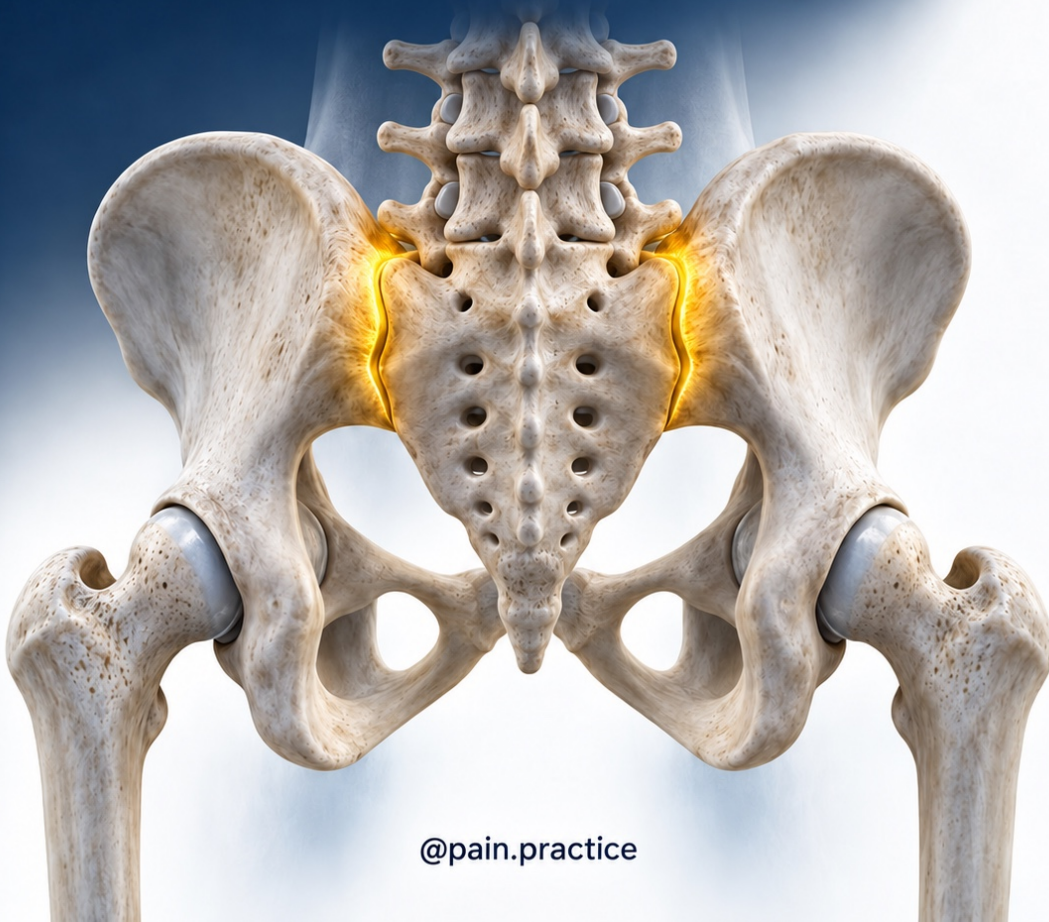


SACROILIAC JOINT PAIN

Could the joint between your spine and pelvis be causing your pain?



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PATIENT EDUCATION GUIDE

Understanding SI joint pain

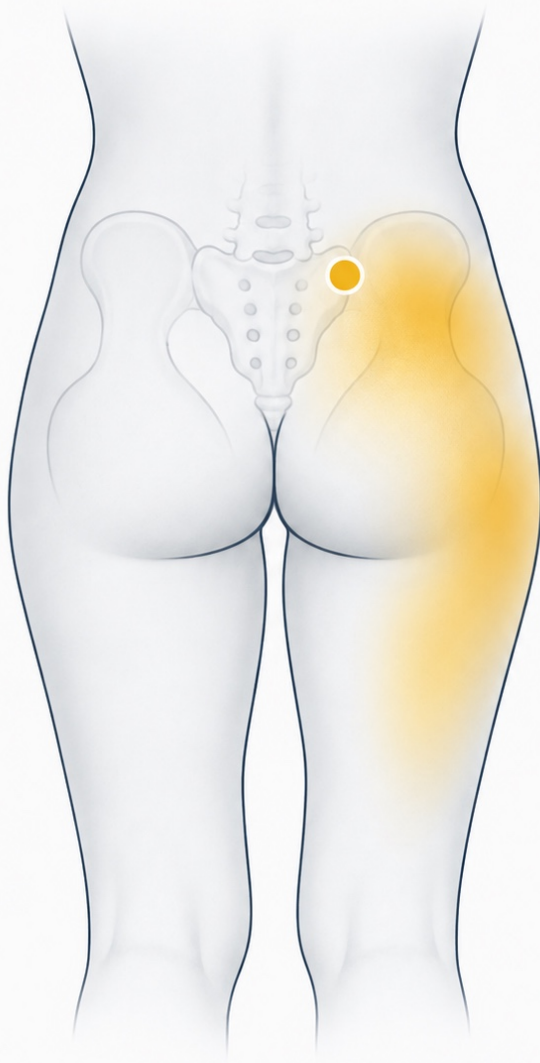
The sacroiliac (SI) joints connect the spine to the pelvis. Pain from this region is commonly felt below the beltline and often affects one side more than the other.

Because symptoms can overlap with lumbar-spine, hip, and muscular pain, identifying the true pain generator matters before choosing treatment.



SI joint pain is a clinical diagnosis - not simply an imaging finding.

WHERE IS THE PAIN FELT?



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Most often:

- Below the beltline
- One side of the buttock

It may also spread toward the hip, groin, or thigh.

PAIN PATTERN

Where is it usually felt?

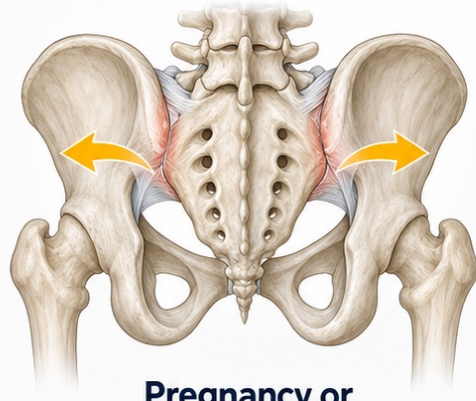
The pain is often located over the posterior beltline or upper buttock, usually on one side.

It may extend toward the lateral hip, groin, or thigh. The pattern varies, and symptoms alone cannot reliably separate SI joint pain from other conditions.

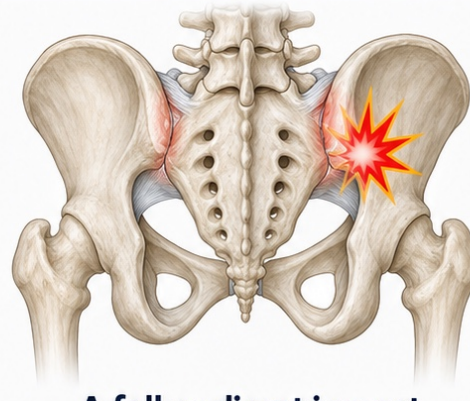


The location provides a clue, but it does not confirm the source.

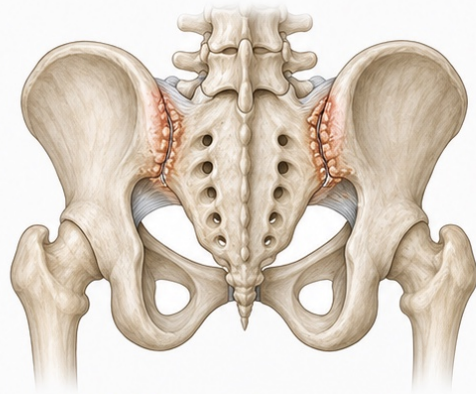
WHY CAN THE SI JOINT BECOME PAINFUL?



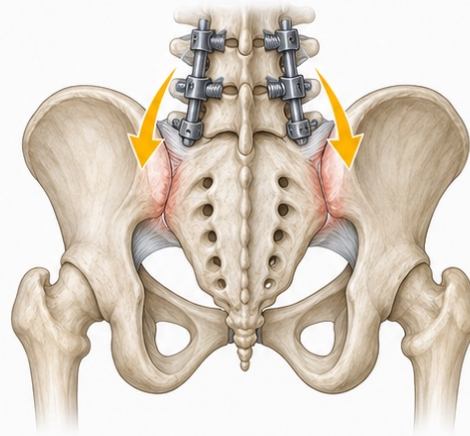
**Pregnancy or
postpartum changes**



A fall or direct impact



Arthritis or degeneration



**Altered movement or
prior lumbar fusion**

Often, more than one factor contributes.

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COMMON CONTRIBUTORS

Why can the joint become painful?

Pregnancy or postpartum changes, a fall or direct impact, arthritis, and altered movement can increase stress across the SI joint.

Pain may also develop after lumbar fusion because forces can be redistributed to the pelvis. More than one factor may contribute in the same patient.



**The cause and the pain generator
are not always the same thing.**

WHAT MAY MAKE IT **WORSE?**



Rising from a chair



Climbing stairs



Turning in bed



Standing on one leg

These clues are helpful—but they do not confirm the diagnosis.

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FUNCTIONAL CLUES

What may aggravate it?

Symptoms may increase during transfers, stair climbing, turning in bed, prolonged standing, or activities that load one leg more than the other.

These activities stress several nearby structures as well, so the pattern must be interpreted together with the examination.



No single symptom or movement is diagnostic by itself.

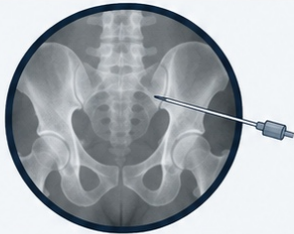
HOW IS SI JOINT PAIN DIAGNOSED?



1 History and pain pattern



2 A cluster of examination findings



3 A diagnostic injection when needed



Imaging can help rule out other causes, but it does not confirm SI joint pain by itself.

THE FULL CLINICAL PICTURE MATTERS.

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DIAGNOSIS

The full clinical picture matters

Diagnosis begins with the history and pain pattern, followed by several examination maneuvers considered together.

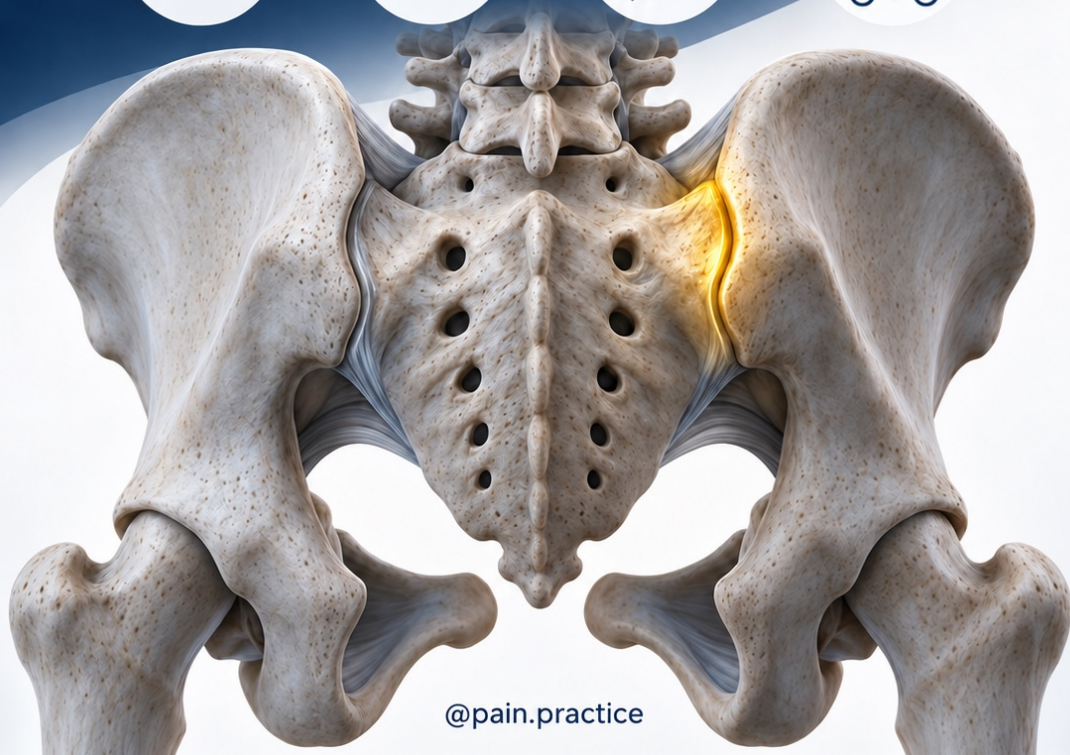
X-rays, CT, or MRI may help identify other conditions, but mechanical SI joint pain is not confirmed by imaging alone. When uncertainty remains, an image-guided diagnostic injection may provide additional information.



History + examination + selective diagnostic procedures.

TREATING SACROILIAC JOINT PAIN

Treatment should match the diagnosis—and usually progresses step by step.



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TREATMENT OVERVIEW

A stepwise, individualized approach

Not every patient needs a procedure. Treatment usually begins with lower-risk measures and progresses only when symptoms and functional limitations continue.

The best option depends on the suspected pain generator, examination findings, response to diagnostic procedures, medical history, and the patient's goals.



The treatment should match the diagnosis.

START WITH THE FOUNDATIONS



Medication

May help reduce pain and inflammation when medically appropriate.



Targeted physical therapy

Focuses on pelvic stability, hip strength, and movement control.



Activity modification

Reduce aggravating loads while gradually restoring movement.



These treatments are often used together.

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FOUNDATIONAL CARE

Medication and physical therapy

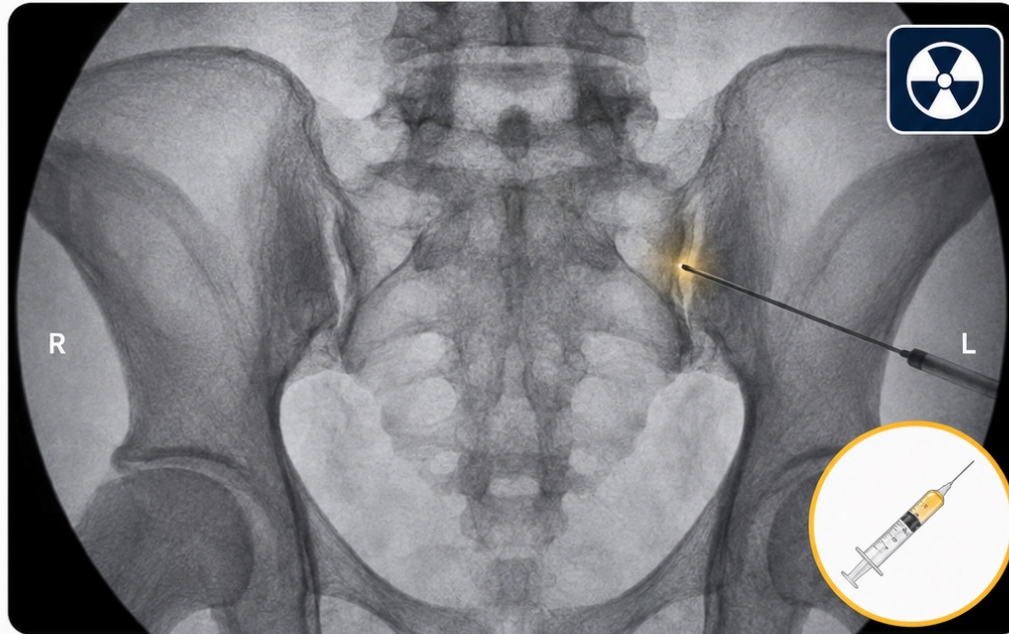
When medically appropriate, medication may help control pain or inflammation while activity is gradually restored.

Physical therapy may focus on pelvic stability, hip and trunk strength, movement control, and a progressive home program. Temporary activity modification can reduce aggravating loads without encouraging prolonged inactivity.



These strategies are commonly used together.

STEROID INJECTION



Placed accurately
with image guidance



May reduce
inflammation and
provide short-term relief



Response can also
help guide the next step



Relief varies from person to person.

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IMAGE-GUIDED INJECTION

Corticosteroid injection

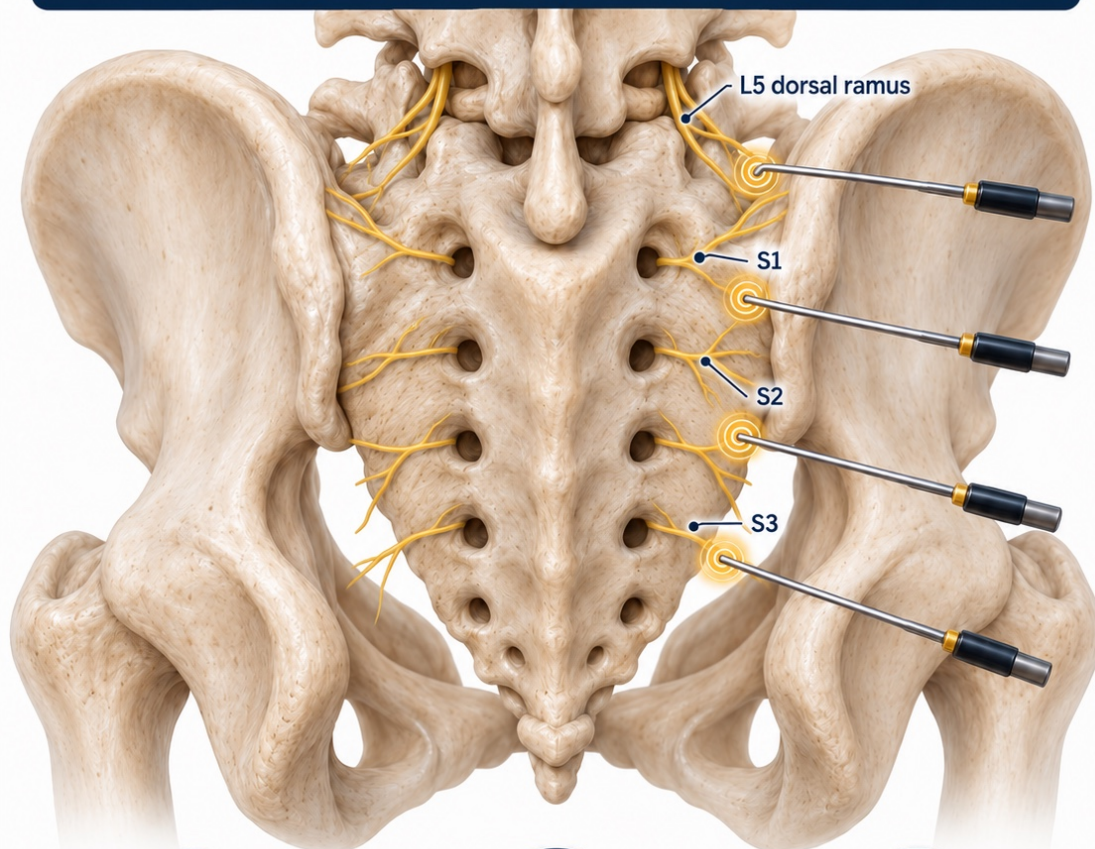
A corticosteroid injection is placed accurately with fluoroscopic or other appropriate image guidance.

In a well-selected patient, it may reduce inflammation and provide short-term relief. The degree and duration of benefit vary, and the response can help inform the next step in care.



An injection is one part of a broader treatment plan.

LATERAL BRANCH NERVE ABLATION



Targets small sensory nerves behind the SI joint



Diagnostic nerve blocks help determine candidacy



May provide longer relief than an injection in selected patients

Nerves can recover over time, and results vary.

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RADIOFREQUENCY ABLATION

Targeting the lateral branches

Small sensory lateral branches travel from the dorsal sacral foramina toward the posterior SI joint and its supporting ligaments.

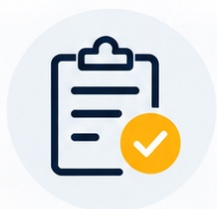
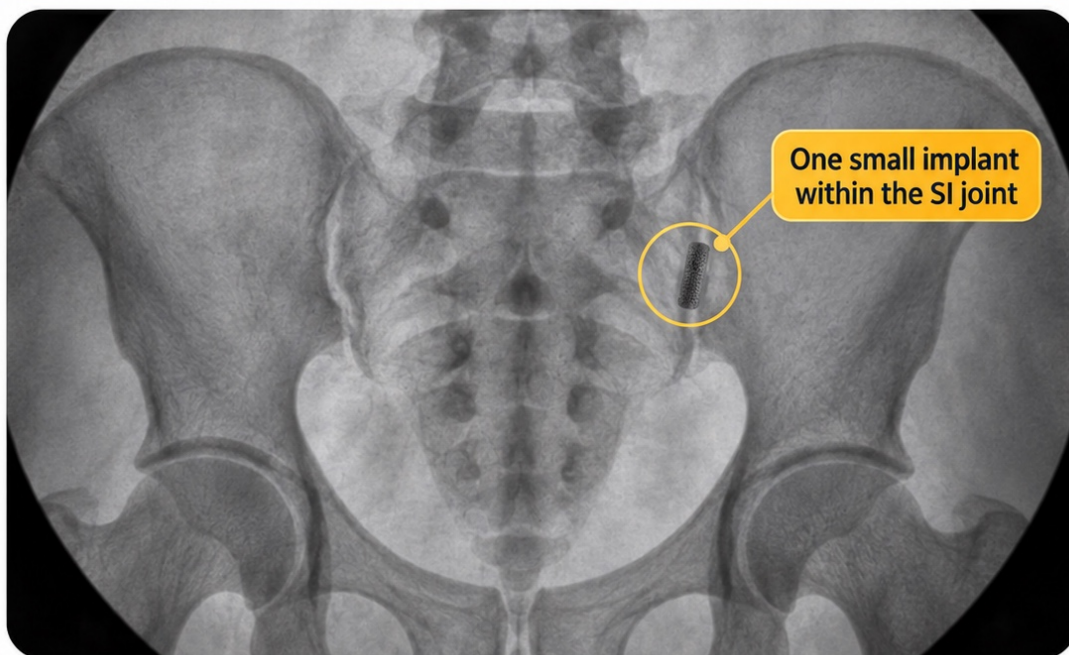
After an appropriate response to diagnostic nerve blocks, radiofrequency ablation may provide longer relief than an injection for selected patients. Nerves can recover over time, so relief is not necessarily permanent.



Careful selection and an anatomically validated technique matter.

MINIMALLY INVASIVE SI JOINT FUSION

For persistent, function-limiting pain after non-surgical care



The diagnosis must
be carefully confirmed



A small implant stabilizes
the joint and supports fusion



Reserved for carefully
selected patients.

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MINIMALLY INVASIVE FUSION

When pain remains disabling

SI joint fusion may be considered when persistent, function-limiting pain continues despite non-surgical care and the diagnosis has been carefully confirmed.

A small implant can stabilize the joint and support fusion. This option is reserved for carefully selected patients after discussion of alternatives, expected recovery, risks, and realistic goals.



Fusion is not a first-line treatment.

Questions about your pain?



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A careful evaluation comes first

The goal is to identify the most likely pain generator, understand how symptoms affect function, and choose the least invasive treatment likely to help.

Educational content only. This guide does not replace an individualized medical evaluation.

Selected guidance
McCormick ZL, et al. Consensus practice guidelines on sacroiliac joint complex pain. Pain Med. 2025. PMID: 41318933.
Sayed D, et al. ASPN best practice guideline for treatment of sacroiliac disorders. J Pain Res. 2024. PMID: 38716038.

Accurate diagnosis | Careful patient selection | Personalized treatment