

SURGICAL OPTIONS FOR RECALCITRANT GROIN INJURIES

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Adductor problems are common and account for about 1/5 of all the muscle injuries in professional football.

Any patient with an adductor problem will classically have a history taking, clinical examination and pelvic X rays. Overlap between adductor related groin pain, hip pain and inguinal disruption is common. Pain in the adductor area can be confusing and is not always adductor-related. Hip conditions such as femoro-acetabular impingement can often give referred pain to the adductors. Pain with kicking usually refers to adductor related groin pain whilst significant pain after sports activities usually points towards a hip condition.

Adductor related groin pain will typically give pain over the adductor enthesis and pain on predominantly resisted long lever adduction. Isometric strength testing can help to stage the severity of the adductor dysfunction but also can be an important tool to differentiate between hip conditions and adductor related groin pain.

The majority of chronic adductor related groin pain has an insidious onset although a subset of patients have an acute onset following eccentric loading of the adductor longus with persistent pain at the adductor longus enthesis. With the second type an Magnetic Resonance Imaging (MRI) with specially designed groin study protocol for acute fibrocartilage injuries of the adductor longus is indicated. Partial tears of the fibrocartilage are often missed and can be a cause of unexplained adductor enthesis pain. The role of MRI is probably more useful for acute fibrocartilage injuries of the adductor longus. For chronic adductor pain the role of MRI is relative because features such as a secondary cleft sign or symphyseal bone marrow oedema are often present in asymptomatic athletes as well.

Image guide pubic cleft injection can be employed after failure of conservative management. But a rapid return to sports without achieve good adductor strength puts the athlete at risk for reinjury or an avulsion of the fibrocartilage of the adductor longus. Pubic cleft injections are more likely to give good long term results in recreational football players than in professionals.

Surgical management is indicated for adductor pain resisted to conservative management. Historically adductor tenotomy was the procedure of choice. A reason for concern was that not all football players were able to return to the same level of activity and reduced adductor strength was measured in some of the athletes. The overall return to the same level of sports following adductor tenotomy ranges in most papers between 54 to 69 percent and with an average return between 16 to 18.5 weeks.

A partial selective adductor release gives a more predictable return to sports with 98% of the professional soccer players able to return to the same level of activity. Those athletes who had strength measurements pre and post op demonstrated excellent adductor strength improvement after the procedure.

Following this procedure, running is initiated after a week and program consisting of closed and open chain adductor strengthening exercises followed by balance work to educate adductor proprioception.

Some athletes return to competition as early as 4 weeks but with an average of around 10 weeks.