
Preface

The editors are pleased to present the first book published on the topic of sports hernia and athletic pubalgia. The culmination of this effort is timely because this increasingly recognized problem affects a significant number of competitive athletes and is often confusing for health care providers of various specialties. It is only fitting that we begin this work by establishing some of the anatomic and pathophysiologic principles underlying this entity and what we should call it. One of the benefits of editing this book is the opportunity to assemble chapters from thought leaders across the world that collectively help to arrive at some common understanding of the etiology and treatment of this condition.

First, we should establish that an athlete with groin pain may have very different and quite possibly inter-related diagnoses. The diagnosis of a sports hernia, as several authors point out in this book, is best applied to the condition in which there is exertional pain at the distal rectus/medial inguinal floor in conjunction with a distinct weakness in the pelvic floor/transversalis fascia and/or tear in the rectus abdominus aponeurosis. The result is not a true hernia in the sense of a protusion of a peritoneal sac, but rather a weakness which creates stress across the distal rectus and inguinal floor. While this understanding is consistent across the different authors, variations in the details are apparent, particularly in regard to the role of involvement of nearby sensory nerves, which may be irritated or compressed as a result of the associated defects. The observation that extremely “tough athletes,” accustomed to violent collision sports, are shut down by such a small fascial bulge reflects the significance of this condition. Diagnostic maneuvers that reproduce this pain with Valsalva confirm a sports hernia, and various treatments to correct this weakness in the abdominal wall all appear to be effective. Several chapters outline the technical details of how this can be done, from a general tightening of the soft tissue layers to a selective imbrication under the nerve, to mesh repairs done open or laparoscopically. As you will see in these chapters, all can be successful as they all correct this underlying area of weakness. The benefits of one approach over another have never been directly studied, but the authors here provide a good overview of pros and cons to each method as well as individual results.

Second, athletic pubalgia is best used to refer to a collection of problems associated with the groin region in athletes involving assorted tendinopathies and insertional tendon strains. The differential diagnosis and imaging

approach that are essential to selection of athletes for conservative versus surgical management are therefore paramount to arriving at a precise diagnosis. Most commonly, the tendons affected are the rectus femoris or the adductor longus. The strains represent partial tears at the tendinous insertions on the pelvis and result in chronic pain with exertion. Such strains may be associated with a sports hernia type area of weakness or a bulge as well. Repair hinges upon addressing the specific tendon that is injured, with a heavy reliance on MRI for an accurate diagnosis.

Lastly, we are just beginning to understand the strong correlation and interplay between hip impingement problems (femoral acetabular impingement or FAI) and sports hernia type problems. It appears that impingement at the hip can cause altered mechanics in the pelvis, such that the hemipelvis is subject to increased rotation during aggressive athletic motions such as kicking or twisting the torso. The muscles attaching to the pelvis are then subject to increased stresses as they work to stabilize the pelvis. Injury to the tendon attachments or to the transversalis fascia may then occur. However, confirming this theory doesn't prove to be so simple. Not every athlete with radiographic evidence of FAI ends up with a sports hernia, and not every athlete with a sports hernia has FAI radiographically. Even those athletes with both sports hernia and FAI, if only one is fixed surgically, do not necessarily require the other to be addressed. However, this correlation may explain the failures of operative treatment that can occur with any approach to either problem.

Establishing what exactly is injured and what ultimately is repaired is important as we move forward to have any ability to compare outcomes. Any publications should strive to make these issues clear. The contributors to this book were selected for their extensive experience with these problems and to cover the range of etiologies and treatment options for problems in the athletic groin. We feel that we have been successful in covering the landscape well, but recognize that opinions vary on what exactly is going on and how to make it better as illustrated by the differing operative approaches among the various contributors. By providing all of these opinions together, the readers can draw their own conclusions about similar themes that strive to stabilize the posterior inguinal floor and associated structures and to decrease tension across the affected area. Treatment of damaged or inflamed tendon attachments for pain associated with stress on these attachments, whether by conservative or surgical means, is another consideration.

These diagnoses are clearly real. Treatments are effective and athletes do return to compete effectively. We hope this book helps to establish credibility in these areas where there has been doubt and reduce confusion where there have been differences of opinion.

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