The groin triangle: a patho-anatomical approach to the diagnosis of chronic groin pain in athletes

E C Falvey,1,2 A Franklyn-Miller,2 P R McCrory1

ABSTRACT
Chronic groin pain is a common presentation in sports medicine. It is most often a problem in those sports that involve kicking and twisting movements while running. The morbidity of groin pain should not be underestimated, ranking behind only fracture and anterior cruciate ligament reconstruction in terms of time out of training and play. Due to the insidious onset and course of pathology in the groin region it commonly presents with well-established pathology. Without a clear clinical/pathological diagnosis, the subsequent management of chronic groin pain is difficult. The combination of complex anatomy, variability of presentation and the non-specific nature of the signs and symptoms make the diagnostic process problematic. This paper proposes a novel educational model based on patho-anatomical concepts. Anatomical reference points were selected to form a triangle, which provides the discriminative power to restrict the differential diagnosis and form the basis of ensuing investigation. This paper forms part of a series addressing the morbidities attached to chronic groin pain means it is behind only fracture and joint reconstruction in terms of lost course from injury.4,5

This gives an incomplete portrayal, however, as the morbidity attached to chronic groin pain means it is behind only fracture and joint reconstruction in terms of lost course from injury.4,5

All these sports involve kicking and twisting movements while running. These actions place a strain on fascial and musculoskeletal structures that are fixed to a number of bony anatomical points in close proximity. The resultant tissue damage and/or entrapment of anatomical structures may cause pain.

This paper sets out a method based on patho-anatomical principles for a systematic examination of the chronically painful groin, which enables the clinician to discriminate more easily between pathological conditions and target their investigation and subsequent management to specific diagnoses.

THE GROIN TRIANGLE
The specific anatomical landmarks and borders of the groin triangle are set out in fig 1.

APEX POINTS OF THE GROIN TRIANGLE
The anatomical apex points of the triangle are as follows: the anterior superior iliac spine (ASIS); the pubic tubercle and the 3G (groin, gluteal and greater trochanter triangles) point.

The 3G point
From anthropometric measurements, the authors defined a new reference point at the apex of the triangle. This point was termed the “3G point” in reference to the three-dimensional pathology and the groin, gluteal and greater trochanteric regions. The relationship of this point in the anterior coronal plane was the mid-distance point between the ASIS and the superior pole of the patella, and in the posterior coronal plane double the distance from the spineus process of the L5 lumbar vertebrae to the ischial tuberosity in the line of the femur.

ANATOMICAL RELATIONS OF THE BORDERS OF THE GROIN TRIANGLE
Superior border of the groin triangle
The line between the pubic tubercle and the ASIS forms the superior border of the triangle. This corresponds to the anatomical position of the inguinal ligament, a thickening of the aponeurosis of the external oblique muscle. Superior to this line, working from the pubic tubercle medially to the ASIS laterally the following structures will be encountered: the rectus abdominis and rectus abdominis sheath insertions; internal oblique, external oblique and transversus abdominis insertions and aponeuroses; inguinal canal, medially the superficial inguinal ring and conjoint tendon, more laterally the canal and further laterally the deep inguinal ring; the ilioinguinal, iliohypogastric and genital branch of the genitofemoral nerve; the conjoint tendon of ilio-psosas as it passes under the lateral third of the inguinal ligament; the visceral contents of the abdomen and pelvis.

The insertion of the rectus abdominis and its sheath are intimately related to the aponeuroses of the obliques and transversus abdominis. The junction of where these structures converge at the pubic bone revolves around the inguinal canal. The internal inguinal ring is located at a point between the mid-inguinal point (situated midway between the anterior superior iliac spine and the pubic symphysis) and the midpoint of the inguinal ligament.6 The transversalis fascia and the conjoint tendon, a confluence of internal oblique and transversalis fasciae, form the posterior wall of the canal. The superficial inguinal ring, the opening in the external oblique aponeurosis is situated a
centimetre above and lateral to the pubic tubercle. The anatomy of the ilioinguinal and iliohypogastric and genital branch of the genitofemoral nerves is extremely variable, between them they supply the skin of the lower abdomen, medial thigh and scrotum.\(^7\)

**Medial border of the groin triangle**

The line from the pubic tubercle to the 3G point inferiorly forms the medial border of the triangle. Although neither the medial or lateral borders of the triangle comprise a muscular line, in both instances they work to separate the clinically important “groups” of structures that lie on either side of them. Medial to the border lie the adductor muscles, from superficial to deep—adductor longus, gracilis, adductor brevis, adductor magnus.

The adductor longus and gracilis tendons are the most commonly affected and lie in an almost continuous site of origin along the body of the pubis. The other adductor muscles (brevis and magnus) arise more posterolaterally along the inferior pubic ramus. The ramus forms a direct continuum between the pubic body and the ischial tuberosity. The obturator nerve divides in the obturator canal (2–3 cm long canal situated in the anterosuperior aspect of the obturator foramen containing the obturator nerve, artery and vein) to anterior and posterior divisions. The anterior branch innervates the adductor longus, brevis, gracilis and, occasionally, the pectineus; it supplies sensory innervation to the skin and fascia of the inner distal thirds of the medial thigh.\(^8\)

**Lateral border of triangle**

The line from the ASIS superiorly to the 3G point forms the lateral border of the triangle: femoro-acetabular joint; trochanteric bursa; tensor fasciae latae and iliotibial band.

Although the surface marking of the femoro-acetabular joint lies within the triangle, the pathology of the joint is usually referred to as the greater trochanter, as such it is considered in this section. Gluteal bursae underlie the gluteus maximus and
gluteus medius tendons proximal to their insertions. The iliobial band or tract is a lateral thickening of the fasciae latae in the thigh. Proximally it splits into superficial and deep layers, enclosing tensor fasciae latae and anchoring this muscle to the iliac crest.

Within the triangle

Within the triangle the following structures are encountered: conjoint tendon of the iliofemoral muscle; rectus femoris muscle; femoral canal.

The iliacus arises as a series of slips, each of which arise from the adjacent margins of the vertebral bodies and the intervening discs from the lower border of T12 to the upper border of L5. The iliacus arises from the upper two-thirds of the concavity of the iliac fossa and the inner lip of the iliac crest, as well as the ventral sacro-ilac and iliolumbar ligaments and the upper surface of the lateral part of the sacrum. The two muscles converge and pass downwards and medially beneath the iliac spine and a reflected head arising from the superior acetabular rim and joint capsule. The femoral ring is the base of the femoral canal. Its surface marking is medial to the femoral artery, palpable at the mid-inguinal point. The femoral ring is bounded in front by the inguinal ligament, behind by the pectineus, medially by the crescentic base of the lacunar ligament and laterally by the fibrous septum on the medial side of the femoral vein.

Nerve entrapment

The classic distribution of the cutaneous innervation of the area incorporated in the triangle and their potential neuropathies is shown in fig 2; these, however, must serve as a guide only, as in vivo considerable variation occurs. The clinician will appreciate that in addition to paresis, a compressed nerve can give rise to pain. The additional possibility of referred or radicular pain from T12, L1, L2 and L3 must also be considered.

Table 1: Patho-anatomical approach: pubic tubercle region (diagnoses appear in order of frequency in an athletic population)

<table>
<thead>
<tr>
<th>Define and align</th>
<th>Pathology</th>
<th>Listen and localise</th>
<th>Palpate and re-create</th>
<th>Alleviate and investigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pubic tubercle</td>
<td>Adductor tendon enthesopathy</td>
<td>Insidious onset, warms up with exercise</td>
<td>Guarding on passive abduction, weakness</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Rectus abdominis enthesopathy</td>
<td>Well localised to insertion, acute or insidious onset</td>
<td>Pain from resisted sit-up, &quot;pubic &quot;clock&quot;: 6–8</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Pubic bone stress injury</td>
<td>Non-specific diminished athletic performance, loss of propulsive power</td>
<td>Bone tenderness predominates</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Degenerative pubic symphysis</td>
<td>Central pain, associated with stress through symphysis—stair climbing</td>
<td>Diagnosis of exclusion</td>
<td>Plain film, magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Incipient hernia; conjoint tendon tear</td>
<td>Insidious onset, diminished performance, warms up</td>
<td>Tender on symphysis. Pubic “clock”: 3</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Incipient hernia; external oblique aponeurosis tear</td>
<td>Acute onset, related to sport-specific movement eg, “slap shot”</td>
<td>Pain on resisted “torsion” of trunk “ipsilateral direction”. “Pubic “clock”: 11</td>
<td>Ultrasound</td>
</tr>
<tr>
<td></td>
<td>Nerve entrapment; ilioinguinal nerve</td>
<td></td>
<td>Tenderness and dilation of superficial inguinal ring on invagination of scrotum</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Genitofemoral nerve (genital branch)</td>
<td>Altered skin sensation</td>
<td>Superficial pain with or without hyper/dysaesthesia to skin over pubis</td>
<td>Relief of pain by ultrasound-guided local anaesthetic infiltration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post inguinal surgery</td>
<td>Absence of muscular component</td>
<td>Nerve conduction studies</td>
</tr>
</tbody>
</table>

Table 2: Patho-anatomical approach: medial to the groin triangle (diagnoses appear in order of frequency in an athletic population)

<table>
<thead>
<tr>
<th>Define and align</th>
<th>Pathology</th>
<th>Listen and localise</th>
<th>Palpate and re-create</th>
<th>Alleviate and investigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medial to triangle</td>
<td>Adductor/gracilis enthesopathy</td>
<td>Insidious onset, diminished performance, warms up</td>
<td>Proximal adductor pain, at enthesis. Guarding, weakness</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Adductor longus pathology at musculotendinous junction</td>
<td>Acute onset, worse during exercise</td>
<td>Pain in proximal adductor (2–4 cm distal to enthesis), guarding, weakness</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Pubic bone stress injury</td>
<td>Pain primarily at pubis radiating to proximal thigh</td>
<td>Bone tenderness, lack of point muscular tenderness</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Stress fracture inferior pubic ramus</td>
<td>Insidious onset, heavy training load pain</td>
<td>Hip test, associated deep buttock pain</td>
<td>Plain x ray, magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Nerve entrapment</td>
<td>Claudicant-type pain of medial thigh, which settles on resting</td>
<td>Exercise-related adductor weakness, superficial dysaesthesia of mid-medial thigh</td>
<td>Electromyography of adductor longus</td>
</tr>
<tr>
<td>I. Obturator nerve</td>
<td></td>
<td></td>
<td></td>
<td>Guided local anaesthetic injection to obturator foramen</td>
</tr>
<tr>
<td>II. Ilioinguinal nerve</td>
<td>Altered skin sensation</td>
<td></td>
<td>Dysesthesia/hyperaesthesia over area of skin supplied by nerve in question</td>
<td>Relief of pain by ultrasound-guided local anaesthetic infiltration</td>
</tr>
<tr>
<td>III. Genitofemoral nerve (genital branch)</td>
<td>Post inguinal surgery?</td>
<td></td>
<td>Exercise-related lower limb weakness, exercise-altered gait/brachial index</td>
<td>Nerve conduction studies</td>
</tr>
<tr>
<td>External iliac artery endofibrosis</td>
<td>Thigh discomfort post high-intensity exercise mainly in cyclists</td>
<td></td>
<td></td>
<td>Doppler ultrasound</td>
</tr>
</tbody>
</table>

...
A PATHO-ANATOMICAL APPROACH USING THE GROIN TRIANGLE

The diagnostic process of history and examination is often abbreviated. There is a growing tendency to rely on investigational studies as the initial diagnostic step (eg, proceeding to magnetic resonance imaging of a painful groin in the absence of a clear differential diagnosis). The authors propose a four-step approach to the diagnostic process emphasising history and examination and limiting investigation to the final step as follows.

Step 1: define and align
Define the anatomical points and borders of the triangle on the patient (ASIS, pubic tubercle and 3G point).

Step 2: listen and localise
Listen to the patient’s history and obtain as many localising factors as possible, then pinpoint the pain in relation to the groin triangle.

Step 3: palpate and re-create
Carefully palpate the identified area and determine which anatomical structures are painful. The use of provocative manoeuvres/examinations (eg, exercise) to re-create the patient’s pain can be a critical diagnostic step. To describe all of the manoeuvres in detail is beyond the scope of this text; readers are referred to reviews on this topic.

Step 4: alleviate and investigate
When a number of anatomical structures are in close proximity, clinical presentations can be very similar. The manner in which pain can be removed may be very helpful. A decrease in pain following abstinence from aggravating activity is revealing. If a distinct structure can be identified, the elimination of symptoms following guided injection of local anaesthetic into the structure is invaluable. The authors recognise that a number of conditions discussed in this text may only be diagnosed definitively following radiological investigation; in these instances the most discriminative, evidence-based investigation is recommended.

Table 3 Patho-anatomical approach: superior to the groin triangle (diagnoses appear in order of frequency in an athletic population)

<table>
<thead>
<tr>
<th>Define and align</th>
<th>Pathology</th>
<th>Listen and localise</th>
<th>Palpate and re-create</th>
<th>Alleviate and investigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior to base</td>
<td>Rectus abdominis tendinopathy</td>
<td>Well localised to insertion, acute or insidious onset</td>
<td>Pain from resisted sit-up; pubic “clock”: 12</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Incipient hernia; conjoint tendon tear</td>
<td>Insidious onset, diminished performance, warms up</td>
<td>Pain on resisted “torsion” of trunk “ipsilateral direction”; pubic “clock”: 11</td>
<td>Ultrasound</td>
</tr>
<tr>
<td></td>
<td>Incipient hernia; external oblique aponeurosis tear</td>
<td>Acute onset, related to sport-specific movement, eg, “slap shot”</td>
<td>Pain on resisted “torsion” of trunk “contralateral direction”</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Inguinal hernia</td>
<td></td>
<td>Tenderness and dilation of superficial inguinal ring on invagination of scrotum</td>
<td>Confirmation by direct vision at arthroscopy</td>
</tr>
<tr>
<td></td>
<td>Nerve entrapment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ilioinguinal nerve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Iliohypogastric nerve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Genitofemoral nerve (genital branch)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lateral femoral cutaneous nerve</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specific Scenarios Using a Problem-Oriented Approach

The diagnostic stepwise approach using the groin triangle is summarised in tables 1–5. The triangle is used to localise the pathology to a particular area. We refer the reader to the specific table relating to that border of the triangle. This provides a differential diagnosis and clarifies the most discriminative evidence-based tests.

Table 4 Patho-anatomical approach: lateral to the groin triangle (diagnoses appear in order of frequency in an athletic population)

<table>
<thead>
<tr>
<th>Define and align</th>
<th>Pathology</th>
<th>Listen and localise</th>
<th>Palpate and re-create</th>
<th>Alleviate and investigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral to triangle</td>
<td>Impingement/labral pathology, femoro-acetabular joint</td>
<td>Mechanical signs, clicking in joint and/or catching</td>
<td>Impingement test</td>
<td>Magnetic resonance imaging, arthrography</td>
</tr>
<tr>
<td></td>
<td>Osteoarthritis/chondral damage, femoro-acetabular joint</td>
<td>History of traumatic/congenital insult, older age group</td>
<td>Limited range of movement, pain on weight bearing</td>
<td>Plain film x-ray, magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Iliotibial band friction syndrome</td>
<td>Persistent lateral hip pain worse on lying on affected side</td>
<td>Pain on transition between lying/standing</td>
<td>Ultrasound</td>
</tr>
<tr>
<td></td>
<td>Stress fracture neck of femur</td>
<td></td>
<td></td>
<td>Relief of pain by ultrasound-guided local anaesthetic infiltration</td>
</tr>
<tr>
<td></td>
<td>Nerve entrapment; lateral cutaneous femoral nerve/meralgia paraesthetica</td>
<td>External “snapping” and/or lateral knee pain</td>
<td>Re-create snapping</td>
<td>Ultrasound</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heavy training load, biomechanical/gait abnormality</td>
<td>Ober’s test</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exercise induced, obesity</td>
<td>Hop test, fulcrum test</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reproduction of symptoms on pressure inferior to anterior superior iliac spine</td>
<td></td>
</tr>
</tbody>
</table>

216
**Table 5** Patho-anatomical approach: within the groin triangle (diagnoses appear in order of frequency in an athletic population)

<table>
<thead>
<tr>
<th>Define and align</th>
<th>Pathology</th>
<th>Listen and localise</th>
<th>Palpate and re-create</th>
<th>Alleviate and investigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the triangle</td>
<td>Iliopsoas syndrome</td>
<td>Pain above and below inguinal ligament—associated snapping at hip joint</td>
<td>Thomas test, modified⁷</td>
<td>Ultrasound scan dynamic view of snapping⁵ with or without injection¹⁰</td>
</tr>
<tr>
<td></td>
<td>Rectus femoris tendinopathy/ apophysitis</td>
<td>Does knee movement affect pain?</td>
<td>Rectus femoris contracture test⁶⁶⁶⁶</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Femoral hemia</td>
<td>Painful lump interomedial to pubic tubercle</td>
<td>Minimal relationship to exercise</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td></td>
<td>Nerve entrapment</td>
<td>Altered skin sensation</td>
<td>Dysesthesia/hyperesthesia over area of skin supplied by nerve in question⁴</td>
<td>Ultrasound scan¹¹</td>
</tr>
<tr>
<td></td>
<td>Genitofemoral nerve ( femoral branch)</td>
<td></td>
<td>Relief of pain by local anaesthetic infiltration⁶</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medial femoral cutaneous nerve</td>
<td></td>
<td>Nerve conduction studies⁷</td>
<td></td>
</tr>
</tbody>
</table>

**PUBIC TUBERCLE**

Because many potentially anatomical structures converge at this point, we propose a marking of the structure in similar fashion to a clock face (fig 3, table 1). This schematic representation of the anatomy of the area serves as a guide to what may be palpable following invagination of the scrotum. The examining clinician can therefore “walk their finger” around the tubercle assigning each part of the clock face to the relevant attachment as highlighted in fig 3. The authors recognise the variability of structures in this area, having based diagrams on cadaveric studies performed prior to this paper.⁵⁵ We have employed the term “pubic bone stress injury” for what is often in the literature called “osteitis pubis”. We feel this is a better reflection of the clinical picture in the absence of any evidence of an inflammatory process.

The topic of incipient hernia is included as disorders of the posterior and anterior inguinal walls. These are diagnoses of exclusion and, outside of the most experienced hands, probably inseparable. These may represent different ends of a spectrum of pathology in the area as a result of differing sporting activity.⁴⁴ ²² ⁵⁶ ⁵⁷

**MEDIAL TO THE TRIANGLE**

Adductor longus pathology is the most common cause of pain in this area; differentiation of enthesis-related problems from those at the musculotendinous junction is important. The abnormal mechanics that arise as a result of adductor dysfunction play a critical role in the generation of a chronic pain/dysfunction cycle in the area (fig 4, table 2).

**SUPERIOR TO THE TRIANGLE**

Rectus abdominis pathology tends to be well localised to its insertion at the pubic tubercle, often making it the most clearcut diagnosis in this area. This may arise as a primary diagnosis, or develop secondary to pubic overload originating from adductor or iliopsoas pathology (fig 5, table 3).

**LATERAL TO THE TRIANGLE**

As a cause of recalcitrant groin pain, pathology of the femoroacetabular joint should not be underestimated. The joint is prone to degenerative, inflammatory and infective processes. The long-term contribution of acute or repetitive trauma to the...
development of degenerative conditions such as osteoarthritis is of particular concern in the sports setting (fig 6, table 4).

WITHIN THE TRIANGLE

Pathology of the iliopsoas muscle may cause pain that is referred in the area superior to the triangle, but the conjoint tendon is the most palpable structure within the triangle when the hip is flexed. This is a common, although underdiagnosed, cause of groin pain.\(^5^\) It is particularly prone to irritation when over-loaded secondary to dysfunction of other muscular structures around the groin, such as the adductors (fig 7, table 5).

INTRA-ABDOMINAL PATHOLOGY

Discussion of this topic is beyond the scope of this paper; gastrointestinal and genitourinary pathology may mask as groin discomfort or pain. Key discriminating symptoms may be signs of systemic illness, systemic inflammatory response and no

**Figure 4** Medial to the triangle. AB, adductor brevis; AL, adductor longus; AM, adductor magnus; Gr, gracilis; S, sartorius.

**Figure 5** Superior to the triangle.

**Figure 6** Lateral to the triangle. RF, rectus femoris; TFL, tensor fasciae latae; VL, vastus lateralis.
Experience and a thorough knowledge of the anatomy of the region remain vital in any complete understanding of groin pain. By providing a means of focusing the differential diagnosis in a structured manner, practitioners who lack expertise may approach this problem with more confidence.

Competing interests: None.

REFERENCES
Occasional piece


