

Sacroiliac Syndrome usually refers to pain arising from one or both joints connecting the sacrum to the pelvis (SI joints). Diagnosis is mainly clinical and is generally based on location of symptoms and SI-joint provocation tests. If restriction of SI motion is palpated along with these findings, then a segmental dysfunction diagnosis may be used. However, many clinicians consider these two diagnoses synonymous.

History	
Back Pain	
- Posterior pelvic, paraspinal (below L4) or gluteal pain - The patient pointing to the SI joint as the location of pain (Fortin's Finger Sign) is considered a reliable finding - Typically aggravated by sitting, flexion, extension, or transitional movements - With or without referred buttock, lateral hip, groin, or posterior leg symptoms - May be relieved by walking but walking may be provocative in more severe or acute cases.	

Physical Examination Findings	
Physical examination of lumbar suspected SI pain focuses on orthopedic, mechanical, and neurologic examination to identify the pain generator.	
Observation/Posture	AROM
Normal or antalgic	Often painful in flexion but may be painful in other directions as well
Palpation	SI Provocation Tests
- Tenderness medial to the PSIS and over long posterior SI ligament - Painful joint play localized to the SI joint - Paraspinal muscle tenderness is common	- A test is considered positive when it reproduces the patient's familiar, concordant pain, not merely discomfort from pressure. Individual maneuvers are weak diagnostically; a cluster is more useful. - The Active Straight Leg Raise was found to be reliable in identifying posterior pelvic pain in pregnant and post-partum patients. (Mens 2001, 2002) - Laslett's Cluster (Sacral Thrust, SI Compression, SI Distraction, Thigh Thrust, Gaenslen's) was shown to be helpful in ruling in SI joint as the location of pain if at least 3 tests were positive (Laslett 2005). A more recent systematic review concluded that the cluster is more useful at ruling out SIJ pain when none of the tests are provocative. (Saueressig 2021)

Ancillary Tests
- Imaging is not indicated in the absence of red flags. - Radiographs are not useful in diagnosis SI syndrome but may be used to look for signs of sacroiliitis in cases of suspected Axial Spondyloarthritis - An image-guided anesthetic injection can help confirm the pain source but this is generally unnecessary not routinely done. - Laboratory studies are not useful for diagnosis of SI pain but may be helpful in cases of suspected Axial Spondyloarthritis.

Treatment Options	
- Should be treated conservatively. - The emphasis of care is to decrease pain and improve function; improve range of motion and increase tolerance to sensitive movements or activities. Activity Modification - Stay active - Flexion load sparing strategies (hip hinge, lumbar support while sitting, etc.) May be useful in the short term Exercise - Walking - Exercises based on functional assessment - Lumbar stabilization exercises may be helpful - Graded exposure to sensitive motions	Manual Therapy - SI Manipulation/Mobilization - Soft tissue work to regional muscles Common Treatment Duration: 4-6 weeks Other Options (rare) - Cognitive-behavior therapy - Acupuncture/dry needling - Pharmaceuticals: NSAID - Steroid Injections

Potential ICD 10 Codes	DDX List for this Condition
- M54.59 = Other Low Back Pain - M54.50 = Low Back Pain - M99.05 = Segmental Dysfunction Pelvic Region - M99.04 = Segmental Dysfunction Sacral Region	- If pain is paraspinal, consider segmental dysfunction, facet arthropathy, soft tissue injury. - Disc derangement should be ruled out if the patient presents with sensitivity to flexion. - If pain radiates, neurogenic causes of leg pain should be ruled out.



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