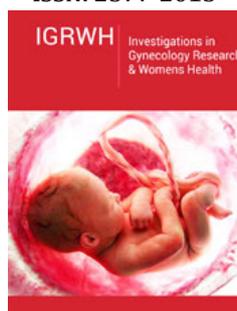


Abdominal Stress in Performance Athletes: What is the Cure?

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Introduction

Currently maybe in positive perspective maybe in negative perspectives stress has been affecting our lives in many creational fields for sure. Changing from different atmospheres in life both in sports arena and in the daily life activities which has been in the growing changing probability from the moments that people are living, sports people have always been suffering from stress in many various types. Stress definitely causes changes in body both in gastrointestinal and physical ways. One of the most common pains which is caused by stress is abdominal stress. Abdominal stress can cause some defects in body. Abdominal stress is frequently known for athletic pubalgia. Athletic pubalgia, also called sports hernia, core injury, hockey hernia, hockey groin, Gilmore's groin, or groin disruption is a medical condition of the pubic joint affecting athletes [1]. Actually, athletic pubalgia is seen as an important cause of lower abdominal or groin pain in high-performance athletes. Many sports people, team physicians and trainers which are diagnosed earlier, and many high-level athletes continue their careers as possible as they can. For the most part, there has been considerable progress. However, some misunderstanding remains in minds. Clearly, more surgeons perform predictably unsuccessful operations. It is important that underappreciated causes of chronic pain that also afflict these athletes must be also considered in this aspect. This article reviews some of our current understanding of these abdominal stress pain and treatment modalities.

Methods

Certainly, athletic pubalgia is the most common fixable problem that is seen, but it's hard to diagnose. The syndrome is mostly common in high-performance athletes. Unfortunately, most of these athletes who are experiencing this problem face an end to their career because of the lower abdominal and groin pain. The pain progresses over months to years and involves the adductor longus tendons and then the contralateral inguinal or adductor regions. Most patients remember a distinct injury during exertion. Usually, the abdominal pain involves the inguinal canal near the insertion of the rectus muscle onto the pubis. Generally, the diagnosis is empiric [2]. In general, the pain is Chronic Lower Abdominal and Groin Pain in High-performance Athletes minimal at rest and begins unilaterally, but becomes bilateral within months or years if the injury is untreated [2]. Two thirds of the patients describe the pain with adduction of the hip, which can occasionally be more prominent than the abdominal findings. The pain may also be fleeting, appearing and disappearing on one or the other side or involve both abdominal and adductor components. Fewer than 25% of patients have significant symptoms attributable to the posterior perineum [3]. Interestingly, involvement of the posterior perineum is associated with a decreased likelihood of successful repair. When examining a patient who are suspected of having athletic pubalgia, the physical examination must be directed to get key findings. Most patients exhibit pain with adduction of the hip

against resistance and pain with resisted sit up. Twenty-five percent of patients have pubic or peripubic tenderness. One third has some degree of subjective tenderness along the adductor tendons near the pubis [4]. Superior inguinal or real abdominal tenderness is uncommon. By definition, no patients have hernias. Positive traps as findings that might mistakenly dissuade someone from making the diagnosis and negative traps as findings that probably should dissuade one from making the diagnosis [2]. Probably the most common positive trap is the MRI or bone scan finding of osteitis pubis. When the first activity started doing pelvic floor repairs in the late 1980s, operating on anyone with an MRI or bone scan diagnosis of osteitis is avoided [5]. After first report is published, a Swedish group reproduced the results and told that they had operated on similar patients but with MRI-diagnosed osteitis and obtained similar success [2].

Result

The patients who did well with pelvic floor repairs showed some treatment results. Perhaps the second most common positive trap is the absence of MRI findings is the issue that patients are suffering from the abdominal pain in regular standards. In fact, the vast majority of patients that have been operated do not exhibit MRI findings of rectus muscle disruption. But the fact remains that most patients do well with pelvic floor repair in the absence of definitive MRI findings [6]. When it is looked upon the MRIs of a large number of patients with this syndrome, only 12% had MRI findings that clearly indicated a problem at the rectus insertion site. The relatively small incidence of a specific diagnosis by imaging studies suggests that the problem may be an attenuation of the muscle or tendon due to repeated microtrauma which affects most of the athletes [7]. Nonspecific MRI findings, on the other hand, occur frequently. Openly, the nonspecific findings include focal osteitis and nonspecific abdominal wall, perineal or adductor findings. The findings strikingly also include asymmetry, distinct inflammation, cortical irregularity, distinct fluid accumulation, irregularity of the rectus abdominis, atrophic changes, small pelvic avulsion fractures or disruption of the pectineus muscle. The latter observation reinforced the perspective that the actual problem is the instability of a complex joint [8].

The most common negative trap is pain that is resulted being without exertion. A certain amount of mild discomfort at rest can be felt, but severe pain in the absence of exertion is a tip off that the patient probably does not have the diagnosis of athletic pubalgia. If it becomes chronic, the pain begins to interfere with some activities of daily living [8]. Some of the pain may persist after exercise, but almost never is the pain particularly serious at rest. The second most common negative trap is lateral pain in the inguinal region that is felt in this stream. If the pain is clearly lateral to the adductors, it should be understood that intrinsic hip disease or a variety of other pelvic disorders are on the way. The third negative trap is true testicular or epididymal pain which are extremely serious. Upper scrotal pain can be in the distribution of the ilioinguinal nerve that is easily be involved in the inflammatory process. The inevitable

pain and tenderness along the lateral edge of the pubic symphysis is consistent with this problem, but true testicular or epididymal pain generally is not. The other serious pain which is felt with sexual activity is consistent with the syndrome as long as simple exertion causes the pain; pain with ejaculation only is not consistent with the syndrome. The final negative trap is the finding of cyclical pain in women athletes. If this case continues, endometriosis should be considered.

Discussion

Abdominal stress is a syndrome characterized by chronic groin pain in athletes and it affects them both internal as well as external. Football and ice hockey players are affected most frequently from this syndrome. Also, recreational and professional athletes may be affected. When it is looked upon the treatment ways conservative therapies (gentle stretching and a short period of rest) may temporarily ease and decrease the pain, but definitive treatment is needed as surgical repair which should be followed by a structured rehabilitation. Another solution for this problem can be sleeping in a prone position with the hip on the affected side flexed and externally rotated can be a cure in some individuals. Pain can also be eased with the patient in a "frog position", in which the patient is supine with knees bent and heels together.

The Cooper's ligament or McVay repair for inguinal hernia seems more likely to treat the problem, but also may unnecessarily stretch the anterior abdominal musculature down to the more posterior attachments of the pelvis. Therefore, this operation may not provide optimal anterior stabilization [2] The inconsistent results with the McVay approach; thus, it is recommended performing a rectus reattachment and adductor release to treat athletic pubalgia. To eliminate the stress in the abdominal is to restrict the consumption of large volumes of food and drink which should be avoided at least 2 hours before exercise. Possibly 3-4 hours for those consumption is more preferable. During exercise, small sips but regular volumes of fluid might be better taken. Hypertonic beverages should be avoided in this perspective. Morton and Callister suggest that taking deep breathes (40%), pushing on the affected area (31%), stretching the affected site (22%) and bending over forward can be helpful too to lower the abdominal pain in this aspect.

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