

# Athletic pubalgia (sports hernia) surgery

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Policy contains: athletic pubalgia, sports hernia, groin pain.

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## Coverage policy

Surgery for athletic pubalgia/sports hernia is investigational/not clinically proven and, therefore, not medically necessary.

### Limitations

No limitations were identified during the writing of this policy.

### Alternative covered services

- Cortisone injection.
- Nonsteroidal anti-inflammatory drugs.
- Physical therapy.

## Background

The American Academy of Orthopaedic Surgeons defines sports hernia as a strain or tear of any soft tissue in the lower abdomen or groin, typically after sudden changes of direction or twisting movements. While sports hernia may lead to an abdominal hernia, the two conditions are different, and thus many medical experts use the term "athletic pubalgia" instead of sports hernia. Athletic pubalgia is typically diagnosed after a history and physical examination, and subsequent confirmation with X-rays or magnetic resonance imaging (Ellsworth, 2014).

Achieving a standard taxonomy of athletic pubalgia has been a challenge. Some experts prefer to use the terms inguinal disruption and athletic pubalgia separately, despite symptoms and pathologies being similar in both (Ellsworth, 2014). Some refute the diagnosis due to lack of clinical evidence of hernia or hip pathologic findings in spite of patient-reported pain. Lack of consensus and clear comprehension of basic pathophysiologic features also present obstacles (Zuckerbraun, 2020).

Athletic pubalgia is marked by severe pain at the time of injury; pain resolves with rest but can return after subsequent twisting movements in athletic activities. The condition requires treatment, or pain can become chronic and prevent athletic activity that requires twisting and changes of direction. Treatment of the condition consists of (Witstein, 2022):

- Rest, ice, or a compression wrap for seven to ten days.
- Physical therapy to improve strength and flexibility in the abdomen and inner thigh, starting two weeks after the injury.
- In some cases, a nonsteroidal anti-inflammatory drug, such as ibuprofen or naproxen, to reduce swelling is recommended.
- For persistent symptoms, a cortisone injection.

In many cases, the pain resolves and the athlete returns to sports after four to six weeks of physical therapy. In unresolved cases, surgery has been used as an option. Types of surgery include laparoscopic repair and open repair (including plication of the transversalis fascia, reapproximation of the conjoint tendon to the inguinal ligament, and approximation of the external oblique aponeurosis) (Elattar, 2016).

## Findings

### Guidelines

Historically, caregivers have struggled to achieve agreement on the terminology, definitions, and classifications that guide diagnosis and treatment of athletic pubalgia. Recent efforts at consensus have shown improvement, but uniform treatment guidelines are still lacking (Biscotti, 2016; Delahunt, 2015; Weir, 2015).

### Evidence review

The heterogeneity in the literature complicates efforts to summarize therapeutic efficacy and determine the optimal surgical candidates. Diagnostic terms include “athletic pubalgia,” “sports hernia,” “femoroacetabular impingement,” “adductor-related pathology,” “inguinal pathology,” and “labral pathology” (de Sa, 2016; Kraeutler, 2021). The most common procedures are open or laparoscopic mesh repair, adductor tenotomy, primary tissue (hernia) repair, and rectus abdominis repair, and both general and orthopedic surgeons performed the procedures (Kraeutler, 2021).

Both conservative and surgical management approaches may achieve successful return to play. In general, conservative management is the preferred initial approach, reserving surgical intervention for demonstrated higher grade injury accompanied with an active postoperative rehabilitation program. There is insufficient evidence to determine the superiority of one approach over another for higher grade injury or the factors leading to more successful outcomes.

A systematic review included ten studies of mixed quality (n = 216) of treatment for acute adductor injury in athletes at least 15 years of age. Participants with partial acute adductor tears were treated with physical therapy in all studies and had an average return to play ranging from 1 to 6.9 weeks depending on the injury grade. For participants with complete adductor tears, the frequency on magnetic resonance imaging in the study base was 21% to 25%, and the average time to return-to-play was shorter for those undergoing nonoperative treatment

than surgical treatment (8.9 weeks versus 14.2 weeks). However, those treated surgically had more severe injuries (e.g., greater stump retraction) (Farrell, 2023).

Another systematic review included ten studies (n = 468) of mixed quality. For participants who underwent conservative management, the time to return to play ranged from 9.14 weeks to 18.5 weeks, with a success rate of 14% to 100%. For those who underwent surgical management, the time to return to sport ranged from six weeks to 12 weeks with a success rate of 90% to 100%. The factors affecting the range of return to play timelines, success rates, and the shorter return to play among the surgical cohorts require further study (Serafim, 2022).

Hatem (2021) compared the outcomes of different surgical techniques for treatment of chronic groin pain in athletes in 47 studies (n = 2,737). Most were observational surgical series generally of low quality and lacking in comparison groups. The rate of return to play at preinjury or higher level was 92% in athletes after surgery to the inguinal area, 75% after surgery to the adductor origin, 84% after surgery to the pubic symphysis, and 89% after combined surgery in the inguinal and adductor origin.

A systematic review of 28 studies, only two of which were randomized, found no significant difference between totally extraperitoneal and transabdominal preperitoneal laparoscopic surgical approaches for sports hernia. Median time (28 days) from surgery to activity was similar between groups (Kler, 2021).

A systematic review of 72 studies of patients with long-standing groin pain (n = 3,629), five of which used a comparison group, compared surgical and nonsurgical approaches. Compared to the nonsurgical group (80%), return to habitual activity occurred in 94%, 90%, and 97% after inguinal hernia repair, adductor tenotomy, and a combination. Similar results were observed in the percent of pain-free patients (67% versus 92%, 90%, and 92%). A total of 21% of nonsurgical patients shifted to surgery (Jorgensen, 2019).

In 2022, we added one new systematic review and deleted one older one. The results are consistent with previous findings and warrant no policy changes.

In 2023, we added two systematic reviews to the policy. No policy changes are warranted.

In 2024, we deleted older references, reorganized the findings section, and identified no newly published, relevant literature to add to the policy. No policy changes are warranted.

## References

On September 5, 2024, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “athletic pubalgia,” “groin pain,” “core muscle injury,” and “sports hernia.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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## Policy updates

10/2021: initial review date and clinical policy effective date: 11/2021

10/2022: Policy references updated.

10/2023: Policy references updated.

10/2024: Policy references updated.