

EFFECTIVE DATE:
POLICY LAST UPDATED:

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 (eg 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 (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 unlisted procedure, pelvis or hip joint

49659 unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy

49999 unlisted procedure, abdomen, peritoneum and omentum

RELATED POLICIES

None

PUBLISHED

Provider Update, 2015

REFERENCES:

1. Litwin DE, Sneider EB, McEnaney PM et al. **Athletic pubalgia** (sports hernia). Clin Sports Med 2011;30(2):417-34.
2. Khan W, Zoga AC, Meyers WC. Magnetic resonance imaging of **athletic pubalgia** and the sports hernia: current understanding and practice. Magn Reson Imaging Clin N Am 2013; 21(1):97-110.
3. Holmich P, Uhrskou P, Ulnits L et al. Effectiveness of active physical training as treatment for long-standing adductor-related groin pain in athletes: randomised trial. Lancet 1999; 353(9151):439-43.
4. Holmich P, Nyvold P, Larsen K. Continued significant effect of physical training as treatment for overuse injury: 8- to 12-year outcome of a randomized clinical trial. Am J Sports Med 2011; 39(11):2447-51.
5. Meyers WC, McKechnie A, Philippon MJ et al. Experience with "sports hernia" spanning two decades. Ann Surg 2008; 248(4):656-65.
6. Paajanen H, Brinck T, Hermunen H et al. Laparoscopic **surgery** for chronic groin pain in athletes is more effective than nonoperative treatment: a randomized clinical trial with magnetic resonance imaging of 60 patients with sportsman's hernia (**athletic pubalgia**). Surgery 2011; 150(1):99-107.

7. Ahumada LA, Ashruf S, Espinosa-de-los-Monteros A et al. **Athletic pubalgia**: definition and surgical treatment. *Ann Plast Surg* 2005; 55(4):393-6.
8. Steele P, Annear P, Grove JR. **Surgery** for posterior inguinal wall deficiency in athletes. *J Sci Med Sport* 2004; 7(4):415-21; discussion 22-3.
9. Paajanen H, Syvahuoko I, Airo I. Totally extraperitoneal endoscopic (TEP) treatment of sportsman's hernia. *Surg Laparosc Endosc Percutan Tech* 2004; 14(4):215-8.
10. Kumar A, Doran J, Batt ME et al. Results of inguinal canal repair in athletes with sports hernia. *J R Coll Surg Edinb* 2002; 47(3):561-5.
11. Irshad K, Feldman LS, Lavoie C et al. Operative management of "hockey groin syndrome": 12 years of experience in National Hockey League players. **Surgery** 2001; 130(4):759-64; discussion 64-6.
12. American Academy of Orthopaedic Surgeons. OrthoInfo: Sportman's Hernia/**Athletic Pubalgia**. 2010. Available online at: <http://orthoinfo.aaos.org/topic.cfm?topic=A00573>. Last accessed May, 2014.
13. Sheen AJ, Stephenson BM, Lloyd DM et al. "Treatment of the Sportsman's groin": British Hernia Society's 2014 position statement based on the Manchester Consensus Conference. *Br J Sports Med* 2013.

Public Policy Description

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

