traction, then mobilized from non-weight bearing to partial weight bearing, and is now fully recovered.

Case 2
A 48-year-old man presented after being involved in a crash with other riders and landing on his left side while his toes were strapped into his pedals. He presented two days after his injury with left hip pain, limited range of movement, and pain on bilateral pressure. Plain x-ray (Figure 3) showed an undisplaced posterior acetabular fracture. He was treated with three weeks' bed rest, then mobilized non-weight bearing, and he made a full recovery.

‘Gilmore’s groin’—or is it?

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Groin injuries are common and often difficult diagnostic problems. This paper reviews six patients presenting with symptoms highly suggestive of the syndrome ‘Gilmore’s groin’, but in whom the pathophysiology of the groin disruption and its surgical management differed from Gilmore’s description.


Keywords: groin injury; Gilmore’s groin; pathophysiology of groin disruption; surgical management

Groin injuries are common in sport and their management must be based on accurate diagnosis. This is difficult, as symptoms and signs are often diffuse and non-specific. Many patients undergo lengthy periods of conservative management and numerous radiological investigations before surgical intervention is contemplated.

A syndrome of groin disruption has been described as ‘Gilmore’s groin’. Patients present with chronic groin pain which is aggravated by sudden and twisting movements and, in particular, by the action of kicking a ball, coughing and even sneezing; even rolling over in bed may be enough to exacerbate symptoms. Few patients recall an actual ‘event’ or moment when the injury was first sustained. Other authors have used the terms ‘pubalgia’, ‘groin disruption’, and ‘the sportsman’s hernia’ to describe the syndrome.

Gilmore’s description includes a lack of visible external signs in the affected groin, dilatation of the superficial inguinal ring (felt by inversion of the scrotum with the little finger tip), a cough impulse, and marked tenderness on the affected side, although he does not specify the anatomical site of this tenderness.

We report a series of patients who presented with symptoms and signs highly suggestive of ‘Gilmore’s groin’, but in whom the pathophysiology of the groin disruption and its surgical management differed from Gilmore’s description.

Patients
All complained of chronic groin pain exacerbated by sudden sharp movements, especially when kicking. Patient 1 also complained of pain in the groin when rolling over in bed. In all patients, tenderness was elicited just above the deep inguinal ring, but no dilatation of the superficial inguinal ring was noted and no cough impulse or hernia was identified.

All patients claimed relief of symptoms following operation. In patient 1 relief was virtually instantaneous on waking from his general anaesthetic. Patient 5 underwent bilateral groin exploration and repair. All patients returned to full active participation in their chosen sport within 6 weeks of operation.

Follow up at 6 weeks revealed no further pain. Only one patient has since suffered further pain (patient 5) and this was from a new adductor origin strain.

Discussion and pathophysiology
Gilmore describes the pathophysiology of the groin disruption as being caused by a number of combined factors: (1) a torn external oblique aponeurosis causing dilatation of the superficial inguinal ring; (2) a torn conjoint tendon; (3) dehiscence between the inguinal ligament and the torn conjoint tendon, constituting the major injury.
Table 1. Summary of patient’s symptoms, signs and investigations

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Site of pain</th>
<th>Sport</th>
<th>Duration of symptoms (months)</th>
<th>Investigations and previous treatment</th>
<th>Age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Left groin</td>
<td>Soccer (midfield)</td>
<td>8</td>
<td>Physiotherapy, no investigations</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>Right groin</td>
<td>Soccer (midfield)</td>
<td>3</td>
<td>Physiotherapy, prolonged rest</td>
<td>27</td>
</tr>
<tr>
<td>3</td>
<td>Right groin</td>
<td>Soccer (midfield)</td>
<td>6</td>
<td>Physiotherapy, normal</td>
<td>29</td>
</tr>
<tr>
<td>4</td>
<td>Right groin</td>
<td>Rugby (full back)</td>
<td>8</td>
<td>Physiotherapy, orthopaedic consultation, no other investigations</td>
<td>31</td>
</tr>
<tr>
<td>5</td>
<td>B/L pain (right more than left)*</td>
<td>Soccer (midfield)</td>
<td>6</td>
<td>Physiotherapy</td>
<td>29</td>
</tr>
<tr>
<td>6</td>
<td>Right groin pain</td>
<td>Cricket (bowler)</td>
<td>8</td>
<td>Previous physiotherapy, acupuncture</td>
<td>30</td>
</tr>
</tbody>
</table>

Figure 1.

(i) Torn external oblique aponeurosis causing dilatation of superficial ring. (N-V = Neurovascular)

He describes surgical restoration of this disruption by way of a modified herniorrhaphy with plication of the transversalis fascia and vicryl repair to the conjoined tendon. A nylon dam is performed to approximate the repaired conjoined tendon to the inguinal ligament. The external oblique is then repaired and the wound closed in layers.

There seems little doubt that Gilmore has highlighted a number of symptoms and signs peculiar to one form of groin disruption and that he has had good results from his surgical management. The patients presented in this paper had many of the symptoms described by Gilmore and others. We agree that there was no clinical evidence of a hernia, and that there is an area of localized tenderness in the groin. This area we believe to be superior to the deep inguinal ring. However, we have not found a cough impulse or a dilated superficial inguinal ring on digital scrotal inversion. Like Gilmore’s patients, those presented here had undergone lengthy periods of varying conservative management regimes, including physiotherapy, rest, and acupuncture.

In our experience, the anatomy and pathophysiology of the groin disruption is not as complex as Gilmore describes and we believe that surgical correction can be performed by a much simpler approach. In the patients presented, the major disruption seen was a small tear in the external oblique aponeurosis at the site of emergence of the small neurovascular bundle associated with
From the clinic

Site of tear in external oblique

(i) Tear in external oblique aponeurosis
at site of emergence of terminal
branches of iliohypogastric N-V bundle
(equates to point of maximal tenderness)

(ii) Normal conjoined tendon - no tear
or dehiscence from inguinal ligament

Figure 2.

the terminal branches of the anterior primary ramus of
the iliohypogastric nerve (see Figures 1 and 2 for
comparison of ‘Gilmore’s groin’ and the author’s
description).

The tear is revealed by a routine inguinal incision and
blunt dissection onto the external oblique aponeurosis.
In all papers reviewed we could find no specific mention
of such disruption, although reference to ‘microscopic
tears’ or ‘avulsions’ have been made. We found no
surgical evidence of herniae, or indeed of a
bulge in the posterior wall of the inguinal canal as described by
Malycha and Lovell.4

We have shown that approximation of the torn
edges of the external oblique aponeurosis with simple
interrupted nylon leads to a return to full sporting
activity within 5 to 6 weeks. It is interesting to note that
in the ‘modified herniorrhaphies’ described in previous
reports, a repair of the external oblique aponeurosis is
always made, and perhaps this explains the similarity in
results with either technique.

Groin strain is a common complaint, particularly in
soccer players, and we suggest that many of these
patients would benefit from earlier groin exploration
and accurate identification of the pathophysiology. We
believe this to be a tear in the external oblique; in our
small series we have not noted disruption of the
conjoint tendon.

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Wild water rapid burns

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Swimming pool water slides are becoming increasingly
long and adventurous. This case report and survey suggest

that they may carry with them a notable risk of friction
burns.


Keywords: friction; burns; swimming pool