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Assessing Groin Hernias

Groin pain and suspected inguinal hernias are common presentations in general practice. However, diagnosis and referral have become increasingly complex. Advances in imaging, evolving surgical thresholds, growing recognition of chronic post-operative pain, and medico-legal pressures have transformed what was once considered a largely clinical diagnosis. This article explores key controversies facing GPs when assessing suspected groin hernias, with particular emphasis on patients with pain but no lump, imaging dilemmas, conservative measures, "sports hernias," referral timing, and medico-legal considerations.

1. Groin Pain but No Lump

Traditionally, an inguinal hernia has been defined by the presence of a palpable or visible groin bulge with a cough impulse. Increasingly, however, GPs encounter patients with groin pain in the absence of a lump, creating significant diagnostic uncertainty.

Common mimics of inguinal hernia

- Musculoskeletal strain or tendinopathy
- Hip pathology (e.g. osteoarthritis, labral disease)
- Inguinal lymphadenopathy
- Femoral hernia (particularly in women)
- "Sports hernia" / inguinal disruption

Pain without a lump raises an important clinical question: is this an early or occult hernia, or an alternative pathology?

From a surgical perspective, there is understandable reluctance to operate without a clear anatomical defect. Several studies demonstrate that pain alone is a poor predictor of a surgically correctable inguinal hernia, and operative exploration in such cases carries an increased risk of chronic post-operative pain without symptom resolution (1,2).

For GPs, this reinforces the importance of:

- Careful musculoskeletal and hip examination
- Awareness of femoral hernia risk, particularly in women
- Avoiding premature "hernia labelling" when no lump is present

2. Ultrasound-Confirmed Hernias

Ultrasound (USS) has become the most commonly requested investigation for suspected groin hernia, particularly when examination findings are equivocal.

Areas of controversy

- Groin ultrasound is highly operator-dependent
- False-positive rates are significant, especially for small "fat-containing" hernias
- Poor correlation exists between USS findings and intra-operative anatomy in asymptomatic or minimally symptomatic patients (3)

Many hernia specialists argue that ultrasound should not override clinical assessment. Nonetheless, GPs often feel compelled to request imaging to support referrals or reassure patients.

A frequent clinical dilemma arises when an ultrasound reports a "small inguinal hernia," yet no lump is palpable and symptoms are non-specific. Surgeons may decline operative intervention in such cases, leading to patient frustration and return to the referring GP for further explanation.

3. Dynamic MRI

Dynamic MRI provides superior soft-tissue resolution and can identify subtle abdominal wall defects during a Valsalva manoeuvre.

Advantages

- Greater sensitivity for occult hernias
- Ability to identify non-hernia causes of groin pain (e.g. adductor pathology, rectus abdominis injury)

Limitations

- High cost
- Limited availability
- Rarely alters management when no clear hernia is identified (4)

Current evidence suggests that dynamic MRI is most useful for excluding hernia and identifying alternative diagnoses, rather than confirming a surgically actionable lesion. Its role in routine GP assessment therefore remains limited and should be selective.

4. Hernia Trusses and Supports

Hernia trusses were historically used as a conservative measure, particularly in patients deemed unfit for surgery.

Current evidence indicates:

- No robust evidence that trusses reduce the risk of incarceration or strangulation
- Poor tolerance, with risks of discomfort and skin breakdown
- Potential for false reassurance, leading to delayed presentation (5)

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Most contemporary hernia guidelines discourage routine truss use, except in exceptional circumstances where surgery is contraindicated and symptoms are minimal. For GPs, managing patient expectations can be challenging, as some patients believe trusses prevent complications.

5. "Sports Hernias"

The term "sports hernia" is a misnomer, as there is no true hernia. Preferred terminology includes:

- Inguinal disruption
- Athletic pubalgia

Pathophysiology

- Imbalance between abdominal and adductor forces
- Microtears of the posterior inguinal wall
- Typically no palpable hernia

Clinical considerations

- A detailed sporting and activity history is essential

Management controversy

- First-line treatment is physiotherapy, focusing on core stability and adductor strengthening
- Surgery is reserved for refractory cases following structured rehabilitation (6)

Misdiagnosis as an inguinal hernia can lead to inappropriate surgical referral and poor outcomes.

6. When to Refer?

Clear indications for referral

- Symptomatic hernias
- Increasing hernia size
- Features suggestive of incarceration or strangulation

Grey areas

- Asymptomatic hernias
- Very small hernias
- Pain without a demonstrable lump

Public patients

Public hospital waiting lists for hernia repair often exceed one year. Large randomised trials confirm low complication rates for asymptomatic or minimally symptomatic inguinal hernias managed with watchful waiting (7). Early referral may nonetheless be justified in public patients due to anticipated delays. GPs must balance evidence-based conservatism with patient anxiety and system realities.

7. Referral Urgency

Emergency referral

- Irreducible and tender hernia
- Symptoms of bowel obstruction

Patients with intermittent reducibility or episodic pain or obstructive symptoms remain diagnostically challenging and require careful safety-netting and follow-up.

8. Medico-Legal Risk

From a medico-legal perspective, inguinal hernias present a paradox:

- Watchful waiting is evidence-based
- Fear of missing strangulation encourages defensive referral

Contributing factors include:

- Variable surgical acceptance criteria
- Inconsistent imaging reports
- Patient expectations
- Prolonged surgical waiting lists

Clear documentation of:

- Clinical findings
- Shared decision-making
- Safety-netting advice is essential to mitigate medico-legal risk.

Conclusion

Assessing suspected groin hernias in general practice requires navigating diagnostic uncertainty, evolving evidence, and system pressures. While clinical examination remains central, imaging and referral decisions must be individualised. Recognising common mimics, avoiding over-reliance on ultrasound, and engaging patients in shared decision-making are key to safe, effective care and reduction of medico-legal risk.

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