10,15 years that has blossomed and built to a tremendous point where it's available almost everywhere. And there's a lot of really good pregnancy yoga courses. But that's more gentle type yoga.

Steven Bruce
I tell you what, Elisabeth, it sounds to me a little bit like that, you get blamed in the first 12 weeks of pregnancy if something goes wrong. How on earth can anyone know that it was the yoga that caused the cord to go around the baby's neck? It's, well, I bet the yoga practitioner gets blamed. Or yoga gets blamed.

Elisabeth Davidson
Well, that's right, I've never heard that actually. And so that's an interesting point. I mean, a baby will twist and turn and move and flip. And yeah, sometimes they do inwriggle themselves in the cord and sometimes they don't, I don't think we can predict that to be honest. And I've actually never heard it being associated with yoga but I'll look into it.

Steven Bruce
Now, Pippa has now sent in, could you could you please talk about some of the techniques you find useful in treating pelvic girdle pain? People want to know what they do when they get their hands on?

Elisabeth Davidson
Well, I'm obviously a chiropractor. So, I learned a technique many years ago called sacro-occipital technique, which is a very whole body cranially based drill technique.

Steven Bruce
So, the osteopaths will know it as craniosacral technique, as far as I'm aware, they're almost identical, so they'll understand what you're talking about.

Elisabeth Davidson
Craniosacral therapy as well. And it is quite similar. So that's what I tend to use, I will use activator, which is a little tool that we have. And I use blocking quite a lot. Pelvic blocks, to, if you have say, a pelvis that's slightly torsioned because of muscular imbalance and ligament imbalance, then you block them so that the pelvis basically, untorques by itself *audio problems*, and it's very useful, and that's part of SOT. What else do I use? I don't do needles, but the clinic I used to have we had an acupuncturist who specialised in pregnancy care, so I would often send them for acupuncture. That's actually got really good research behind it. And probably more than just about anything else. And then I would do quite a bit of soft tissue work and work with the woman with things like insoles and making sure her posture was correct. I would talk about things like optimal foetal positioning, particularly towards the end of the pregnancy, talk about sitting upright and forwards like on a ball rather than sitting on an office chair. So it's quite, quite diverse, you know, depends on the woman's ability to do what we'd like them to do, but I have a huge arsenal of different techniques for different people.

Steven Bruce
Do you find trigger points have a role to play in treating pregnancy?

Elisabeth Davidson
Oh, absolutely. Yeah, they don't like them particularly much, but they are extremely helpful. I find a lot of the pelvic girdle pain can be eased greatly if you focus on particularly the muscles obviously of the pelvic girdle so your glutes, your iliopsoas is extremely important for the pelvis stability, and that's tied in with the hamstrings of course, which can be extremely tight in pregnancy and the hamstrings have fibres that go into the sacrotuberous and the sacrospinous ligament. And so, if you have a lot of pain over there, you need to look at their hamstring and the adductors can get excuisitely painful, in particular if they've got pubic symphysis pain. I don't really do any intra pelvic work as such, I work with a local physiotherapist who specialises in that. But I do some gentle pelvic floor release, which is a spinosacral therapy technique. And then we talk about what they can do to help themselves. I'm very much into giving the patients exercises to do at home.

Steven Bruce
Right? Okay. So, a little while ago, you said after 22 weeks, you don't treat patients sidelying. Why?

Elisabeth Davidson
Because you can be careful, if you're not careful, you can torsion the pelvis way too much. And therefore, the ligaments and especially the round ligament, the broad ligaments and you don't really want to do that and and also because I find it difficult to stabilise a large pregnant belly on a bench basically. So, I just, I mean I used to, but I just find it's uncomfortable for her. And, I mean, you can do it, provided you support the belly with a pillow underneath. But you just need to make sure you don't torque too much. And I just find it easier not to do it. It doesn't mean you can't do it. But I just personally don't like it.

Steven Bruce
Yeah, I don't think any of us would want to do something which has the chance of exacerbating the problem, would we? Gina has asked whether you recommend the use of support belts in pelvic girdle pain?

Elisabeth Davidson
For some women, that's absolutely a necessity. And there's some really good ones are Serola Belt. There's some called Belly Bandits. I don't know if you've seen them. They're very keen on selling them. But they're actually super, and I had sort of two or three that I bought and just lend out to patience, because some women absolutely need them. It's ideal if you can do without them. Because obviously they tend to take the strain that the body's own should be able to do but if if her body can't cope with it, then that can be a great help for her.

Steven Bruce
Right. Okay, thank you. Somebody taking us back to your comments about increased vascularity and stroke. They haven't given me their name, but they've asked whether pregnant women are prone to clots, they say due to resource factors, but for any reason I'd have said.

Elisabeth Davidson
They are more prone, simply because of the increased vascularity, yeah. So that is something that needs to be taken into consideration when you're doing your risk assessment.

Steven Bruce
So, it's not a question of them suddenly becoming more clotting it's just that there are more veins and arteries in which clots might occur.

Elisabeth Davidson
Yeah, and also, you've got suddenly a huge weight gain. Some women take getting pregnant as a licence to eat so they can put on four stone, I've seen is not uncommon. They don't need to but they do, and some

women do tend to put on a lot of, or rather retain a lot of fluids. So that puts pressure particularly on the lower limb muscularity as well. So yeah, definitely need to be mindful of that.

Steven Bruce
Okay. Jeff has asked whether it's fair to say that you're actually aiming for pain management rather than cure in the PGP of a third trimester?

Elisabeth Davidson
I would say so. Yeah.

Steven Bruce
Well, I guess, given that the alternatives are, there isn't anything better, is there? Nobody's going to cure the pain? It's not unreasonable to do pain management?

Elisabeth Davidson
No, because in terms of what the medical profession has to offer, I mean, they used to offer support belts and crutches and painkillers, but a lot of women are not happy about taking medication during pregnancy. And a lot of them are unsafe. So, they tend to rely on paracetamol unless they're on prescription drugs.

Steven Bruce
So, when you say a lot of them are unsafe, a lot of what are unsafe?

Elisabeth Davidson
A lot of medications are unsafe in pregnancy. Things like opioids, for instance, they are really not advised to be a first line treatment

Steven Bruce
Presumably they're not going to be prescribed by the GP, are they?

Elisabeth Davidson
You'd be surprised.

Steven Bruce
Right, I would. Theo has sent in, I hope I'm pronouncing your name correctly, Theo says if found, if you find the muscles to be tight, would you recommend stretching exercises to a pregnant patient who's already increasingly mobile?

Elisabeth Davidson
Yes, and this is where you have to really look at the woman as a whole. Why are certain muscles tight? Is it because she's sitting in an office chair all day? In which case the hamstrings are likely to be tight? Or is it because they're trying to compensate for the pain? So, you need to try and figure out, where is that, is it a

compensatory muscle tension, in which case you need to find out the original factor why it's tight and correct that, so I find they do incredibly well with a combination of stretching and just gentle cardiovascular exercise, whether it's swimming, well, of course, you can't do that at the moment. But it can be difficult for them to walk sometimes because of the pain. So, I always prefer things like water exercise, because that also has a lot of good research behind it. And things like pregnancy yoga that we talked about earlier.

Steven Bruce
Okay, interesting that there is research around this. I wonder why there's so much research around relief of pain and in these circumstances as opposed to other?

Elisabeth Davidson
Yeah, it's because the physios have taken a great interest in this. And there's been some fantastic research actually looking at different aspects, an enormous body of evidence, particularly by a Norwegian physio, called Britt Stuge, who's also published, and if I can plug that, a fantastic outcome measurement questionnaire, it's a 25-point questionnaire that I've been using in practice for 10 years nearly, no, it was published in 2011. And I wish we could get everyone in the country and see pregnant women to use this questionnaire because it would produce an enormous amount of research, that would be good. So, Britt Stuge, and if you google pregnancy outcome questionnaire.

Steven Bruce
How do I spell Stuge?

Elisabeth Davidson
S,T,U,G,E, I can send you that paper?

Steven Bruce
Thank you. Because one step towards that, is if I can just send it out to people and then hopefully, they can choose to use it if they're so inclined. Allsainte, again, I hope I'm pronouncing your name correctly. She asks, have you ever had experience turning a baby? And are you allowed to do that where you are? And what are your thoughts about it? I tell you what, before you answer that question, all three of my children were breech births. And I think my ex-wife went to an acupuncturist for moxibustion for all of them because moxibustion was meant to encourage them to turn, didn't work at all. But they were all born perfectly healthy.

Elisabeth Davidson
Well, we don't turn babies. That's an obstetric manoeuvre. What we do is, we correct the biomechanical imbalances that may be in the pelvis and the spine, which creates optimum space for the baby to manoeuvre in. And in some cases, the baby will actually turn itself. So, I just want to make that really clear. Do not turn babies, that's illegal. So, you have to be really careful how you phrase it. Having said that, I have seen many babies turn themselves after treatment over the years.

Steven Bruce
And do you think, I'm guessing you do, imagine that the treatment contributed to that?

Elisabeth Davidson
Oh, sometimes it's almost within five minutes of treatment. I always make the mum get up and walk around the room to try and ensure that the treatment will hold and sometimes she goes, oh, oh, my goodness, oh, something's happening. It can be as quick as that. Or I've seen quite a number of workshops, for instance, when I've been teaching courses, and we've had a few pregnant participants, and the baby has turned later that day after 10 people were working on this problem. And so yeah, it can be as quick as that, it doesn't always work. You know, there are reasons why, either the cord can be short, or, like you said earlier, the cord can be around the neck, and then no amount of treatment is going to turn that baby. But I can't actually see the percentages that I've seen where it's happens. And there's not a lot of good research on it. There's a couple of papers by the people in America that teach the Webster technique, but they're not efficacy papers. They're just outcome measurement papers, and they do show something like, I think it's 75% improvement in positioning after treatment.

Steven Bruce
That raises an interesting question, actually, doesn't it? I mean, someone with your great knowledge about treating pain in pregnancy and your great experience about treating pregnant patients, what are you allowed to say on your website or in any other advertising about what you can do for the pregnant patient?

Elisabeth Davidson
Very little, unfortunately. We've been trying to lobby the ASA for a number of years and we managed to get them to change the wording a few years ago, the Royal College was very much involved in that lobbying, so that we can now say that we treat pregnant women for the musculoskeletal discomfort that they may experience. That's it. No conditions. Don't mention pelvic girdle pain, you know, don't mention any conditions or such. And that's very frustrating. But it's the law of the land and we just have to stick to it.

Steven Bruce
Yeah, it's interesting. We had a very interesting talk with the ASA ages and ages ago and Jonathan, I think it was Jonathan Field from the RCC on the panel with a load of others. And at that time, chiropractors weren't even allowed to say they could treat sciatica. You know, but osteopaths were and you think, well, what the hell do we suddenly know that chiropractors don't know about treating sciatica. And I know the ASA has to act in accordance with the available evidence and so on. But it's sometimes a little bit frustrating, isn't it?

Elisabeth Davidson
It is very frustrating. And I don't know really why, but the bottom line is until we produce the research that shows efficacy, we have to stick to the guidelines.

Steven Bruce

Of course, yeah, yeah. And actually, it's very easy to find out what those guidelines are, because you can, well, actually we sent them out before from the Academy, but you can go to the ASA and you can look at what chiropractors are allowed to say and what osteopaths are allowed to say, and they are different, weirdly.

Elisabeth Davidson
I actually contacted the ASA a couple weeks ago, because I wanted to produce some leaflet on pregnancy. And I had a lot of to and fro and backwards and forwards. But eventually they accepted the wording that I put in the leaflet. So, I'm more than happy to share that as well with you.

Steven Bruce
Oh, please, that would be so kind. Yeah.

Elisabeth Davidson
And then we at least know that that has been accepted by the ASA. It's very big, very blunt, but I think it's a nice little leaflet.

Steven Bruce
Yeah. Okay. Pippa sent in another observation and she's put a kiss at the end of it, so I'm going to read it out. It says optimal foetal positioning can help encourage babies to turn into the right positions, or I thought optimal foetal positioning is the right position, isn't it? You know what that means? What does that actually mean, optimal foetal positioning?

Elisabeth Davidson
It is a term that was coined by a midwife called Jean Sutton, an Australian midwife, about 20 years ago, I think, and there is actually quite a bit of research behind it now, there wasn't back then. But now we know that if the baby is not in the right position, as in occiput anterior, which is the ideal position, if the baby has the occiput the wrong way, then labours are more painful and much longer. And you know, normal first time labour can be anywhere from two to 24 hours. But if the baby's in the wrong position, it can be up to 48 hours or even longer. We also know that if the baby's in the wrong position, you're more likely to get intervention, to be induced to have a C-section and with all the cascade of things that that can then cause. So, and I think the medical world has become aware of this much more, particularly in the midwifery teams at the hospitals. So, they are aware of this, and they are more happy to work with what we do and understand what we do and how that can help. So, it's a really interesting phenomenon. I was taught initially by an American chiropractor, Carol Phillips, and her work has since been turned into an amazing, oh, what's it called? Spinningbabies.com. I don't know if any of you have heard of spinning babies.

Steven Bruce
I think I have actually. Yeah.

Elisabeth Davidson

And there's courses on that all over the country now. And it's about how to basically, the woman, for us as practitioners to help not just chiropractors and osteopaths, but yoga teachers and midwives as well can do this course learning how to help the baby turn. So that's really been fascinating to watch that develop over the years.

Steven Bruce
Interesting, the person running the spinningbabies.com is allowed to see that's what they're doing. But we can't.

Elisabeth Davidson
I know it's not fair, is it?

Steven Bruce
It's not fair. Life isn't fair. Apparently, there's a debate going on on the Vimeo team, because we have two teams watching this, Facebook and Vimeo. And there's a debate going on on the Vimeo team about which positions are best to treat, especially in late-stage pregnancy. And I know we talked about it before, but could you just recap and confirm what are the best positions?

Elisabeth Davidson
To treat the woman in general? Well, I tend to predominantly treat in the prone position, I have a specialised pregnancy pillow that she can lie on comfortably. You have to be careful not to keep her in the supine position for too long. And if you do have her in supine position, you really should try and elevate her upper body by about 30 degrees because otherwise she's likely to feel faint or actually faint. Basically, because if the baby's very big, or towards the latter stages of pregnancy, the baby can lie on her aorta and have her in the supine position. So, you should try and avoid that for as long as, or a minimal amount of time as possible. So, I prefer to do everything I need to do supine first and then at the very end, I'll have her supine and do a little bit of neck and cranial work and then get her up and walking as quickly as possible. Now if you can't get her supine, or if you don't have a pregnancy pillow, then you can have her in side posture. *audio problems* You just got to make sure she's got a pillow between her knees and so that her spine is nice and straight and not torqued or torsioned at all.

Steven Bruce
Do you prefer one particular side because there is a problem of potential vascular compromise isn't there in side lying?

Elisabeth Davidson
Yes. And we also, the midwives will encourage a woman to sleep on her left-hand side towards the end of the pregnancy, because we really want the baby to lie on her left-hand side to get, again, to get into optimal positioning. Because basically, the uterus has a little bit of dextral rotation built into it. So, the baby will come out in a corkscrew fashion. And if you have her on the right side, it's more difficult for the baby to get into the right position. So yeah, left side.

Steven Bruce
I mean, you've you've talked about some interesting cases, just there. I mean, I imagine with your experience, you've got some quite stunning success cases that you might want to tell us about. Give us some encouragement that, you know, we can make a big difference with this, Elisabeth.

Elisabeth Davidson
Well, I had a woman that probably shouldn't have had more than two babies, but I saw her through the second, third and fourth pregnancy. And she had the most horrific pelvic girdle pain that you can imagine, she's very tall, very thin. And she produced 10-pound babies every single time. And she had them quite close together. She had about two years between all of them, which is also one of the things that can predispose to pelvic girdle pain.

Steven Bruce
Women don't learn, do they?

Elisabeth Davidson
Amazingly, you forget, once that baby is not in your belly, you forget how sore it was. Yeah. So, she was one of those people that, the latter weeks of each pregnancy, I had her in almost every day or every other day. But we managed to get every single baby full term because they did actually threaten to induce her early, because she was in so much pain. The baby was getting a little bit distressed, but she stuck with what we did. And just coming back to what we were talking about earlier with the vascularity and the miscarriage, I have a woman who I knew had ehlers danlos syndrome, she was very hypermobile. So, we were very careful in how we were treating her, we didn't do any manipulation whatsoever, because that's contraindicated in anyone with danlos, so we just purely did soft tissue work. And after she had been in, this was her second pregnancy as well, she'd been in to see one of my colleagues around about 14 weeks. And two, three days later, she started spotting. So, she was very, very concerned that the treatment might have caused this. And she called me up and asked to speak to me and I explained that actually spotting round about that time is not uncommon. And that I didn't think it had anything to do with what we've done. Because I knew that we had been extremely gentle, if you like. Not that I think chiropractic osteopathy could cause that. But I encouraged her to speak to her midwife, and just to get reassurance that everything was okay. And she went in, she had another scan, and everything was fine. And we managed to see her all the way through her pregnancy as well. And she was thankfully...

Steven Bruce
Can I just stop you for a second, Elisabeth. Justin, we got the right picture going out. Right. Carry on, please. Sorry.

Elisabeth Davidson
Yeah. So, I think those are probably the ones that I find, not pride in, but I am really happy that I've made their life a lot easier, and alleviated some of their fears and some of their concerns. And then I had another

lady that had such a bad experience in her first pregnancy, she almost died. I saw her all the way through her pregnancy and she was responding really well. But the baby just wasn't coming out. I think this baby was wrapped up in the cord. And so, she ended up with this whole cascade of intervention, unfortunately, and she came back to me afterwards, she says, I'm not having any, any more babies. I'm too horrific. But thank you so much for what you did.

Steven Bruce
So bottom line is we can actually make a big difference to you know, the process, can't we? We're just about at the end of our time. One quick question from Ben. Ben says, do you recommend any particular pregnancy pillow? He apparently uses the Belloost. But as he's never been pregnant, not yet, anyway. He just wanted to check for comfort purposes.

Elisabeth Davidson
Well, I've used three different ones over the years. The developer of Balloost sent me one kindly to try out on our patients when she was just producing it. And I hands down, that is the one that the women that I see love more than any of the pillows I've tried. So, I would highly recommend it. I mean, there are good ones too, but that's exceptionally good. It's really well designed because it's been designed by, you know, a manual therapists.

Steven Bruce
Elisabeth that has been great, thank you. We've had lots of people thanking you for this, Monika in particular, I got one comment from her saying this has been a fantastic talk and we should thank you very much. I'd really like to know the results of that delphi study that you've been involved in when we're allowed to know it eventually. And if you can share those other resources with me, I'll make sure that all of our viewers get hold of those and we'll put them on the website with the recording so hopefully we can improve not just pregnancy care, but we can improve the research behind it as well. Thank you.