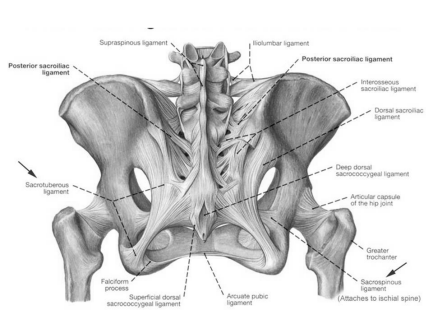
SI Joint ligaments



Introduction

- Two Types:
Mechanical and arthritic

- **Mechanical:** Alteration of normal joint mechanics (hyper/hypomobility, leg length inequalities, gait abnormalities, lower extremity joint pain, pes planus, improper shoes, scoliosis, prior lx fusion, lp myofascial dsyfunction, repetitve strenuous activity and trauma, pregnancy)

- **Arthritic:** OA/ inflammatory arthropathy (AS, psoriatic arthritis, enteropathic arthritis, reiters arthritis)

Presentation

- Patients place their index finger over PSIS (Fortin finger test)

- Pain in lower back, groin buttock/thigh, sometimes in lower leg (chemical radiculopathy of the nearby L5-S1 NR)

- Referral depends on which part of SI joint is irritated (Upper 1/3 = region of PSIS)
Mid-section = pain in mid gluts
Lowest = lower gluteal region

- Exacerbated by weight bearing and arising from a seated position, long car rides, in and out of a vehicle, rolling from side to side in bed, flexing forward whilst standing

- Relieved by lying down or shifting weight off the affected side

- 2 of the 4 tests have a high predictive value: SI distraction, thigh thrust, SI compression and sacral thrust (+ve test = reproduction of symptoms unilaterally and located near PSIS)

- Pain on Gaenslen's, FABER

- Stiffness/apprehension in SI joint MP

- Check for TrPs, tightness, weakness in muscles

- Check for biomechanics of LS and LL

- SI stress tests can be +ve in discogenic patients
- **Pain in SI joint is lumbar until proven otherwise**
- NTT and neurological exam are unremarkable in SIJD

CPR

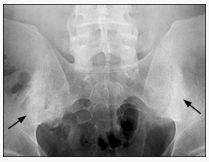
High sensitivity and specificity when patient scores >4 on:

- One finger test - 3 points
- Groin pain - 2 points
- Pain when sitting on a chair - 1 point
- SI shear test - 1 point
- Tenderness of PSIS - 1 point
- Tenderness of sacrotuberous ligament - 1 point

DDx

- Inflammatory Arthropathy
- Middle cluneal nerve entrapment
- LS referral (discogenic)
- Hip DJD/pathology
- Myofascial pain (piriformis syndrome, gluts)
- Sacral insufficiency f#
- Neoplasm
- Infection
- Viceosomatic referral

Imaging



- X-ray showing bilateral sacroilitis (AS)
- SIJD usually diagnosed clinically
- Rule out other pathology
- MRI and CT more sensitive
- Erosions, sclerosis, joint space narrowing
- Changes does not correlate with symptoms

Management

- Ice, NSAIDs
- Ultrasound
- EMT of SI joint
- CFM of tendons and ligaments (especially long dorsal sacroiliac ligament
- Myofascial release of gluts, hamstrings, piriformis, TFL, QL, lumbar erectors, contralateral lats
- Strengthening lumbopelvic stability - transverse abdominus, abdominal obliques, lumbar erectors, gluteus, hip abductors and adductors
- Education on posture and ergonomic awareness

Management (cont)

- Avoid prolonged standing, sitting and forced hip abduction
- Arch supports/orthotics/ SI belt
- Surgery for failure to respond to conservative care with continued/ recurrent SIJ pain and +ve response to SI injection with >75% relief

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