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OVERVIEW

Athletic pubalgia, commonly known as sports hernia, is characterized by disabling activity-dependent lower abdominal and groin pain that is not attributable to any other cause. Athletic pubalgia is most frequently diagnosed in high-performance male athletes, particularly those who participate in sports that involve rapid twisting and turning such as soccer, hockey, and football. Alternative names include Gilmore groin, osteitis pubis, pubic inguinal pain syndrome, inguinal disruption, slap shot gut, sportsmen groin, footballers groin injury complex, hockey groin syndrome, athletic hernia, sports hernia, and core muscle injury.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

Surgery for athletic pubalgia is not medically necessary for BlueCHiP for Medicare members and Commercial products as there is insufficient medical literature to support the efficacy of this service.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit Booklet for not medically necessary coverage/benefits.

BACKGROUND

Athletic pubalgia is thought to be a cause of groin pain in athletic people. It is a poorly defined condition, for which there is not a consensus regarding the cause and/or treatment.⁽¹⁾ Some believe athletic pubalgia to be an occult hernia process, a prehernia condition, or an incipient hernia, with the major abnormality being a defect in the transversalis fascia, which forms the posterior wall of the inguinal canal. Another theory is that injury to soft tissues that attach to or cross the pubic symphysis is the primary abnormality. The most common of these injuries is thought to be at the insertion of the rectus abdominis onto the pubis, with either primary or secondary pain arising from the adductor insertion sites onto the pubis. It has been proposed that muscle injury leads to failure of the transversalis fascia, with a resultant formation of a bulge in the posterior wall of the inguinal canal.⁽¹⁾ Osteitis pubis (inflammation of the pubic tubercle) and nerve irritation/entrapment of the ilioinguinal, iliohypogastric, and genitofemoral nerves are also believed to be sources of chronic groin pain.

An association between femoroacetabular impingement (FAI) and athletic pubalgia has also been proposed. It is believed that if FAI presents with limitations in hip range of motion, compensatory patterns during athletic activity may lead to increased stresses involving the abdominal obliques, distal rectus abdominis, pubic symphysis, and adductor musculature. Surgery for athletic pubalgia has been performed concurrently with treatment of FAI, or following FAI surgery if symptoms did not resolve.

A diagnosis of athletic pubalgia is based primarily on history, physical exam, and imaging. The clinical presentation will generally be one of gradual onset of progressive groin pain associated with activity. Physical exam will not reveal any evidence for a standard inguinal hernia or groin muscle strain. Imaging with MRI or ultrasound is generally done as part of the workup. In addition to exclusion of other sources of lower

abdominal and groin pain (e.g., stress fractures, femoroacetabular impingement, labral tears), imaging may identify injury to the soft tissues of the groin and abdominal wall.

Many injuries will heal with conservative treatment, which includes rest, icing, nonsteroidal anti-inflammatory drugs, and rehabilitation exercises. A physical therapy program that focuses on strength and coordination of core muscles acting on the pelvis may improve recovery. In a 1999 study, 68 athletes with chronic adductor-related groin pain were randomized to 8 to 12 weeks of an active training program consisting of physical therapy (PT) that focused on strength and coordination of core muscles, particularly adductors (PT+), or to standard physical therapy without active training (PT-).⁽³⁾ At 4 months after treatment, 68% of patients in the active training group had returned to sports without groin pain compared with 12% in the PT group. At 8 to 12 year follow-up, 50% of athletes in the active training group rated their outcome as excellent compared with 22% in the PT group.⁽⁴⁾ For in-season professional athletes, injections of corticosteroid or platelet-rich plasma, or a short corticosteroid burst with taper have also been used.

The evidence to date on the surgical treatment of athletic pubalgia consists of 1 small randomized controlled trial (RCT) that used laparoscopic total extraperitoneal repair with mesh reinforcement behind the pubic bone/posterior wall of the inguinal canal, and a number of uncontrolled case series. The single RCT is insufficient to determine outcomes of surgical treatment for this relatively common condition. Further high-quality RCTs are necessary to determine whether improvements in pain and functional status with surgical treatment of athletic pubalgia exceed that of alternative treatments.

Surgical treatment for athletic pubalgia has not demonstrated improvements in health outcomes and remains not medically necessary for all indications.

CODING

There is not a specific code for the surgical treatment of athletic pubalgia. The following unlisted CPT codes may be used.

27299

49659

49999

RELATED POLICIES

None

PUBLISHED

Provider Update, MONTH? 2015

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