

CULPRIT OR VICTIM? RECONSIDERING THE ROLE OF THE PELVIC FLOOR IN ATHLETIC HIP AND GROIN PAIN

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INTRODUCTION

Hip and groin pain remain one of the most prevalent and treatment-resistant presentations in athletic populations², with assessment and management in the past 10 years guided by the landmark Doha Agreement³. The Doha agreement, informed by the available evidence and expert consensus⁴, serves as a roadmap for clinicians to systematically assess, investigate, and manage athletes with hip and groin pain.

In a recent editorial, Cooke and colleagues⁵ drew attention to a structure that has been largely absent from the guiding framework of the Doha agreement: the pelvic floor. Their observations that i) the pelvic floor is anatomically proximate to the structures implicated in groin pain, ii) pelvic floor dysfunction (PFD) is prevalent in athletic populations, and iii) PFD is systematically underassessed reflect a clinical reality

that many practitioners working in sports medicine have encountered without having the awareness, language, or framework to act upon it. Supporting this, new insights from Cunningham et al (2026)⁶ highlight that over 40% of female Australian rules footballers and Super Netballers experience self-reported urinary incontinence and that urinary incontinence was associated with hip and groin pain (OR = 2.66, 95% CI [1.03, 6.86], $p < 0.05$).

The question this paper asks is the one that follows naturally: when the pelvic floor is involved in hip and groin pain in athletes, what is it actually doing? Is it, in the language of clinical reasoning, the culprit or the victim?

This is not a trivial distinction. In some athletes, PFD may act as a precipitating factor: the primary driver of symptoms referring to the pubic ring or inguinal canal region that satisfy the criteria for a Doha clinical entity diagnosis even though it is

mechanistically driven by the pelvic floor. Treating the entity without identifying and addressing the pelvic floor contribution in these athletes may result in incomplete resolution of symptoms. In others, PFD may emerge as a perpetuating factor, i.e. not the origin of the problem, but a consequence of the injury, pain inhibition, and altered loading mechanics that accompany it.

Despite its landmark contribution to clinical taxonomy, the Doha Agreement³ provides no mechanism for determining whether, and in what capacity, the pelvic floor is involved in hip and groin pain presentations. The clinical examination framework proposed by Thorborg and colleagues⁴ and incorporated into the Doha Agreement does not include a pelvic floor screen. Similarly, the Hip and Groin Outcome Score⁷ (HAGOS), a validated patient-reported outcome measure designed specifically for athletes with groin pain, does not capture

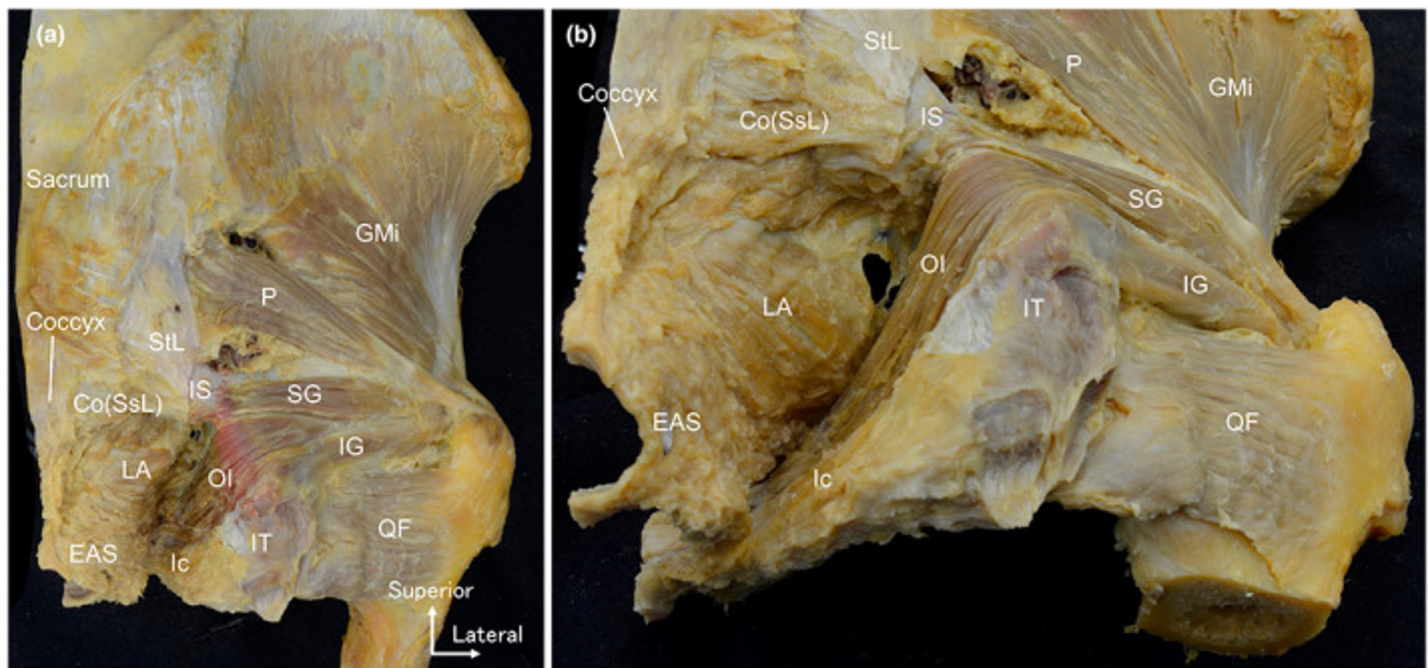


Figure 1: The levator ani and obturator internus located medial and lateral to the ischioanal fossa. (a) A female hemipelvis as seen from the posterior aspect. The rotator muscles of the hip joint and pelvic floor muscles were both observed. (b) Posteroinferior aspect. The obturator internus and levator ani are relative to each other through the ischioanal fossa. Co, coccygeus; EAS, external anal sphincter; GMi, gluteus minimus; Ic, ischiocavernosus; IG, inferior gemellus muscle; IS, ischial spine; IT, ischial tuberosity; LA, levator ani; OI, obturator internus; P, piriformis; QF, quadratus femoris muscle; SG, superior gemellus muscle; SsL, sacrospinous ligament; StL, sacrotuberous ligament.

Figure reproduced with permission under an open access Creative Commons license from: Muro et al. (2022) Anatomical basis for contribution of hip joint motion by the obturator internus to defaecation/urinary functions by the levator ani via the obturator fascia. *J Anat.* 2023 Apr;242(4):657-665. doi: 10.1111/joa.13810.

pelvic floor, urinary, faecal, sexual, or pelvic pressure symptom domains. Conversely, one of the few pelvic floor symptom outcome measures validated in a population with hip pain was done so in individuals with osteoarthritis rather than athletes with groin pain⁵.

A recently proposed Pelvic Health Clinical Reasoning Model (PHCRM)⁸ explicitly differentiates central, regional, and local mechanisms contributing to pelvic health presentations, and uses clinical reasoning to determine which mechanism predominates before treatment selection. Importantly, the model conceptualises the presenting condition as dynamic and responsive to management, rather than fixed at the point of diagnosis. Integrating pelvic health clinical reasoning with existing literature that recognises the pelvic floor as a legitimate contributor to athletic hip and groin pain may therefore strengthen a whole-systems approach to assessment and management^{9,10}.

Building on the call to “Ask, Assess and Action” by Cooke and colleagues⁵, this clinical commentary proposes a framework

for recognising the role that the pelvic floor may play in hip and groin pain. Rather than simply identifying the presence or absence of pelvic floor involvement, the proposed framework aims to help clinicians consider underlying mechanisms and determine whether the pelvic floor is acting as a culprit (primary driver), a victim (secondary consequence), or an unrelated finding.

THE CULPRIT: PELVIC FLOOR DYSFUNCTION AS THE DRIVER OF GROIN PAIN

The Doha agreement³ classifies groin pain according to the anatomical structure considered to be driving symptoms, including adductor-, iliopsoas-, inguinal-, and pubic-related groin pain. The culprit hypothesis proposes that PFD is not merely a secondary consequence of hip or groin pain, but may instead act as a primary driver of symptoms or, at minimum, an independent contributor operating alongside an initial injury that may have since resolved.

Pain distribution and referral patterns are commonly used to infer the symptomatic structure. However, this approach is particularly challenging in hip and groin

pain because of the close anatomical proximity of regional structures and the substantial overlap in pain distributions, as demonstrated by Serner et al (2022)¹¹. When considered alongside known pelvic floor pain referral patterns¹² this overlap raises questions about the validity of relying on pain distribution as a defining criterion for each clinical entity. It also creates potential for PFD to be overlooked.

In postpartum athletes, childbirth-related trauma may also contribute to hip or groin pain. Birth history should therefore be discussed and explored as part of the athlete’s past medical history¹³. Significant birth-related injury, such as levator ani avulsion and other forms of active or passive tissue trauma, may compromise the structural integrity and load capacity of the pelvic floor¹⁴. By association, this may impair pelvic load transfer at the pelvis and contribute to persistent or recurrent hip or groin symptoms.

When considering the pelvic floor as a primary symptom driver of athletic hip or groin pain, three anatomical arguments provide tentative support for this hypothesis.

1. The obturator internus:

In its extra-pelvic role, the obturator internus functions primarily as a hip external rotator. Its intra-pelvic portion lies along the lateral wall of the pelvis, in close proximity to the pudendal nerve and levator ani. It originates from the internal surface of the obturator foramen, exits the pelvis through the lesser sciatic foramen, and then bends approximately 90° to attach to the greater trochanter of the femur^{15,16}. This anatomical course means that the obturator internus does not observe a clear physical boundary between its extra-pelvic function as a hip external rotator and its intra-pelvic role as an accessory pelvic floor structure; rather, these roles are continuous within the same anatomical structure (see Figure 1).

Although the mechanisms by which the obturator internus may influence pelvic floor function remain poorly understood, dysfunction of this muscle is increasingly hypothesised to be clinically relevant in both PFD¹⁷ and posterior hip instability¹⁸. For example, athletes presenting with posterior hip pain and deep groin symptoms may demonstrate positive findings on hip examination^{19–21} such as restricted internal rotation, a positive FADIR test, and deep posterior buttock tenderness, while also reporting pelvic floor symptoms during the subjective history, including pelvic pain with sitting, dyspareunia, and pelvic pressure.

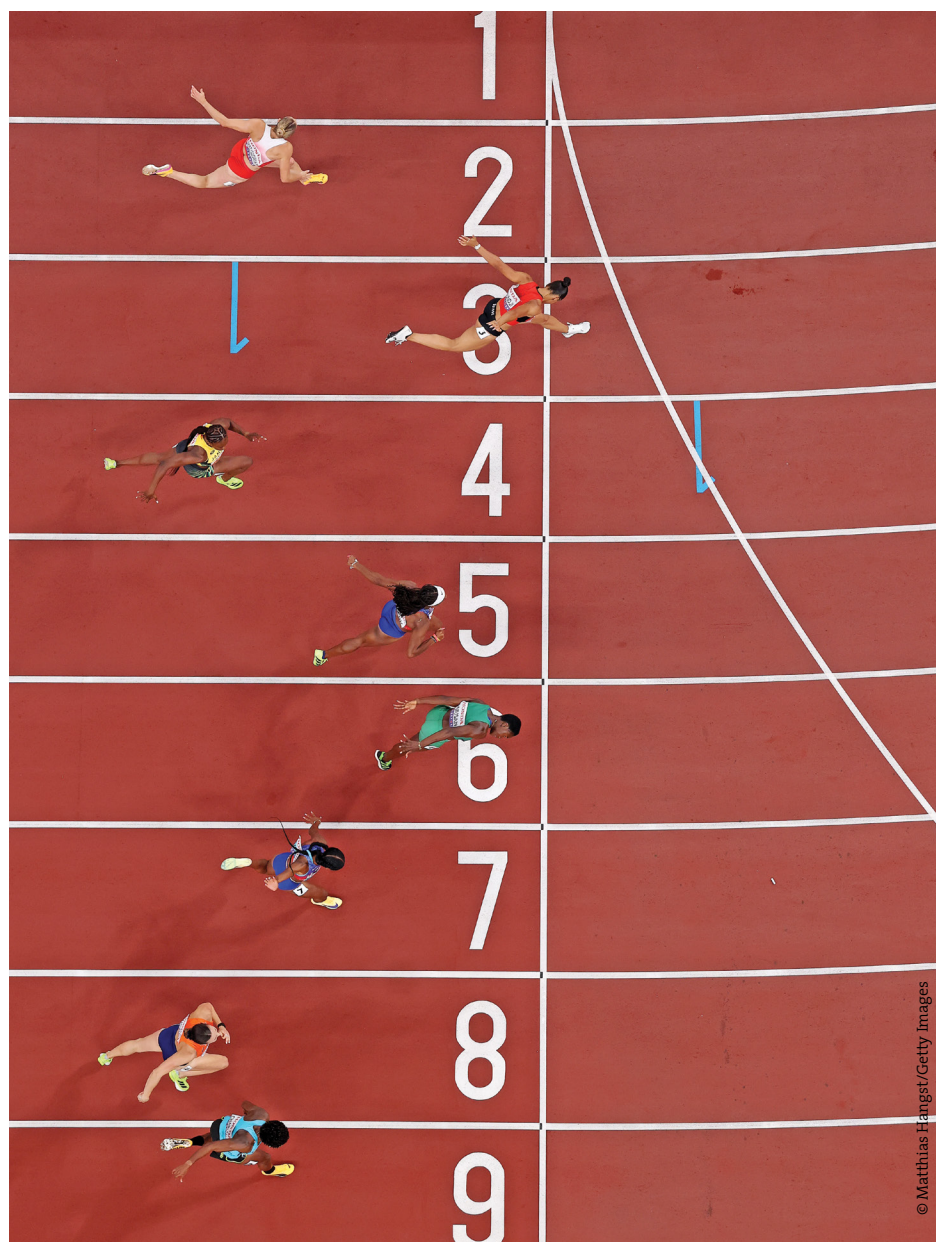
2. The PLAC–perineal membrane continuum

The pyramidalis–anterior pubic ligament, adductor longus complex (PLAC) is well established as the convergence zone for anterior pelvic musculotendinous structures, including the adductor longus, rectus abdominis, pyramidalis, external oblique, and the pubic ligaments^{22–24}. Its clinical relevance for adductor-related and pubic-related groin pain has been described by Schilders and colleagues^{23,24}. In addition, sex-specific morphological differences have been reported, including a direct medial rectus abdominis insertion onto the antero-superior pubic symphysis in female cadavers, in contrast to the recto-gracilis extension seen in males. These differences may partially explain distinct presentations of pubic-related pain in women, particularly given that much of the literature underpinning the Doha clinical entities is derived from predominantly male cohorts²².

What has not been clearly articulated in the groin pain literature is that one structural component of the PLAC: the inferior pubic ligament, also known as the arcuate pubic ligament, may provide a potential anatomical bridge between the anterior pubis and the pelvic floor. The inferior pubic ligament forms the inferior border of the pubic symphysis, blends with the fibrocartilaginous interpubic disc, and, in males, serves as the anterior bony anchor of the perineal membrane²⁵. In females, the perineal membrane is more complex, with distinct dorsal and ventral components^{26,27}. The dorsal aspect consists of transverse fibrous sheets that serve to attach the

lateral vaginal wall and levator ani to the ischiopubic ramus, whereas the ventral aspect is not a sheet-like structure but a three-dimensional fused mass comprising the perineal membrane, portions of the urethra, and the anterior vaginal wall, with lateral attachments to the ventral two-thirds of the ischiopubic rami^{9,28}. The levator ani muscles directly attach to the cranial surface of the perineal membrane and body^{26,28}.

Taken together, these anatomical relationships may create a direct structural continuum in males, and a more complex or indirect continuum in females, from the PLAC convergence zone, through the



Illustration

inferior pubic ligament, into the perineal membrane, and subsequently upward into the pelvic floor musculature.

From this perspective, load applied to the PLAC through athletic impact, torsional movement, or Valsalva-type intra-abdominal pressure (IAP) may not be mechanically isolated to the anterior pubis. In males, the shared ligamentous anchoring of the inferior pubic ligament and the perineal membrane may permit force transmission into the pelvic floor with repeated loading cycles. In females, the anatomical relationships described above suggest a less direct, but potentially relevant, mechanical association, although the likelihood and nature of force transmission may differ because of sex-specific morphology. For example, increased pelvic floor muscle tone or dysfunction may alter the mechanical environment of the perineal membrane and adjacent pelvic structures. This could theoretically influence stress distribution across the pelvic floor, reduce its capacity to attenuate load, and increase mechanical demand on surrounding tissues, including the hip and groin musculature. Clinically, anecdotal reports describe pain referral from higher-tone pelvic floor muscles to the lumbopelvic and hip regions, with symptoms reproducible during direct pelvic floor palpation.

This proposed continuum has not previously been described in the athletic groin pain literature and may provide a mechanistic, rather than merely associative, basis for the culprit hypothesis. However, an important caveat is required: this argument is an anatomical inference drawn from

established structural descriptions and anecdotal clinical observations. It has not yet been tested in appropriately designed prospective studies. It is therefore presented here as a mechanistic hypothesis requiring further investigation.

3. IAP dysregulation and the inguinal criterion

Within the Doha classification, inguinal-related groin pain may be aggravated by manoeuvres that increase IAP, including Valsalva, coughing, or sneezing³. A positive response to these manoeuvres is commonly interpreted as suggestive of posterior inguinal wall deficiency; however, the physiological stimulus is not specific to the inguinal canal. Increased IAP also challenges pelvic floor load capacity and, in individuals with reduced pelvic floor load capacity, may provoke symptoms of PFD, including urinary, faecal or flatal leakage, vaginal heaviness or pressure, exacerbation of prolapse-related symptoms, pelvic pain, or referred musculoskeletal pain. This distinction is clinically important: symptom reproduction during Valsalva, coughing, or sneezing should not be taken to exclude pelvic floor involvement, as these manoeuvres primarily generate a pressure response that may be expressed through inguinal, pelvic floor, musculoskeletal, or overlapping mechanisms. Accordingly, in athletes with reproduction of groin pain during pressure provocation but no palpable posterior wall deficiency, no herniation, and an otherwise unremarkable inguinal canal examination, PFD should remain within the differential diagnosis.

THE VICTIM: GROIN PAIN AS THE CAUSE OF PFD

A further proposition is that PFD may arise secondary to local or regional musculoskeletal injury, rather than acting as the primary driver of symptoms. The deep lumbopelvic cylinder, comprising the diaphragm, transversus abdominis, multifidus, and pelvic floor, normally functions through coordinated, anticipatory activation before movement^{25,29}. Pain can disrupt this motor strategy, with delayed deep trunk muscle activation demonstrated in low back and pelvic girdle pain populations and attributed to central nervous system reorganisation rather than isolated local muscle failure^{30–32}. Following a groin or hip injury, impaired force transfer through the trunk and pelvis may expose the pelvic floor to altered or excessive mechanical demands during return to sport. This local tissue overload could result in pelvic floor symptoms not because the pelvic floor is the primary problem, but because the system around the pelvic floor has not yet regained the capacity to tolerate the demands being placed on it. Similar downstream effects may arise from more distal kinetic-chain disruption, with altered ankle shock absorption shown to influence pelvic floor loading and stress urinary incontinence in runners³³. In this model, pelvic floor symptoms reflect reduced system capacity under load rather than primary pelvic floor pathology. The mechanical basis for this secondary, or 'victim', presentation may include altered load distribution across the pubic ring after adductor injury, progressive asymmetrical symphyseal loading in pubic-



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related groin pain, or compensatory IAP events in inguinal-related presentations. These pathways are unlikely to be identical across sexes: Schache and colleagues³⁴ proposed that the wider female pelvis and larger angle between the inferior pubic rami modify adductor-origin force vectors, reducing strain at the muscle insertion relative to males and potentially explaining the lower incidence of adductor-related groin pain reported in female athletes. Although direct empirical evidence remains limited, the pelvic floor should not be considered exempt from adaptive or maladaptive responses to altered musculoskeletal loading. Clinically, a 'victim' pelvic floor pattern would be suggested by PFD symptoms emerging after hip or groin injury, tracking with the acute, subacute, or return-to-sport phases, and improving as the primary pathology and regional load capacity recover. In this scenario, direct pelvic floor intervention may be a useful adjunct, but the principal therapeutic target remains restoring capacity, coordination, and load tolerance in the injured hip or groin region.

A MULTI-SYSTEM VIEW OF THE PELVIC FLOOR IN CHRONIC HIP AND GROIN PAIN

The pelvic floor may also present as one component of a wider regional or biopsychosocial symptom presentation. Chronic hip and groin pain should therefore not be conceptualised solely as a localised musculoskeletal disorder, but rather as a multidimensional regional pain presentation shaped by biomechanical, neurophysiological, psychosocial and socioenvironmental contributors. Within this framework, PFD may represent an important and often overlooked contributor to pain and dysfunction. From a biological and neurophysiological standpoint, myofascial dysfunction of the pelvic floor is characterised by increased muscle tone, tenderness, and impaired tissue compliance^{12,35}, generating nociceptive input capable of referring pain to the groin, medial thigh, pubic region and hip through shared lumbosacral segmental innervation and interconnected fascial pathways³⁶. Pain-mapping studies demonstrate that pelvic floor tenderness can reproduce patients' familiar symptoms and distinguish symptomatic from asymptomatic individuals, supporting the pelvic floor as a clinically relevant source of referred

pain rather than merely a consequence of chronic pain¹². Similarly, digital body mapping in athletes with longstanding groin pain has shown substantial overlap in pain distributions across adductor-, inguinal-, pubic-, and iliopsoas-related groin pain entities, indicating that pain location alone has limited diagnostic specificity despite differing presumed tissue sources³¹. Collectively, these findings caution against attributing hip and groin pain to a single anatomical source and instead support a regional framework in which the pelvic floor, abdominal wall, hip musculature, and surrounding soft tissues may each contribute, alongside psychosocial factors. Assessment of persistent hip and groin pain should therefore extend beyond the traditional musculoskeletal examination to include screening for pelvic floor involvement, with recognition and onward referral where indicated, particularly when symptoms are disproportionate, poorly localised, or refractory to conventional management.

A further example seen in female athletes, for whom systemic physiology may create an additional secondary pathway. Relative energy deficiency in sport (REDs)³⁷, menstrual-cycle dysregulation, and hormonal changes associated with the postpartum period and age-related transitions may reduce tissue resilience across the lumbopelvic region, including the pelvic floor. An athlete with REDs who develops adductor-related groin pain may therefore simultaneously present with compromised pelvic floor tissue quality as a consequence of the same hormonal and nutritional environment³⁶. In this context, the pelvic floor can be conceptualised as affected by a systemic physiological state rather than the primary driver of the groin pathology⁵.

From a psychological perspective, hip or groin pain may be triggered or exacerbated according to an individual's psychological wellbeing. For example, PFD is associated with psychological states of anxiety and depression^{38,39} in a relationship that is understood to be bidirectional in nature⁴⁰. That is, PFD influences anxiety and depression, and anxiety and depression influence PFD. Similarly, localised hip or groin pain can be heightened by psychological factors. Athletes with longstanding groin pain demonstrate greater pain catastrophizing,

fear of movement and depressive symptoms alongside altered pain sensitivity compared with matched asymptomatic controls⁴¹. Lastly, socioenvironmental factors are also relevant considerations when evaluating an athlete presenting with hip or groin pain. For example, variations in training facilities, coaching, strength and conditioning and training load may influence local and global load capacity⁴² and therefore predisposition to hip or groin pain. Moreover, the overlapping nature of each factor within a multi-system lens is highlighted when we consider how hip or groin pain that is driven by the pelvic floor (culprit) may be negatively influenced by poor access to toilet facilities or unsuitable uniform designs during sport that subsequently provokes or exacerbates psychological symptoms. As described previously, such psychological symptoms may in turn influence hip or groin pain presentation^{42,43}.

DETERMINING THE ROLE: A THREE-PHASE CLINICAL FRAMEWORK

Translating this model into practice requires a way for sports medicine clinicians to routinely consider pelvic floor involvement without specialist health training. Current clinical examination of hip and groin pain has limited sensitivity and specificity for isolating overlapping regional sources⁴. Cooke et al (2025)⁵ proposed a pragmatic three-phase framework where they seek to Ask (screen) at intake, Assess (identify) for pelvic floor involvement, whether primary or secondary, and consequently Action accordingly by stratification and referral. This framework can be integrated into existing sports medicine workflows without specialist pelvic health training for the first two phases and provides the basis for a structured referral decision in the third phase.

Phase 1 Ask: Screen at intake

A five-item symptom screen⁴⁴

1. Leakage.
2. Urgency or urge incontinence
3. Pelvic or perineal pain
4. Pelvic heaviness or pressure
5. Bowel dysfunction (gas/ stool)

Using a simple screen such as the PFD-SENTINEL⁴⁴ in those presenting with hip and groin pain can dramatically increase the visibility of PFD in the early rehabilitation process. It is known that athletes do not disclose pelvic floor

symptoms spontaneously; however, when surveyed 43.7% of 325 athletes reported pelvic floor symptoms across both sexes (females 53.7%, males 29.3%) demonstrating that the prevalence is high enough to justify universal screening rather than selective questioning⁴⁵.

Phase 2 Assess: identify through functional assessment

Standard sports medicine assessment tools, interpreted through a pelvic floor lens, may provide clinically useful indicators of altered motor control, load transfer, and pelvic floor involvement. Building on the assessment suggestions recommended by Cooke et al (2025)⁵, Figure 2 outlines five assessment zones in which common motor-control and loading strategies may be observed. For example, the active straight leg raise (ASLR) assesses lumbopelvic load transfer^{29,46,47}, including potential pelvic floor contribution. The sensitivity of the ASLR has been noted at 0.87 and specificity as 0.94 in a post-partum population with pelvic pain⁴⁸ but not in an athletic hip and groin population. A positive ASLR test in the absence of clear lumbar pathology could therefore prompt consideration of pelvic girdle⁴⁸ and

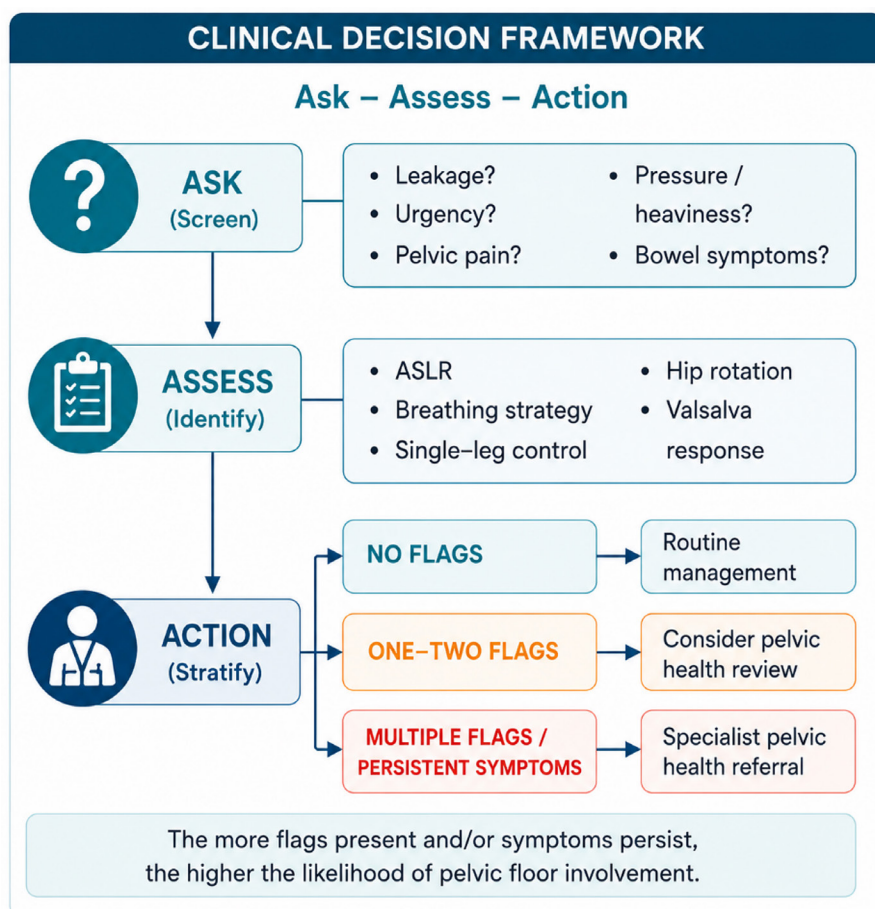


Figure 2: Clinical decision framework, (adapted from Cooke et al (2025)⁵.

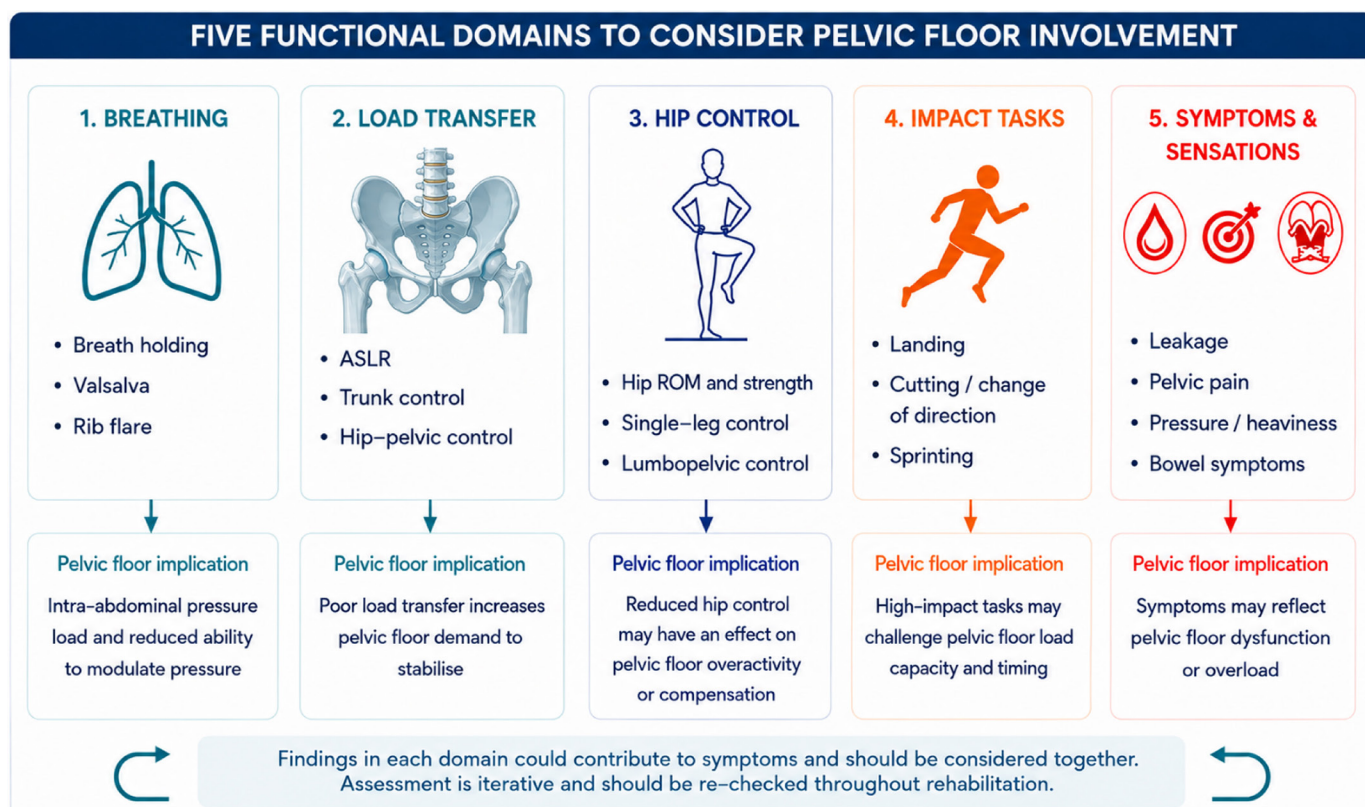


Figure 2: Functional domains for pelvic floor involvement.

TABLE 1

Clinical presentation	Pelvic floor role	Clinical implication
Valsalva-provoked groin pain; otherwise unremarkable examination	Possible culprit	Screen PFM alongside inguinal canal investigations; pelvic health referral may precede surgical opinion
Acute adductor strain, first presentation	Potential victim	Restore adductor load tolerance; monitor pelvic floor; re-screen as necessary.
Recurrent adductor or pubic pain; 2+ failed treatment cycles	Victim → culprit transition	Strongly recommend pelvic floor screen; co-management with pelvic health specialist as priority if appropriate.
Posterior hip and deep groin pain; restricted internal rotation; positive FADIR	Possible culprit (obturator internus-driven)	Rule out other hip pathology (e.g. dysplasia, posterior hip instability). Primary treatment based on clinical assessment or if failing to respond at obturator internus / pelvic floor; hip-directed management adjunctive
Postpartum athlete; groin pain and pelvic symptoms on return to sport	Victim → potential culprit if untreated	Structured postpartum pelvic floor assessment before return-to-sport clearance; groin/ REDs assessment alongside
REDs / menstrual dysfunction with groin pain	Victim of systemic physiology	REDs screening; address energy availability first with multidisciplinary support; pelvic floor screen as part of holistic assessment
Positive ASLR; breath-hold under load; no acute injury	Culprit	Lumbopelvic rehabilitation including the pelvic floor before return to high-load sport

Table 1: Functional domains for pelvic floor involvement. FADIR=flexion, adduction, internal rotation; ASLR=active straight leg raise; REDs=relative energy deficiency in sport.

potential pelvic floor involvement. Similarly, breathing strategy during compound loading tasks, contralateral pelvic drop during single-leg stance, trunk lateral lean under load, and Valsalva-provoked groin pain may all reflect compensatory strategies or impaired IAP management rather than isolated musculoskeletal findings. Valsalva-provoked symptoms should be recorded as a possible dual-mechanism sign: an inguinal-related criterion and a potential pelvic floor signal. Targeted questioning after running, landing, and high-impact testing regarding leakage, heaviness or pressure, and pelvic floor-region pain may identify symptoms that athletes often do not volunteer spontaneously.

Phase 3 Action: Stratify and refer

Stratification follows from the findings of Phases 1 and 2. Athletes without PFD symptom flags or functional compensation patterns have a low likelihood of clinically relevant pelvic floor involvement and should be managed according to the primary musculoskeletal presentation. Those with limited PFD symptom flags and subtle functional findings may warrant co-management or pelvic health screening

to determine whether the pelvic floor is acting as a primary contributor (culprit) or a secondary responder (victim) to altered regional loading. Athletes with multiple PFD symptom flags, load-provoked PFD symptoms, recurrent injury, recalcitrant pain, or clear compensation patterns should be referred for formal pelvic health assessment. Referral should specify the athlete's sport and loading demands, the clinical entity classification of hip or groin pain, relevant PFD symptom flags, and key functional findings. Table 1 offers guidance to inform clinical reasoning and differential diagnosis regarding the role the pelvic floor may play in an athlete presenting with hip and groin pain.

WHAT THE SPORTS MEDICINE FIELD NEEDS TO DO NEXT?

The victim-culprit distinction cannot be addressed systematically in clinical practice unless pelvic floor screening is integrated into routine hip and groin assessment. This requires both simple clinical questions and targeted tests, as well as refinement of outcome measures. The HAGOS, and future hip- or groin-related patient-reported outcome measures, should include a PFD

symptom domain; conversely, pelvic health outcome measures require validation in athletic populations with hip and groin pain. At present, an athlete with landing-related urinary incontinence, urgency limiting training, or pelvic pain exacerbating groin symptoms may score within the normal range on the only validated athlete-specific groin pain outcome measure. This represents a substantive measurement gap, as current trial outcomes may be blind to a prevalent and clinically meaningful contributor. Prospective groin pain research should therefore include pelvic floor function as a standard variable. Recent systematic review evidence identifies previous injury, reduced eccentric hip adduction strength, limited hip rotation range, and inadequate preseason conditioning as consistent predictors of groin injury; however, pelvic floor function was not assessed in the included studies⁴⁹. Until it is measured, its contribution to groin pain incidence, severity, and recurrence will remain unquantifiable.

CONCLUSION

Cooke et al. (2025)² identified the pelvic floor as a potential "hidden presence" in athletic hip and groin pain. The consequential

question is not simply whether the pelvic floor is involved, but the context and direction of that involvement. PFD may act as a culprit and primary contributor, arise as a victim secondary to altered mechanics and load redistribution following hip or groin injury, or coexist with multi-system musculoskeletal pathology in longstanding or recurrent presentations. For athletes with persistent hip or groin pain, we advocate brief pelvic floor screening, interpretation of functional findings through a pelvic floor lens, clear pelvic floor-related referral pathways where indicated, and integrated co-management between pelvic health and sports medicine clinicians. Pelvic floor screening should therefore become a routine component of hip and groin assessment rather than an exception.

KEY MESSAGE

Athletic hip and groin pain is a common and complex clinical presentation that requires systems thinking to account for the range of potential anatomical sources involved. The pelvic floor is a commonly overlooked contributor in the differential diagnosis of athletic hip and groin pain. However, it may act either as the primary driver of symptoms, (the “culprit”) or as a secondary consequence of dysfunction elsewhere, (the “victim”). Distinguishing between these roles is clinically important because it determines whether pelvic floor-directed treatment should be considered primary, adjunctive, or unnecessary.

Accordingly, there is a need for sports medicine clinicians to consider the pelvic floor when assessing, investigating, and managing athletes with hip and groin pain. This clinical commentary examines the role of the pelvic floor in athletic hip and groin pain, reviews the current understanding of the mechanisms through which it may present as either a culprit or a victim, and highlights areas requiring further research.

References

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