CHAPTER

44 Abdomen and Pelvis

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In This Chapter

INTRODUCTION

- Abdominal and groin pain in the athlete can present a diagnostic dilemma.
- Many potential disorders are possible, and a careful history and physical examination are more likely than magnetic resonance imaging (MRI) to find the source of pain.
- A high index of suspicion is necessary with regard to femoral neck stress fractures, as delay in diagnosis can become highly problematic if a displaced fracture results.
- Osteitis pubis symptoms generally resolve with nonoperative treatment, but frequently last 6 to 9 months.
- Most pelvic avulsion fractures can be treated nonoperatively.
- Surgery for athletic pubalgia must be preceded by an understanding of the direct and compensatory parts of the injury.

Abdominal, groin, and pelvis pain in the athlete can be difficult to manage. Part of the reason may have been due to our shortage of good evaluation tools, interest level, and diagnostic tests. In addition, the increased popularity of soccer in North America has brought with it an increase in groin injuries and as a consequence has led to increased awareness and published reports. It is imperative that orthopedic surgeons who take care of kicking sport athletes have a thorough understanding of problems affecting the pelvic and groin areas.

Athletes presenting with groin and hip complaints pose a difficult challenge due to the long and usually unfamiliar list of diagnostic possibilities. The differential list is far reaching and

bursitis, tumors, fractures and abdominal wall te
1). Usually the most sensitive tool for evaluating
problems is not the "high tech" imaging study b
clinical history and a detailed palpation examinat
lenging and rewarding for the clinician to gather
information, formulate a well-defined list of diff
plan a strategy to further define and treat the spe

Before getting into athletic pubalgia and other
tal causes of such debilitating pain in athletes, l
the myriad of other problems that can mimic the
problems. We only mention, with some editorial
problems that have actually been seen[2,3] rather th
the whole potential differential diagnosis. On th
knowing the comprehensive differential is very in
other problems definitely overlap with respect to
pain patterns.

We start with inguinal hernia. The issue here
important since we believe strongly that the term
is a misnomer, leading good general surgeons to be
can repair the athletic problems like hernias. Ing
different. The pain of a direct or indirect hernia is
to the pain found in most athletes. The pain rela
peritoneum poking through a defect in the abdon
the internal ring, either medial or lateral to the i
tric vessels. The pain of a true hernia is usually a
a distinct, palpable bulge.

With little evidence, the claim has been mad
inguinal hernias frequently cause abdominal and
athletes. It is possible, rarely, that one may not
hernia on physical examination. When we have
pain was well lateral to the edge of the rectus
number of years, we have been looking for evid
hernias in athletes but have seen little such evid
difficulty believing reports to the contrary.

We have picked up a number of incidental he
physical examination or at the time of surgery, bu
did not seem to account for the patterns of pai
letes. In each case, the pain was medial to the h
ciated with some degree of adductor pain in the

We have also had three cases of inguinal hernia
after pelvic floor repairs and may have indeed b
tions of the pelvic floor repairs. We believe th
repairs can occasionally create a small abdomi
near the internal ring. In two of our cases, the pati