

CASE 1

HISTORY

27 y.o. male amateur runner (3 x week) and soccer (3 x week) player.

No previous history of groin injuries.

Gradual onset 1st episode left sided groin pain – over the past 8 weeks.

Pain located around proximal adductors and on insertion on the pubic bone.

The pain is worse on sprinting, kicking and changing directions in football and mild pain at the end of 5km runs.

Initially able to train and play without performance being affected.

Now unable to sprint fully or kick with any power.

Past medical history: none.

Previous injury: 2 years ago lateral ankle ligament injury right side, good recovery. Contusions.

Medically fit, no health issues. Medication: none. No allergies.

EXAMINATION

General – healthy athletic male. Mild varus alignment both legs.

Lumbar spine – normal pain free range of motion.

Horizontal pelvis.

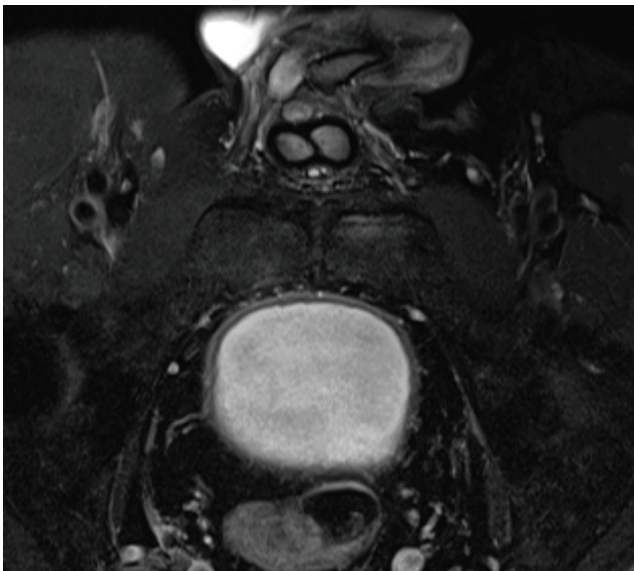
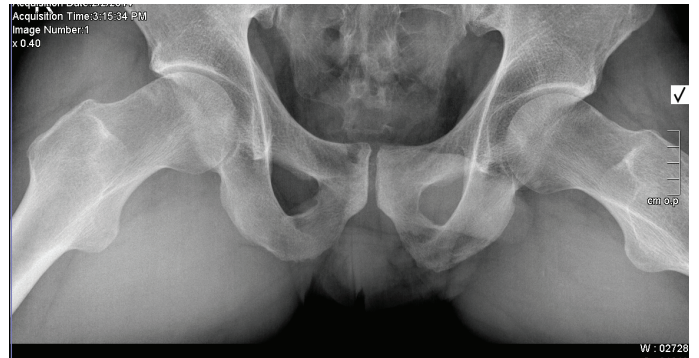
Hip: Normal pain free flexion. 20 degrees internal and 50 degrees external rotation bilaterally. No pain on Faber or FADIR test.

Groin region: no swelling, bruising, scars.

Palpation: Pain on palpation of proximal adductor tendon and attachment at the pubic bone. No pain on palpation of iliopsoas, rectus abdominus, inguinal canal/ring, inguinal ligament, conjoined tendon, other structures in the groin region.

Resistance testing: Hip adduction 0°, 45°, 90° - pain felt at adductor insertion, moderate strength. Hip flexion 0° and 90° - no pain, good strength. Hip abduction 0° and 45° - no pain, good strength. Abdominal – sit up 45° hip flexion – no pain, good strength. Oblique sit ups 45° hip flexion – no pain, good strength.

Stretch tests: symmetrical length of adductors with mild pain on stretching of left adductors felt in proximal adductors. Symmetrical length on testing hip flexors and no pain on stretching.



X-ray report:

There is a moderate reduction of the articular surface of the lateral articular surface of the right hip. There is a reduced head –neck offset junction on the Dunn view.

MRI pelvis:

There is bone marrow oedema of the left pubic ramus. There is no visible cleft or tear of the left adductor tendon but there is adductor longus enthesiopathy. Cystic changes at right adductor tendon origin due to previous injury. No rectus femoris abnormality. No signs of advanced pubic symphysis osteoarthritis. Normal fascia transversalis. Conclusion: left adductor longus tendinopathy without associated cleft or tear.