

ATHLETIC GROIN PAIN REHABILITATION

THE ASPETAR WAY

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INTRODUCTION

Athletic Groin Pain (AGP) is an umbrella term encompassing a range of pain presentations in the anterior hip and groin region¹. It often develops without a clear mechanism of injury and does not follow a predictable biological healing timeline. It may also emerge following an acute injury that fails to fully resolve, particularly when return to sport occurs before achieving adequate recovery and rehabilitation². In sub-elite male football, almost half of players (49%) report AGP symptoms during a season, yet only 46% of these symptomatic players missed any matches as a result, highlighting how much of the burden falls below the threshold of traditional time-loss surveillance³. By the time athletes present for rehabilitation, symptoms are often longstanding, with a median duration of 32 to 40 weeks across prospective cohorts and clinical trials^{1,4,5}. The Copenhagen Hip and Groin Outcome Score (HAGOS) further demonstrates the impact beyond time-loss: athletes with AGP report reduced scores across sport performance, physical activity and quality of life subscales long before they stop participating in training and competition³.

The landmark Hölmich trial demonstrated that active training was

superior to passive physiotherapy for the management of adductor related groin pain⁶, and subsequent work has highlighted that rehabilitation targeting intersegmental control was effective across all entities in returning athletes pain-free to high demand field sports⁴. Despite this, a recent scoping review found that 84% of studies reported exercise content inadequately, providing limited guidance on how rehabilitation should be individualised, structured and progressed⁷.

This article provides a summary of the Aspetar Way, an AGP rehabilitation pathway, focusing on the clinical rationale underpinning its assessment, rehabilitation and return-to-performance framework; the accompanying pathway document provides the corresponding depth, with detailed exercise prescriptions and progression criteria.

FROM ANATOMICAL DIAGNOSIS TO FUNCTIONAL REASONING

Establishing a clear anatomical diagnosis in AGP is rarely straightforward. Over sixty potential diagnoses have been described in the literature⁸ and when using Doha Agreement diagnoses, multiple entities frequently co-exist: Aspetar data show that 44% of athletes present with more

than one entity simultaneously⁹. Digital body mapping studies suggest that pain distribution is diffuse and overlapping across entities, and that pain quality descriptors do not always reliably differentiate one clinical entity from another¹⁰. Imaging adds further uncertainty as findings such as pubic bone marrow oedema, secondary cleft signs and adductor insertion pathology are also common in asymptomatic athletes¹¹.

Once red flags have been excluded and conservative management has been confirmed as the appropriate pathway¹² — recognising that a minority of athletes may require surgical consultation, particularly those whose symptoms are refractory to conservative treatment — the clinical focus shifts. Beyond identifying which structure is involved, we ask why the region has become overloaded and what is sustaining the problem. This shift from an anatomical to a functional diagnosis represents the foundation of the Aspetar Way, built primarily — though not exclusively — around three interconnected pillars: tissue capacity, biomechanics, and training load. Only by understanding how they interact in each athlete does the full picture of the problem emerge. We recognise that other factors — including bony morphology, genetics and psychosocial factors — may

Phases of Rehabilitation

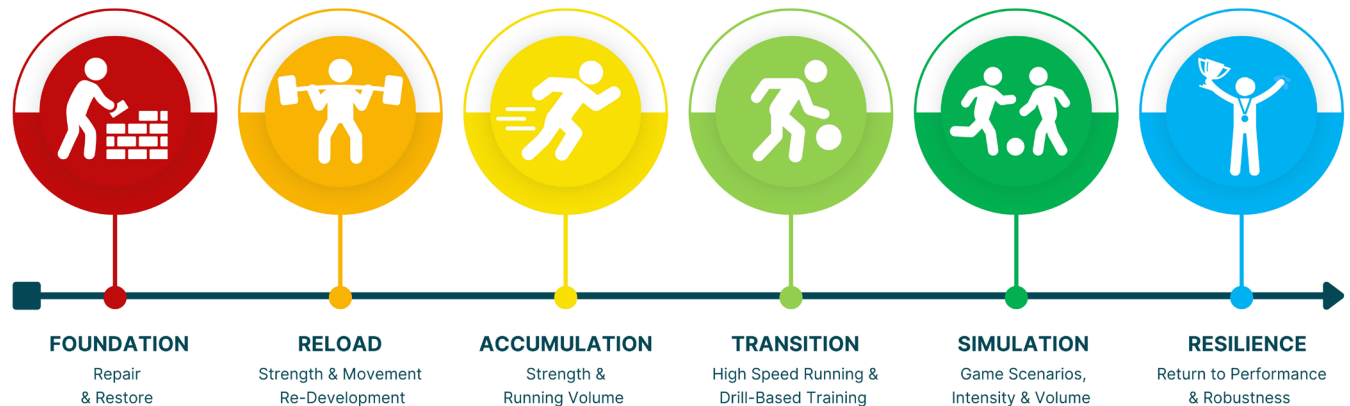


Figure 1: The Aspetar Way: phases of rehabilitation.

Assessment - Clinical

Provocation Testing for Athletic Groin Pain

Dermot Simpson, Michael Palladino, David Power, Helen McKeever, Lindsay Bull, Enda King, 2026.



Positive provocation test:
Reproduction of the athlete's pain in the groin region on resisted contraction or stretch.

Long Lever Crossbody Test

Start position: Athlete supine with both hands behind head and trunk slightly flexed and rotated towards contralateral leg. The athlete raises the contralateral leg, knee fully extended, to approximately 30 degrees of hip flexion.

Test: The clinician places one hand on near-side elbow and one hand just above the ankle of the raised leg.

Cue: "Hold your trunk and leg here, don't let me move it"

Hip Flexion and Crossover Test (modified Thomas Test position)

Start position: Athlete supine at the edge of the bed in the Modified Thomas test position

Test: Apply a downward pressure on the stretched thigh

Cue: "Resist this stretch"

This testing position comprises two separate tests:

Crossover sign - positive test = Contralateral groin pain

Hip flexion - positive test = Ipsilateral pain

Outer Range Stretch / Resisted Test

Stretch Test: The clinician abducts the tested leg, holding the ankle with one hand to ensure the foot points straight up. The contralateral leg hangs over the edge of the bed to stabilise the testing position. The tested leg is then moved into maximal abduction.

Resisted Test: The athlete is asked to perform a maximal hip adduction towards the clinician's body, in a maximally hip abducted position.

Squeeze Test (0°, 45°, 90° Hip Flexion)

Squeeze 0° hip flexion / Copenhagen squeeze

Start position: The clinician stands at the end of the examination bed placing their elbow and hand on the lower legs of the athlete just above the medial malleoli. The legs are in neutral position with the feet pointing straight up.

Test: The athlete is asked to perform a maximal bilateral hip adduction squeeze.

Squeeze 45° hip flexion

Start position: The clinician places their two fists between the knees of the athlete.

Test: The athlete is asked to perform a maximal bilateral hip adduction squeeze.

Squeeze 90° hip flexion

Start position: The clinician places their two fists between the knees of the athlete.

Test: The athlete is asked to perform a maximal bilateral hip adduction squeeze.

On squeeze tests, NRS (0-10) and P1/Max force output are measured. Although a manual squeeze test is performed daily at 0°, 45°, 90°, it is recommended that a force output squeeze test should be performed at least twice per week. A handheld dynamometer is used to assess force output.

Figure 2: Pain Provocation Tests.

also contribute to the clinical presentation; the three-pillar model represents the framework within which these broader influences are considered.

Tissue Capacity

Tissue capacity describes how much load the affected region can currently tolerate.

It is assessed and monitored throughout rehabilitation through pain provocation tests and daily symptom tracking. The level of tissue irritability determines the entry point into rehabilitation, shapes early exercise selection, and provides continuous information about how the tissue is responding to the demands being placed on it.

Biomechanics

Understanding how the athlete moves is central to understanding why the region is being overloaded. Athletes with AGP can present with distinct movement patterns and it is the way load is distributed and controlled across the body segments that often sustains symptoms¹³.

Training Load

Training and playing load describe the current demand placed on the tissue, providing essential context for understanding both the clinical presentation and the return to performance requirements. Most athletes have been competing through pain for a considerable period and mapping the trajectory of load over that period — how much they have been doing, how it has changed, and how much recovery they have had — is a key part of the assessment. In many athletes, training load sits alongside underlying physical, biomechanical and sport-specific factors as a contributor to symptom development. While it may not be the primary driver of the problem, it is often the factor that exposes or amplifies existing deficits¹⁴.

Clinical Pearl — Chase the mechanism, not the label — the same anatomical finding can hide entirely different drivers.

THE ASPETAR WAY

The Aspetar Way is a six-phase pathway that guides the athlete from initial presentation to return to performance (Figure 1). Neither phase duration nor entry point is fixed: progression is determined by the athlete meeting specific objective criteria rather than by time, and following initial assessment, each athlete enters the phase that best reflects their clinical presentation and functional status — some beginning in the Foundation phase, others entering further along the pathway.

The phases represent a structured progression in training demand, movement complexity and sport-specific exposure. In the early phases, the priority is to reduce pain and restore movement control. As clinical criteria are met, load increases systematically until the full demands of the sport are replicated in the Simulation phase, before being consolidated in the club environment during the Resilience phase¹⁵.

Clinical Pearl — Rest can look like recovery. Feeling better once the demand is removed doesn't mean the driver is resolved — it waits for the next sport-specific demand to reappear.

ASSESSMENT

Assessment is a continuous process that spans the entire pathway, guiding exercise selection and progression decisions at each stage. The first objective is to quantify tissue irritability through pain provocation tests (Figure 2), some of which subsequently serve as Key Performance Indicators (KPIs), allowing clinicians to monitor the athlete's response over time and determine whether interventions are producing the intended clinical changes.

Daily Testing

The adductor squeeze test at 0°, 45° and 90° of hip flexion — including the Copenhagen squeeze variant at 0° — is a practical,

Aspetar Milestones - Clinical Athletic Groin Pain

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Athletic Groin Pain							 	
Daily Testing :			FOUNDATION* EXIT CRITERIA	RELOAD EXIT CRITERIA	ACCUMULATION EXIT CRITERIA	TRANSITION EXIT CRITERIA	SIMULATION EXIT CRITERIA	RESILIENCE EXIT CRITERIA
Subjective	Pain During/After Rehab (Excluding DOMS)	Pain (NRS):0-10	≤ 4/10	0/10	0/10	0/10	No Regression	
	Squeeze 0°/45°/90°	P1 / Pain Free Max		Improving (P1)	Pain-Free 45°/90° (Max)	Pain-Free 0° (Max)		
	Range**	Hip Internal Rotation ROM	Degrees (°)	Symmetrical	Symmetrical	Symmetrical		
Twice Weekly Testing :								
Test			Measure					
Hip Adduction Strength	Side-lying Adduction Inner-Range Break test	Peak Force (kg)			LSI ≥ 80%	LSI ≥ 95%	No Regression	
	Supine Adduction Outer-Range Isometric / Break test				LSI ≥ 80% Isometric	LSI ≥ 95% Break		
Hip Flexion Strength	Supine Hip Flexion Break Test (90° Knee and Hip Flexion)				LSI ≥ 80%	LSI ≥ 95%		
Provocation	Modified Thomas Test: Crossover Sign / Ipsilateral Flexion	Pain (NRS) 0-10		Pain-Free Crossover Sign	Pain-Free Ipsilateral Flexion	Pain-Free		
	Outer Range Stretch & Resisted Test		Improving	Improving	Pain-Free			
	Long Lever Crossbody Test		Improving	Pain-Free	Pain-Free			
Capacity***	Adductor Bridge Copenhagen Adduction	Competency & symptom response			Long Lever Bridge 3x20 Seconds	Copenhagen 4x15 Reps		
*To progress from the 'Foundation' phase, there should be no surgical restrictions.			***Monitored during rehab. Not part of formal twice weekly assessment.					
**Clinically reasoned based on presence/absence of hip bone morphology changes.								

reliable^{16,17} and sensitive tool¹ that, combined with the athlete's subjective response, forms the basis of daily monitoring throughout rehabilitation. Changes in pain or force output across sessions reflect how the athlete has responded to the previous training load: an increase in pain may indicate that either the load exceeded tissue tolerance or the underlying drivers are not yet being adequately addressed.

Hip internal rotation range of motion (ROM) is also assessed daily, as restriction is commonly observed in AGP and may reflect altered pubic load distribution¹⁸, particularly with cam morphology¹⁹. Assessing ROM in both supine and prone positions helps differentiate the underlying contributor: differences between positions typically suggest a soft tissue or neuromuscular restriction, while consistent restriction across both may indicate an articular limitation.

Twice-Weekly Testing

This provides the objective criteria that guide phase transitions and the introduction of higher-demand activities (Figure 3). A pain-free crossover sign in the modified Thomas Test position represents a key milestone before beginning linear running. Progression to higher speed and multiplanar activities, including change of direction (CoD) and kicking, additionally requires a pain-free response to ipsilateral resisted hip flexion and to the long-lever crossbody test — often among the last parameters to normalise in athletes with significant abdominal involvement — an improving symptom response to the outer range stretch and resisted test, together with an adductor force limb symmetry index (LSI) $\geq 80\%$ relative to the contralateral limb.

Hip adductor strength, assessed with a hand-held dynamometer in both inner and outer range, is monitored from Accumulation onward. In the early phases strength testing is not a priority, particularly when muscle contraction is often painful, direct strengthening is rarely the primary treatment focus, and, where bilateral symptoms are still present, these may make the contralateral limb an unreliable comparator for LSI. As pain provocation tests begin to normalise, strength parameters become increasingly relevant, not as the primary driver of progression, but as supporting evidence that the athlete is adapting to higher load demands.

Beyond the core assessment framework, additional components are evaluated according to the athlete's presentation and level of tissue irritability. Where the athlete enters the pathway at a more advanced phase, running mechanics analysis is incorporated into the initial assessment, examining key phases of the running cycle.

Clinical Pearl — No single test drives a clinical decision in isolation; it is the overall pattern across all measures that informs each step forward (Figure 3).

REHABILITATION COMPONENTS

Six rehabilitation components are delivered across all phases (Figure 4); each is discussed in greater depth in the rehabilitation pathway document.

Unlike acute groin injury management, where the relative weight of each component follows a more linear progression, in AGP the early phases place a greater emphasis on motor control (Figure 5). Once pain provocation tests begin to normalise and the athlete

demonstrates tolerance to progressive load, the focus shifts toward strength, running, explosiveness and sport-specific demands.

Motor Control

Motor control is a multidimensional construct encompassing neural activation and timing, movement variability, inter- and intra-muscular coordination, force modulation and task- and context-specific control²⁰.

Deficits in the timing and coordination of muscles acting around the hip and trunk are among the factors that may perpetuate symptoms²¹. The potential relevance of these deficits becomes clearer during sport-specific tasks, in which the demand placed on the painful structure depends not only on its local capacity, but also on how force is generated, transferred and controlled across multiple segments⁴. The clinical question is whether the resulting movement strategy contributes to symptom provocation and whether relevant features can be modified. This provides the rationale for addressing intersegmental control alongside isolated muscle function. Rehabilitation incorporating this approach has produced meaningful clinical outcomes, with over 85% of athletes achieving pain-free return to play alongside improvements in HAGOS scores and pain-provocation tests^{4,22}.

Within the Aspetar pathway, this clinical reasoning is applied through two complementary motor control streams: compound and isolated.

Compound motor control provides an early, controlled opportunity to examine how the athlete coordinates movement across the kinetic chain and may identify multiplanar control deficits that remain relevant as demands progress to running, jumping and CoD.

Isolated motor control assessment interrogates the specific deficits identified in the compound screen. Where the compound tests show a pattern — frontal-plane pelvic drop on a single-leg squat, loss of a neutral pelvic position on a split squat, or rotational deviation on a single-leg RDL — isolated testing examines the potential contributors: hip abductor and external rotator control, lumbo-pelvic positioning, ability to dissociate hip from pelvis from thorax, and active control through range.

Across both streams, progression is not strictly linear: exercises are



Figure 4: Aspetar Rehabilitation Components.

Rehab Overview

Acute Groin Injury

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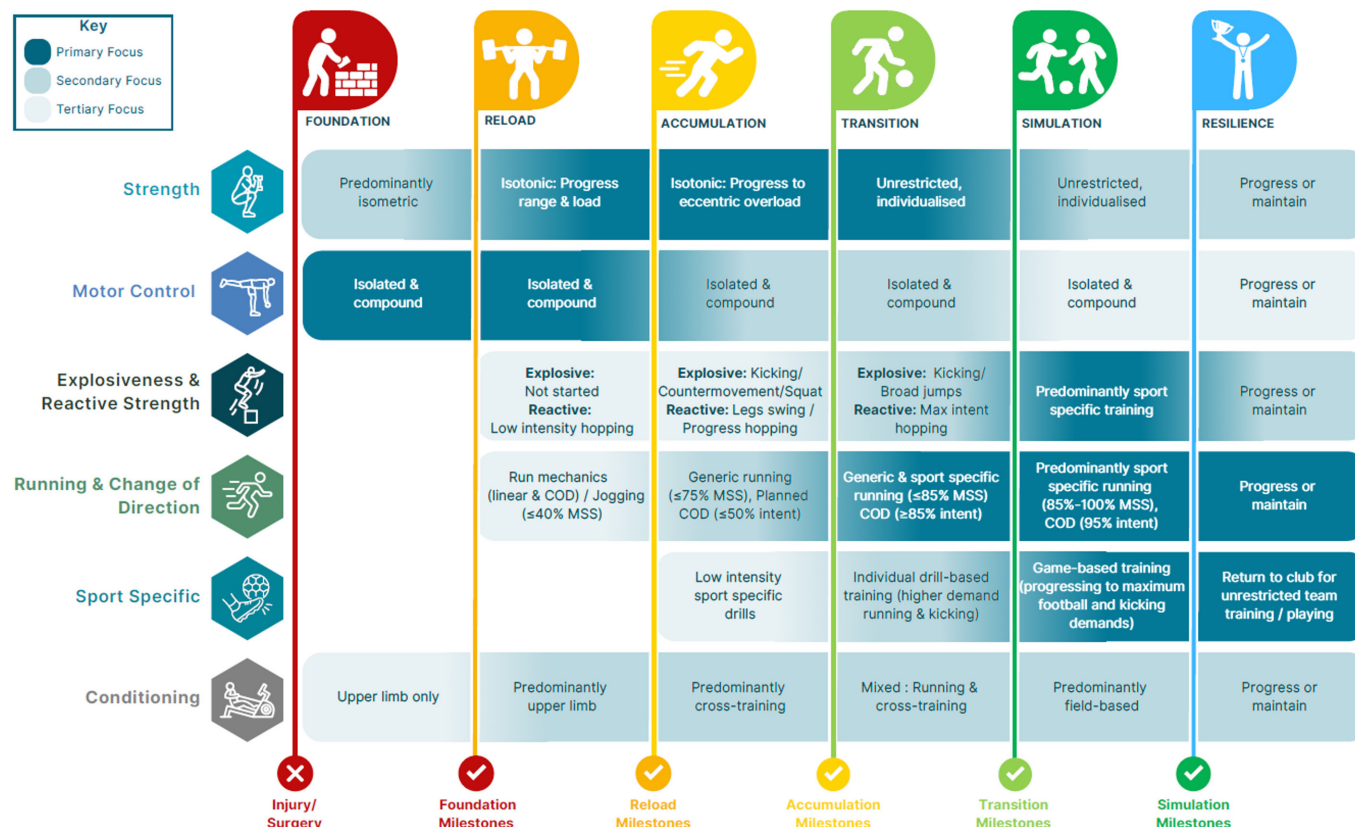


Figure 5: Aspetar Rehabilitation Components across phases.

interchangeable, chosen based on the athlete's current competency, the specific deficits identified, and the demands to be met later in the pathway, with entry point guided by assessment findings rather than a fixed sequence. We recognise that this individualised approach trades some reproducibility for clinical fit, and so the assessment framework, the progression criteria and the symptom-response thresholds are standardised even when exercise selection is not. Movement quality is monitored continuously, with compensatory strategies explored and modified through external cues, positional adjustments or changes in resistance.

The test-retest approach completes the picture: observing whether targeted loading of a specific muscle group reduces the athlete's symptoms helps establish the clinical relevance of the identified deficit and guides subsequent exercise selection.

Motor control principles are not confined to isolated and compound work; they continue to underpin all rehabilitation

components and guide their application throughout the pathway.

Strength

Strength complements motor control work by developing the physical capacity required to tolerate progressively greater rehabilitation loads. Increasing isolated muscle strength, however, does not necessarily ensure it is effectively expressed during sport-specific tasks, and repeatedly loading the painful structure without addressing the factors contributing to its overload may sustain symptoms rather than build capacity.

Changes in hip muscle strength explained only 11% of the improvement in HAGOS sport and recreation scores, indicating that strength represents one component of recovery rather than its sole driver²². Within the same rehabilitation programme, adductor force improved despite the absence of targeted adductor strengthening, alongside reductions in pain and improvements in overall function,

suggesting that local strength may improve as part of a broader rehabilitation process rather than through direct loading alone²².

Strength development begins in the early phases as tolerated, organised across four streams: adductor, hip flexor, compound and synergist. In more irritable presentations, direct adductor loading may initially receive less emphasis, with progression guided by irritability, motor control and symptom response. Exercise demand across all streams is manipulated through different variables: muscle length, tempo, contraction mode, volume, frequency and external load.

As irritability decreases, adductor strength becomes increasingly important both as a load-bearing capacity and as a marker of adaptation to rising rehabilitation demands, contributing to progression decisions alongside the other KPIs.

Explosiveness & Reactive Strength

The force capacity developed through

strength work does not ensure it can be expressed within the limited time available during sport. Athletes with AGP may absorb and transmit load differently during rapid multidirectional tasks, demonstrating longer ground-contact times, greater concentric impulse, reduced peak force and reduced rate of force development, with these characteristics normalising following successful rehabilitation²³ — suggesting a potential limitation in the ability to absorb and redirect force rapidly through the stretch-shortening cycle.

Low-intensity reactive work begins in the Reload phase, reintroducing the stretch-shortening cycle at a tolerable magnitude. Explosive intent is then progressively introduced within existing strength and multi-joint work, with unilateral loading and multiplanar demand increasing as irritability and impact tolerance improve. Within this pathway, reactive and explosive adductor demands are developed through multidirectional tasks rather than a separate isolated stream, reflecting the need to generate, absorb and redirect force rapidly within coordinated actions.

Running & Change of Direction

The movement strategies and physical qualities developed throughout rehabilitation are progressively integrated within running and CoD. Their progression combines two parallel processes: mechanics, which applies motor control principles to the athlete's movement strategy, and exposure, which restores tolerance to the speed, volume and intensity required by sport.

Athletes with AGP do not share a single cutting pattern: three distinct movement strategies have been identified — differing in thorax, pelvis, hip, knee and ankle

kinematics — which do not correlate with the anatomical diagnosis³³. Similar movement strategies are also observed in uninjured athletes²⁴. Certain patterns were more prevalent in groin pain cohorts but these findings highlight how it's not only movement but the areas of tissue capacity and playing and training load that will influence how those patterns are tolerated. Changes in trunk and pelvic orientation during cutting, together with a redistribution of mechanical work between the hip and ankle, have been observed following successful AGP rehabilitation⁴. Mechanics drills therefore use individualised cues and constraints to explore whether modifying relevant movement features improves symptoms, load tolerance or task execution, rather than imposing a universal technique.

In AGP, running mechanics drills begin during Reload, while pain-free running exposure is introduced in Accumulation once the relevant clinical milestones are met. Change of direction mechanics then become a primary focus alongside progressive linear running. Planned tasks initially allow an effective strategy to be developed under controlled conditions before speed, cut angle, volume and intent increase through the Transition phase. The response to running and CoD exposure confirms whether this capacity can be applied repeatedly while maintaining movement competency and clinical stability. During Simulation, these tasks are combined with sport-specific actions and repeated under fatigue.

Clinical Reasoning and Application

The rehabilitation components are not independent streams completed in sequence. Motor control influences

the movement strategy and how force is generated and distributed; strength develops the capacity to tolerate load; explosive and reactive work challenges the ability to express that force within shorter timeframes; running and CoD integrate these qualities under progressively sport-specific demands.

Clinical assessment must therefore determine not only the athlete's capacity within each component, but also whether it is maintained as task demands increase. This requires information from three different layers: isolated testing, compound movement screens and dynamic-task analysis. These layers offer complementary windows on the same athlete rather than interchangeable views, and we do not treat any one of them as the reference standard.

Because movement strategy is task-specific, each layer samples a different demand: a deficit visible in a controlled single-leg squat does not necessarily appear at speed, and a deficit that emerges during cutting or acceleration may not be predictable from isolated testing²⁵.

When the layers are consistent — for example, a pelvic-control deficit on a single-leg squat that often expresses as pelvic drop in mid-stance during running and as altered thorax position during cutting — the clinical formulation is reinforced and the rehabilitation target is clear. The same deficit can then be addressed in isolation to build the underlying capacity, at compound level to integrate it under multi-joint demand, and within sport-specific tasks to consolidate it under the loading conditions in which it will ultimately need to operate.

A deficit that is not apparent on isolated testing but emerges during CoD or acceleration is the more clinically relevant problem, because that is the loading



From where it hurts to why it hurts: the shift from anatomical to functional diagnosis is the foundation of the Aspetar Way.



context in which the athlete's symptoms are produced. Treating the motor control deficit on an isolated muscle group while overlooking a discordant dynamic finding risks missing the actual driver of the presentation.

The relationship between the three layers is not fixed. As rehabilitation progresses, a deficit that was visible in isolation early on may resolve, while one previously masked by guarding or by reduced training load may only become apparent once the athlete is exposed to higher speeds and volumes. Reassessment across all three layers is therefore repeated at each phase transition, and exercise selection is adjusted to whichever layer is currently providing the clearest signal.

Clinical Pearl — When the assessment layers conflict, the finding under the highest sport-specific demand carries the most weight.

RETURN TO PERFORMANCE

Return to the training pitch in Simulation Phase is not the endpoint (Figure 6). How the athlete re-integrates into the team environment and how early symptoms are recognised and managed are the scenarios that most often determine whether recovery is sustained or whether the cycle of recurrence begins again. Because this transition is sport-specific, the following section explores the Resilience phase from the perspective of elite basketball in the NBA.

The Resilience Phase: Perspectives from the NBA

The Resilience Phase consists of a staged reintroduction to sport-specific training. While cross training can be performed during rehabilitation to maintain baseline fitness, the demands of sport must be defined²⁶ and progressively imposed to prepare the athlete for return to competition. Tools such as the

control to chaos framework^{27,28} and team-specific drill databases can help prescribe the specific amounts of distance, jumps, high-speed running, contact, accelerations and decelerations within individual and group sessions. The athlete will return to 3-5 competitions per week, and thus, moderate to high-intensity sessions will be programmed every-other-day, in addition to periodic back-to-back training sessions to simulate in-season demands²⁷.

Objective monitoring allows for a safe estimate of load reintroduction: whatever volume an athlete tolerates in rehabilitation becomes the starting target for return-to-drill work. A reduced target of 70-80% of game external load metrics at the start of each stage may account for spikes in intensity, contact and cognitive/reactive demands difficult to replicate in controlled rehabilitation phases²⁹.

As the athlete increases sport-specific training, there is often a practical time-cost

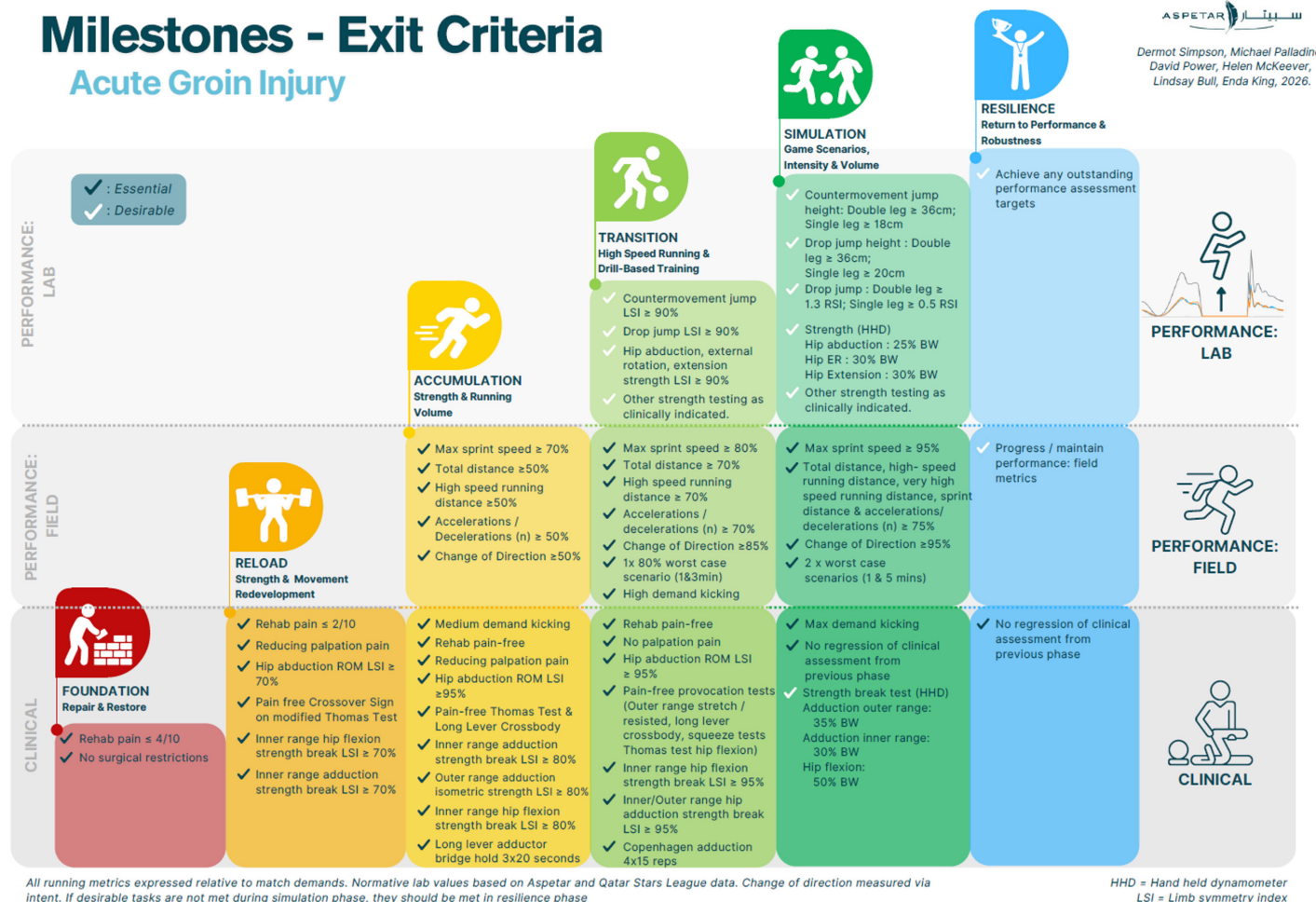


Figure 6: Aspetar Milestones – Exit Criteria across all phases.

conflict in maintaining the rehabilitation components versus reconditioning. The dynamic warm-up helps offset this by incorporating isolated and compound exercises addressing the specific deficits identified earlier in rehabilitation, alongside low-volume, high-intensity plyometrics and CoD drills^{4,30}. Intensive training sessions (e.g. post-practice/competition) are typically concluded with individually selected exercises — such as eccentric Copenhagen adduction, multiplanar lunging^{31,32} and repeated-effort drills — prescribed according to the athlete's presentation^{33,34}. High-demand exercise days are matched with high-demand sport days to allow adequate recovery and adaptation of the affected tissues³⁵.

The same KPIs described in the Assessment section above are used to track response across individual non-contact, individual and group-controlled contact, team practice, small-sided games, and competition phases. The clinician should consider delayed presentation 48-72 hours following demanding sessions and can utilise tools such as the Soreness Rules to make real-time decisions on daily progressions³⁶. Higher-fidelity testing such as dynamometry-based force assessment³⁷ and 2D or 3D movement analysis^{4,34} can be performed weekly to monthly to ensure maintenance of restored impairments, identify accumulated fatigue, or sub-clinical regression due to current training demands.

Clinical Pearl — Targeted dynamic warm-up and “top-off” exercise sessions post-participation are two methods to maintain rehabilitation goals during the resilience phase.

The In-Season Athlete

In-season management builds on the athlete's established clinical and physical profile, with daily-to-weekly monitoring of symptoms and force measures, such as the adductor squeeze, used to detect early changes and reduce injury burden when effectively integrated with match participation³⁸. Questionnaires such as the HAGOS³⁸ or Oslo Sports Trauma Research Center Overuse Injury Questionnaire³⁹ combined with a numeric pain scale to a light system¹⁷ informed by pain provocation tests and the KPIs described above, may guide decisions on whether training should proceed as planned, be modified,

or be paused. Worsening symptoms are often accompanied by reductions in hip ROM and force output⁴⁰, assessed through hip and trunk dynamometry to identify force tolerance and impairment requiring intervention². Modifications to an athlete's training schedule should prioritise competition and minimise additional stress to the region in individual and group work. If these modifications are not enough to stop a worsening presentation, a brief bout of rehabilitation to normalise an athlete's profile to pre-season benchmarking may reduce the risk of greater time-loss in-season.

A key strategy to minimise in-season management is to build high sport-specific training loads during the off-season and pre-season, supplemented with eccentric exercise and repeated high-intensity efforts^{41,42}. Athletes who can sustain high chronic loads can then focus in-season work on maintenance — manual therapy⁴³, modalities⁴⁴ and low-volume exercises⁴⁵ — that preserve off-season resilience during competition. Athletes with a history of AGP, lower fitness, poor mobility and impaired local and compound force output are less able to tolerate in-season demands — creating a clinical paradox between the need for recovery and the need to develop physical capacity — and often require a longer, more gradual return to competition.

Return to Performance – A Cross-Sport Perspective

Regardless of sport, the principles underpinning AGP rehabilitation remain consistent: progression is guided by objective KPIs, rehabilitation is delivered across multiple components and load is reintroduced systematically as clinical criteria are met. From the Accumulation phase onwards, however, the programme begins to diverge: the volume and nature of sport-specific loading differ by sport and by playing position. The Resilience section above illustrates this for basketball, while a parallel article on acute groin injuries illustrates the equivalent process for football⁴⁶. For other sports, the same underlying principles apply: a gradual exposure to sport-specific demands, continuous monitoring of both clinical and performance-based parameters and ongoing decisions on training modifications, while maintaining the physical qualities built in rehabilitation as sport-specific

load increases — applied according to the demands of each sport and the expertise of the medical and performance staff involved.



Scan to access the full Athletic Groin Pain Rehabilitation Pathway — The Aspetar Way

References

Available at www.aspetar.com/journal

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