Gilmore’s Groin and Hernia

Steven Bruce
Good afternoon. Welcome to the Academy of physical medicine. It's great to have you with us as always, and today I am talking to consultant growing and hernia surgeon Simon. Simon is the surgical director of the Gilmore groi and hernia clinic in London. And that is part of the London sports injury clinic as well. So he's got a direct application to injuries which quite often find their way into our own clinics. So what we're gonna be talking about today, and he's off direct relevance to the sort of patients that you're likely to see. Now suddenly you get you trained at Cambridge A long time ago, didn't you? And you are apparently one of the few people to twice win the William Harvey studentship which makes you even more brainy than most Cambridge students I imagine.

Simon Marsh
All Stephen Thank you. Yes, that's slightly embarrassing that also makes me feel very old. Yeah, it was it was the the surgical side of things that interested me then. Alice's kept me going since Anyway, it was a surgical prize, and I was lucky enough to win it twice. Yeah, I don't think many people have done that. But you know, I'm just an ordinary surgeon, really,

Steven Bruce
just an ordinary surgeon. I was saying earlier on before we go on air that an ordinary day to you is quite extraordinary to most people, the fact that you've got to rush off after this and start carving people's greens. I think you've got three to do this afternoon. You know, it's it's an unusual day, I imagine in most people's minds. I was gonna say as well you've got an unusual accolade. Haven't you in that. Gilmore's growing that we're going to talk about today has a modified repair technique, which is named after you.

Simon Marsh
It is Gary Dumont who did that he wanted to get my name on it and bless him. That all came about in 2010. Now in 2010, I was slightly stupid enough to stand behind a horse who was trying to kick me in the head and I got my right arm up instead, it only got shattered. And that took a couple of operations and five months out. And during that time, Jerry and I spoke to as many people around the world as we could, who were doing similar sorts of operations to see what they were doing. And we looked at what they did and the techniques they used to compare with, if you like, the basic technique that he described, and we just picked a couple of things that we thought would be useful and incorporated them into the standard Gilmore technique. And Jerry decided very kindly that this should be called the marsh modification which is which is what we call it now.

Steven Bruce
Which is so much nicer than having a disease named after you isn't it is yesterday. We're gonna be talking about the about Gilmore's going particularly and, and various aspects. So for how one distinguishes it from other injuries and from hernias and so on. There are a number of slides, which

we'll be showing, and there will be a handout issued this afternoon after the show where you'll have all those slides on the handout. So don't worry if you don't catch them all as we go through. I suppose Actually, we ought to warn the audience as well. But one of the slides probably is best shown after the watershed. If there are any sensitive particularly young female viewers, then they perhaps would not watch for the the main picture slide that we have this afternoon. So over to you Simon I mean, what is Gilmore's growing?

Simon Marsh
Yes, thank you. And what I'd like to try and do is clear up a lot of confusion about what Kim was going is because as you all know, there are a whole lot of things that can cause pain in the groyne. And it can come from the back it can come from the sacroiliac joint it can come from the bowel, it can come from ovary pain or testicular pain, or appendicitis or hernias. And just to get this out of the way, Gil was going he's not a hernia. hernia as was drummed into us when we were medical students is the protrusion of cart or all of a viscous through the wall of the cavity that normally contains that viscous. So with a hernia, you've got a lump and you can push it back and that's fine. And we'll put that to one side. Although we might come back and talk about the best way of fixing hernias these days, particularly with the potential problems with mesh that seems to be arising.

Steven Bruce
Simon I think when we spoke about this before you said that Gilmore's growing can often be confused with, I think other growing strains. But do you also say that it is sometimes confused with a hernia? Which would seem unlikely given what we would expect from hernias?

Simon Marsh
Yes, I think that is often called a sportsman's hernia, because I think the general public understand that a hernia occurs in the groyne Oh, interestingly, there's still some confusion as to what the groyne is now to us. The groyne is what we call the inguinal region, sorting the lower part of the abdomen but a lot of people think the groyne is the inside of their thigh, which is nothing muscle. So there's still that confusion. But with a hernia usually likes to lump but I appreciate people understand the term hernia. I think probably the best term is actually yours growing because people understand that and we'll talk about the symptoms and the signs, signs and the specific syndrome a girl was growing, but if you want to be more anatomical about it, then probably the term grown And disruption is not is not a bad one, because it makes you think that the muscles and tendons in the groyne are torn, which is basically what we're talking about. So you're almost gone, I think everybody can understand but a groyne disruption if you want to be more anatomical about it.

Steven Bruce
Okay. So what sort of people are presenting with this?

Simon Marsh
So it's basically a sporting injury and what you have to remember as we were saying, there's a whole lot of things that cause pain in the groyne. And within that set of growing pain, there is a distinct subset of people who will have symptoms and signs and perhaps imaging findings that fit with the Gilmore's crime. And it is basically a sporting injury and Jerry Gilmore first described it in 1988, when he saw

three what were then first division football as all internationals who'd all got groyne injuries, and hadn't been able to play for between four and six months because their groyne injuries, they'd all had lots of opinions. They'd had x rays, and CT scans and ultrasound scans and MRIs didn't exist then, and nobody could work out what was going on. And one of them came see Jerry and Jerry did what we're all taught to do. He listened to what the symptoms were, he examined the chap and he thought about it, and actually did an operation because what he found, and we can have a look a bit later at the slide you talked about which shows anatomy quite well. When you examine the groyne compared with the other side, what you find is the superficial inguinal ring is dilated, there's a lot of tenderness on the poster or the will canal and when they cough it bulges. Now this is not a hernia because nothing's coming through. But the muscles are weakened or torn if you like which is why it bulges and each of this sort of lateral leak which is what he was good at one of his Maxim's was always think laterally and realise what was going on when he operated, he could see the tears and the muscles and tendons. And he fixed it anatomically. So knowing good mesh, this, this is just putting the muscles and tendons back where they should be to restore the normal anatomy of the groyne. So it can function again. And the sort of typical symptoms people would get is, you know, for footballers, they'd find them with pain when they push off the sprint when they were kicking, twisting and turning. And the sort of typical history you would get would be a chaplain play football. And when he played Okay, and the next day is quite different sore, but he recovered just enough to train midweek. And then he was different saw played at the weekend. And then the stiffness of soreness lasted a bit longer so he couldn't trade midweek. And then he find the pain came on during the match, and then you'd have to come off earlier and then he couldn't even train. So that's a sort of typical pattern you see. And it was that coupled with the examination and it does involve unfortunately, putting your little finger up the back of somebody's scrotum to get into the abdomen. And it might be this is a good time to put up the the post nine o'clock slide that I think we've got labelled number three, because it's just it just illustrates the anatomy really well. Because what what you sometimes get is quite a lot of bruising. Now, in the centre is bruise, you don't do much but it does just illustrate the anatomy. And sometimes you can see the curve of the superficial inguinal ring where you examine. And you just need that three dimensional picture of what's going on under the skin in the groyne to get an idea of the anatomy and it's one of the things that slightly bothers me. I know it doesn't apply to the audience today. But I'm not I'm not convinced that anatomy teaching is what it was. And I do worry that people are not getting the full anatomical knowledge that they need to work on the guild wars going these days.

Steven Bruce
We were saying earlier to if anyone recognises this patient, they should keep that information to themselves.

Simon Marsh
If we if we can share this it is it is a Premiership football. And if you do recognise I think Halo magazine would probably want to hear from you but I suggest but it just shows it just shows the the arc of the superficial inguinal ring and the bruising in the groyne there's a bit of bruising down the leg as well where this chap had an adductor tear. And what we find is that 40% of people who have told they're growing also getting the doctors hair, the different related, so a Gilmore's groyne doesn't involve an adaptive problem, but 40% of people do have both and in some cases we will fix the groyne and also do an adductor release because it's the tightness in the adductor tendon that causes a problem. And if

you release that the tendon level when it heals, it will heal longer and take away the problem. And Jerry actually produced a drawing again based on another Premiership footballer where he marked on this chap where you get the pain from a Gilmore's groyne and the pain is right over the superficial inguinal ring in the lower abdomen. And he added to that where you get the pain for the doctor which of course is up the inside of the thighs it comes on to the pubic bone. And also people who get pain in the hip where they feel it in the crease of the groyne so it's slightly lower down and Again, you you hear about a single femoral acetabular impingement, you know about this and some of these people will present with pain in the groyne, it can be difficult to work out which is which. And sometimes you get beat with both you think or which one you deal with first. Now, I have to admit, we tend to deal with the groyne. First because it's easier, whereas hip surgery for impingement is actually quite big surgery. So we tend to look at the groyne first, but is that combination of the right sort of people, so it tends to be sporting young men are the right symptoms and the right size we examine. And these days the investigation of choices in MRI scan, and we tend to use a three t scan, which gives us double the resolution. And we know from a study we did a few years ago that in 80% of cases, if you've got the right scanner and the right radiologist because you've got to have the right team looking at people in 800 cases, you will get confirmation of what you think clinically 20% of cases some reason doesn't show and I suspect is the more common situation in chronic tears where all the inflammation is settled down. And the MRI is not picking up the differences in the tissues because the acute inflammation is gone. So with all things, it's the symptoms of signs and investigations you do that give you the diagnosis.

Steven Bruce
That slide you showed us I'm in the the margins of the bruising are very, very distinct, very clear. Is that always the case,

Simon Marsh
which is usually have these things called factual claims, and it's one of the first things we learned about a medical was all these factual claims. And they've all got terribly complicated names. I mean, you all know that that almost gave up. So I thought I can't pronounce all those are in Latin, almost went home, but I stuck it out. But it does, it's a special place. It marks out really nicely in it. It's a living demonstration of the anatomy of the groyne. But to say this chap that I actually saw, we didn't operate on he got better because you can't do anything. When it's all bruised. You've got all the E matome. And the tissues. And he actually recovered and was back playing again in two months time anyway, so he didn't actually need an operation.

Steven Bruce
But well, that actually answers one of the questions that's come in because Jeff was asking whether the bruising was due to the surgery or the injury itself. And obviously there wasn't surgery this case, but

Simon Marsh
yeah, I do cause bruising as well. I admit that.

Steven Bruce
Yeah. Peppers asked how you distinguish or you differentiate growing pain of this nature from referred pain from the SI or the hip?

Simon Marsh
Yeah, and it can be really difficult actually. And it is a matter of just remembering there are lots of other causes. You're right, referred pain is one of them. And it's got to fit the pattern, which is why I think we need to come back to remembering that Gilmore's growing as a specific syndrome within the whole group of growing pains that you see. And if you've got the right sort of person and the say tends to be young fit chaps, it's much less common in ladies because the anatomy of England or region is different. Obviously, men have the spermatic cord that goes down to the testicles. So it's a much bigger sort of archway through the extra and oblique neurosis where the ladies, that's really narrow, because all they have is the round ligament the issue. So it's much less common in women. You tend not to see it in older people, although I did have a chat. It's quite a few years ago. Now he was 78. And he's a retired international tennis player that obviously I can't mention. But he came in and you know, the thing you really hate, he came and said, I've got the groyne I want the operation. And you go okay, right, have you. So I listened to his symptoms. Nice. I've got the groyne Haven't I want the operation? I said, Well, let's just examine you. And I examined you and you fell on the operation. I've got the groyne. And I said well, yeah, I think Yeah, but come on, you're 78 and it's just your body telling you to slow down. He said, But I play tennis three times a week and I can't play I want the operation. And Jerry and I always have this sort of unwritten rule. Don't do it. And people under 45 did never works. But this cat was very insistent. And I crossed everything and did the operation and he didn't have a tone. Ronnie came back as jackal A month later. And he walked in with a little trepidation. You know, how are you feeling? He said, brilliant. I played tennis last week, I'm absolutely fine. which point I threw the age limit out of the window. And what you are finding now is because people are keeping fitter for longer. You do it in older people. I think potentially they've got other things as well. And that's the difficulty. And I've seen a chap recently who who rides horses for a living and came along and he's probably got on the almost grind, but he's got osteitis pubis, he's got sympathy or disc prolapse. He's got arthritis in his hips, because you know these gems ride horses well into their 60s and he's got everything else going on. And you just think, okay, I could offer a new one, but he's not going to stop your pain because you've got so much else going on. And in fact, we've sent him off to some other things done season rejections will help and see where that leads us. It's very easy for a surgeon so you have an operation, but it's not always the right thing. And like any operation, if you pick the right people, you'll get good results. If you don't, you don't get good results. So it's a matter of just remembering that stuff. cific syndrome, if it doesn't fit, then you think about all the other things it could be.

Steven Bruce
Yeah. I thought for a moment back there you said that the previous philosophy was that the operation never worked on people under 45. But over,

Simon Marsh
yeah, I beg your pardon. Yes. Thank you for correcting me.

Steven Bruce
You don't know I probably misheard you. Just one question on this. I mean, the bruising on the photograph that we saw a little while ago, I mean, it, it looks as though that athlete would have known instantly when the injury occurred, because it looks quite serious. Is that always the case? Are they

going to say, Yeah, I know this happened when I did that particular movement, or can it be less obvious? Yeah, that's

Simon Marsh
a really good question. What we find in about a third of people is, as you rightly say, there's a specific injury. And it often used to be the footballer who would go in for a tackle, take their leg taken out from the side, they'd know instantly, they'd done something because they had to stop and come off. And the next few days, the bruising comes out. In about two thirds of people, it seems to be more of an overuse thing, that you get a little bit of a turn a little bit of a turn a little bit of a tear. And then the whole thing goes. And this brings us on quite nicely. So I think that the slide that I've called the aetiology of giving was growing, which actually is Gary Gilmore's, original slide back from the 80s of how it happened. And he talks about how the hip flexors tilt the pelvis and how the tilted pelvis can't stabilise the abdominal muscles and you get these micro tears that then become the Phil Gilmore's guide. It's like the straw that breaks the camel's back. And it's just interesting that I've still got these original slides from Joe's people know, died a couple years ago now. Because they just give people insight into into the leap of lateral thinking he took to realise what was going on, that nobody else had come to that conclusion. It's just that to think laterally.

Steven Bruce
And I think that that's the philosophy which will chime very well with our audience, you know, primarily primarily a manual therapist to be looking at all this business of muscle strength and asymmetries and so on thinking of that that's what we do. JOHN has sent in a question asking whether you give consideration to pubic asymmetry with all without a doctor muscle involvement.

Simon Marsh
Yes, he asked that and we used to do stock X ray views which don't be familiar with where you stand on one leg the other so look for movement of the pubic symphysis I have found one case in 25 years where that was so marked we actually sent the chapter after was beating surgeon hood a plated Crossman whose pelvis was cured his symptoms. But I've only found one case, it's not something I do regularly now. Unless I really can't convince myself something else is going on. So yeah, it does happen, but I think that's quite rare.

Steven Bruce
What about the longer term outcomes of surgery? Peter has said he once said a very good amateur marathon runner who'd had a Gilmore's groyne repair, which was successful, but he ended up having a hip replacement a couple of years later at the age of 41. Of course, that could have been quite coincidental and not related, but is that a likely or common outcome

Simon Marsh
could be unrelated. And you're right, we do see this in in long distance runners. And what they tend to find you just find that time start dropping, they can't quite work out why. And this is almost certainly the overuse time that we talked about rather than a specific incident. The other thing I see very commonly in the long distance runners, if they do get the osteitis pubis and the disc degeneration because of all the pounding in the shop, what goes through the pelvis at the front. That's the other thing I see. And

there is this discussion about whether osteitis pubis is a primary thing on its own, or whether it does relate to for example, that the girl was going with the muscles pull so hard on the pelvis and the tightness that causes it, and I've certainly had a few people who have got Gilmore's groyne. And you mentioned very kindly, the march modification, one of the things we do is we actually release the inguinal ligament from the pubic so take it back and it will go back about 500 metres. It's really tight. And you wonder whether that causes some of the osteitis pubis and in some cases, I suspect it does. And that's one of the things we took up 10 years ago while my broken arm was healing and it does seem to help. But I suspect there are some people who get through primary osteitis pubis, which is really difficult to treat.

Steven Bruce
So when you say you release it, you just cut it.

Simon Marsh
Yeah, exactly right. I do it with electro cautery so it doesn't bleed, but you can you can feel where it runs onto the pubic tubercle and you just run we all know the diathermy round it and it just goes back about five millimetres you can see how tight it is. It also means that when you do the repair, in the old days, the repair was actually stitched to the pubic cubicle, which just seemed to cause a few people have quite a lot of pain afterwards in that area because the ligament comes back five millimetres. The stitch doesn't go into the parallel smooth of the bone. And although I can't give you definite numbers, although I have a big file at home 1000 cases since 2010, which I haven't had time to go through, my feeling is that doing that just stops a small number of people getting back some persistent inflammation, what we call the anchor stage where it's done, because we used to now and again, go back and remove that ditch from people to take that away. I just don't see that anymore. Right.

Steven Bruce
Okay. So when someone comes in to the clinic, I mean, I imagine if they come in with a growing that looks like the photograph we saw a moment ago, you're probably immediately thinking this is this is your line of business. Yeah. If it's not quite as obvious, what are the clinical tests that you would use?

Simon Marsh
So the first step we take is you need to examine them and examine people standing up to start with, and the first thing you do is you just ask them to point to where the pain is. And as we saw the other one, I'm Jerry Gilmore, slide a person with the G and the H and the age on on them.

Steven Bruce
Justin, can we bring that one up? I don't know if we've shown that when we're slow for.

Simon Marsh
Yeah, again, this is another Premiership, footballer Gerry Epstein. And he just drew the G for where you feel the pain he was going over the superficial ignoring the gaze of the oviya doctor on the pelvis. And the H is where you get hip pain in the crease of the groyne if you like. And so you just ask them say, where's your hurt. And that gives you the first clue because some people will point to the adopter, some people will point to the doctor and sort of swing their finger up through the symphyseal desk and

into the inguinal canal. And we begin to talk about if you like adapter, synthesis, inguinal axis syndrome, which you can make engages in if you like, because they're all connected. But that's the first clue. You know, if they point along the front of their thigh thing, well, this is not going to be doing what's going if they run their finger along the hip crease, you think that might be the head, or the other classic one is what we call the see sign where people stand and they put their hand like that around their waist and you think well that's going to be your hip. So that's always the first clue. Why would then take you stand them up you feel you get the cough, make sure they know obvious hernias and any line and down and then the first thing I'll do is wiggle their hips about particularly in flexion, and internal rotation to see whether you feel any signs of femoroacetabular impingement. And you didn't get that and as you internally rotate in flex it and push down, you can feel it and you think okay, there might be a hit going on as well. One of the best tests I've come across is very simply just a woman lying down just my hands over their thighs, and ask them to do a partial setup because when they engage the core muscles, if the groyne is torn, you can watch them grimace because they'll feel it and they get paid over the G where you get the point pain. And I get them for no particular reason to push their legs out. And that's a bit of a red herring and then squeeze them together. And if you squeeze hard, you're looking for adductor pain or weakness in the adductors, which we see in 40% of people. And then comes the fun part because that's when I have to get my little finger out and put it up the back of the scrotum and underneath to get into the superficial inguinal ring to feel it. What you're looking for in somebody with pain on one side is a superficial ignoring on the affected side is widened. It's dilated. And usually at this point, they're already swearing at you because it's quite painful. When you then put it backwards, they get pain in the poster or the inguinal canal where the muscles are torn. And when they cough, we said you get this bulge and we say it's not a hernia, it's just a weakness of the muscles allowing the coffin bolts to come through. And the trick is to compare that with the normal side now to UK to get people who've done both sides and then it's usually very good. But you're looking for that set of signs when you examine somebody and that helps as well. Some people are going to be tender ob duck origins some people are going to be tender over the superseal desk. And as we said we often get people with more than one thing wrong with them. So you've got to look for all those things as well.

Steven Bruce
What's the consequence of us missing this let's say someone comes in and we say obviously is not a Gilmore is growing, it doesn't need surgical repair. What what might go wrong for the patient?

Simon Marsh
The first thing I would say is it's that that's not that uncommon, but I completely understand it because it's quite difficult. I know we spend a lot of time going around doing lectures is why it's really nice to do things on this just to help people understand. I completely also understand why people don't recognise it. I mean it's not a life threatening injury. That's the important thing. And what you might find is people who normally do sports or play squash will just not be able to do them, which is a nuisance if they enjoy it but it is not it's not a life changing event. You know with a professional sport is different. They often come along with their club physiotherapist with their MRI scan and plug it down the table say operation is weak please. You think okay, well we still need to go through the symptoms or signs and the examination and this the MRI scan is really important and what I very commonly find is MRI scan is done outside of our multidisciplinary team often don't give you the information that you need and I have to send the disc off to be double read and they come and say my MRI is normal I send it off and it

comes back to the isn't We can see the signs of the tear. So we're going to double check everything he did the operation the wrong people, it doesn't work. For people who are not professional sports and just enjoy life, you know, they might find that they can't enjoy life because they're growing hearts hurts too much. And they have to modify their lifestyle and stop doing the things they enjoy. Or, you know, they come via the Internet, and they say that I found you can you have a look? Yeah.

Steven Bruce
Okay. And so having had the surgery, how long is the recovery time,

Simon Marsh
it will vary. And in the old days with a professional football is it's very much a week 1234 recovery. And we have a specific set of exercises we get people to do and we started fairly quickly. So I do a lot of operations on Thursdays, as you say, people will start their exercise next Monday, they'll spend the first few days just walking to loosen everything up and start rehab on the Monday. And it used to be 1234 an entry playing at four weeks. Now we have to recognise that not everybody's a professional sportsman. So we change that. And we just call it phase 1234. Because in some people, the first phase might take them 10 days, second one might take two weeks, and everybody needs to listen to their body and do things in their own time. I think my record is a chap who was a triathlete who had both sides done and was competing, again, international level of six weeks. Jerry's record was a former Arsenal footballer who was playing in three weeks. So it can be done. And one of the things we find is the fitter you are before you do it, the quicker you get better, and most of us are not as fit as international athletes. So it will take a bit longer. I also tend to find the older you are, the longer it takes and the longer you've had it longer it takes.

Steven Bruce
I guess most of those would apply to pretty much all surgery wouldn't be.

Simon Marsh
Yeah, I mean, that's probably fair. Yeah. And I've had, you know, I've had my own operations. And it's one of the things I learned how important it is, excuse me, in terms of not just the surgery, but physio therapy, and so on afterwards, in having smashed my right arm, I actually did physio therapy for a year afterwards now realise how important that is. And how important is not just the surgery. It's everybody else involved. We're getting people better. And it's important that this multidisciplinary team that we talk about.

Steven Bruce
Yeah, and you work very much as part of a multidisciplinary team, don't you? Whether with river London sports injury clinic or in your own practice? I'm not quite sure. What sort of do you have? Do you direct the rehab yourself? What do you leave that to the physios

Simon Marsh
and a lot of people have physios in clubs? I'm very happy to leave it to them. But we always send the exercises to know what to do. But professionals obviously they know what to do. We do have physio works with Johnny Wilson, those based in the Midlands will contact people virtually and help them go

through the rehab. We have a specific physiotherapist you need who comes into the hospital where we do and will take people through rehab as well a lot of people can do it themselves because they can just put along at their own pace. And that's fine because they need him we've got all these people that we can ask us as well. And it might it's just not it's not just the physios it's you know, we've got specialist nurses who work with us who know about you know what happens after an operation. So when somebody phones up says I have an operation a week ago, and it feels like this is this, okay? They know exactly what it's like. And it's even down to the neatness at surgery, you're getting the right degree of muscle relaxation, because when you repair the muscles, you've got to be able to move them around. And this is a reason why I don't think you can really repair Gilmore's going under local anaesthetic because the muscles are not relaxed, and you have to be able to move them to reconstruct them. So all these things are really important. And then we say the radiologist as well, you've got to have the right radiologist who works with the team who knows what to look for. Otherwise, you just get a short report saying no hernia MRI is normal. And that doesn't help us at all. So you're absolutely right. And whatever condition you have, if you have a team of people looking after somebody, the results will be better.

Steven Bruce
And the rehab exercises that you mentioned there is there anything out of the anything out of the ordinary thing we wouldn't necessarily think about in terms of rehabbing someone who's growing has been attacked.

Simon Marsh
It's actually relatively straightforward. A lot of it is core stability exercises. And it tends to go through through three phases, you've got the mobility phase, getting going again, then you've got the stretching and increasing strength before you get back to the sport sitting exercises. So it tends to run through the four phases. And again, if everybody does it in their own time, I think the fit sportsmen do it more quickly, as I say, but it's that it's that mobility, flexibility, strength and back to sports specific exercise after that before we return to play.

Steven Bruce
And you might have given this already, but what's your success rate on these operations?

Simon Marsh
Right, that's a really good question. And we know because we've got data since 1981. So we got 40 years worth that we get 91% people back to their pre injury level. No no operators 100%. If ever you go and see somebody who says, first of all, I never have complications or is unplanned successful, I would suggest you go and see somebody else because that neither of those things are realistic. That doesn't include a significant number of people who never come back and see us because obviously professional sports men, if they're fine, we never see them again. But we count those as people we don't know about. So the true success rate is probably higher than that. But we will say 91%, there are always a small number people who do not get better. And often that simply because young got the diagnosis, right, and there's something else going on. And I'm quite happy to accept that because as you suggested, it's not always easy to work out what's going on. But I think 91% is fair 100% just never works.

Steven Bruce
What sort of complications might you have as a result of the operation,

Simon Marsh
I think there are normal complications of any operation, you can get bruising and bleeding and wound infection, which is not common, if anything, one chap who did it again within six months, and that's because he was in Hong Kong when it was raining and he ran and slipped for a taxi and his leg went out beside he did it twice. It does happen again. And we know that 3% of people over a 10 year period will do it again, we know that we also know that over a 10 year period 10% will do on the other side. So we know all these things. We don't normally fix the normal side because nine times out of 10 is not necessary. So we don't do it. We just wait and see but we try and make people aware of this is in the information we give out. So there are a small number who just don't seem to get better. Where the rest of the team comes in other schools next size physicians who will deal with injections and more detailed rehab and so on to try and help. But there are a small number who don't and that's that's a real nuisance for them. And it's disappointing, but I think you have to be realistic and accept that that will always be the case. And it is probably because their pain was not caused by the groyne tear or there's something else going on that we just haven't recognised.

Steven Bruce
But 91% I mean it's a very very reassuring encouraging and yeah, it's a it's a hell of a statistic so weld on you but you are the brains behind the marsh modifications to the Gilmore growing repair. What's the statistic like more genuinely across the country? Do you know

Simon Marsh
that difficult one, there are lots of people who do but I'm gonna put the inverted commas sign up given what's going on repairs. And some of them seem to do with a lack of understanding what they're doing because I will often see people who come and see me and say, for example, I had my hernia repaired six months ago and it still hurts still hurts. Why is that? My hernia repair, you know how big was the lump. So I didn't have a lump. But I play football and every time I played it got pain in my groyne are stiff and sore for a few days afterwards. And it got to a stage where I couldn't play and so on. And what we've had is a mesh but in their drawing over muscles that are tall. So of course you've got a mesh over tall muscles, the muscles are still torn and they don't work. And I do rarely go back in and take the mesh out and reconstruct the groyne. And that's not a common operation. It's not easy and difficult to give you exact figures about that because I don't do it that commonly but my feeling is that will work very well if you pick the right people.

Steven Bruce
So that's the first thing you said which is somewhat less than encouraging is because most people that we see are not going to come to see you personally for their repairs. And clearly we've got to be alert to the possibility that they may have they may have had a Gilmore's repair for something that wasn't the Gilmore's or vice versa, you know,

Simon Marsh

isn't an anatomical repair of muscles and tendons are growing using stitches that will dissolve in the end so you're left with the normal structures. The other thing that I find more than little frustrating is people who deal with Guild Wars go ahead and call it a diagnosis of exclusion. by which they mean Oh, this chaps got growing pain. I can't find out what it is it must be Guild Wars going let's do an operation. Now that that's I mean Please forgive me but I do feel strongly about this, that that's the view of somebody who's intellectually destitute because you do have this specific syndrome. This is what I want to get over specific syndrome symptoms, signs imaging findings, that is Gilmore's groyne. And just to label you know, a 65 year old chap who's overweight and doesn't do much at all we've got a growing pain that scale was growing, Mr. Marshall Curie with an operation that just doesn't make sense and I do see people who come expecting to be cured of their growing pain because they've been told by somebody you've got wrong pain. I don't know what it is Gilmore's going to go and have an operation and of course I'm gonna tell I'm not gonna do that and it's not gonna was growing. So we got to get away from that, that everything you don't know about is getting was growing because there are lots of things that called pain in the groyne that we don't know about.

Steven Bruce
Quick question about the inguinal ligament again, somebody else has followed up on what I was saying because again, I'm I'm still curious about this. Adam has said how far through the inguinal ligament Do you cut because presume you don't detach it completely in order to get a few millimetres? difference.

Simon Marsh
You take your dog home, you run it from the top of the pubic tubercle down into where it begins to fuse with the adductor tendons and the whole thing. We'll come back about five millimetres, what I would say and I'm very happy, but if anybody wants to come and watch at any stage, we can usually arrange that. One of the things I would say that with the pandemic, the number of Gilmore's go into operation doing is not quite as high because people realise they can live with this and don't want to come in for an operation at the moment. And so the numbers are not as high as they used to be. But if people would like to come and watch perhaps even they could let you know, and you could let me know if they want and what's your price, I'm very happy people come and see, and you get a much better idea of what we do. And I think that helps often with with professionals, I'll get the physio deliberately so you must come and watch so they see what's going on. It helps them with the rehab, and it helps with learning about what we do so delighted if people want to come and watch

Steven Bruce
the safe. How many could you cope with at once?

Simon Marsh
Probably not more than one I'm afraid because evictions and so on. A quick

Steven Bruce
word if you don't mind about about hernias, rather than Gilmore as growing, Claire has asked whether you have a recommended rehab protocol before surgery. So prehab protocol, I guess, with hernias.

Simon Marsh

Yeah, and we do that to be almost going as well. And it's basically really concentrating on core stability to work the core muscles as hard as you can. And again, an example I had was an England fast bowler, who actually was playing was 19 at the time who was playing under 19 World Cup did he is growing we got him pushed hard for two weeks fixed is growing the month later, he was bowling in the 19 World Cup. So the fitter you can get people beforehand, the quicker they just recover. And that and applying the same for 200 years, or forgotten was growing.

Steven Bruce
Okay. And I don't know who asked this question, but somebody has asked what you recommend for those longer hernias that are visible in the older gentleman. As they sit up, get off the couch investigation or just ignore it

Simon Marsh
ignore because the first thing is that it's not a true hernia. That's a thing called diversification of the rectus muscles. I will happily show you mine but I don't want to upset anybody. And as we get older, the rectus muscles will normally pass slightly and you get these longitudinal boulders you as you sit up and nothing needs to be done about it again you can work on core stability to try and get it less stop it progressing but you can't get rid of it when you've got it and I wouldn't do anything about that you could I suppose. You know go from top to bottom and open everything up in time and all that but I wouldn't recommend that. I really wouldn't. It's just part of being less young.

Steven Bruce
Yeah. Okay, well, that's reassuring for whoever asked that particular question. Kim's asked whether there are any videos available if the operation

Simon Marsh
and there aren't the difficulty is because it's an open operations are relatively small hole it's very hard to get a camera somebody has suggested that I get myself a webcam to where and film one that is something to think about. There are various pictures that we've gotten a taste of the stage tonight and the best way you know people to come and watch us a very happy, it's just difficult getting people in the moment. But that is something to think about. Whether I get myself a GoPro and film somebodies and if I do I'll let everybody know we'll put it on our own website. I want to wait so you can see it. That's not a problem.

Steven Bruce
But presumably I mean, you're you're filming through a camera or you're filming as you're as you're carrying out the surgery or you're not. Yeah, that's what

Simon Marsh
I'd be doing. The ones we tried have been people filming myself and that just doesn't work, you don't see anything. So I would need to get a GoPro camera and have it in the right place and try and keep my head still, which I'm not very good at to get the degree but even then, you know, the hole is you know, the operation is only through quite a small hole. It's quite hard to do anything. It's different from like the laparoscopic surgery where it's on a big screen. And having brought that up I will point out that

again some people have laparoscopic surgery for Gilmore's growing. What you have to remember is the almost going to tear of the muscles on the front of the abdomen. So putting a big patch inside it again doesn't address the tall muscles of the front and I just don't see the logic of that one.

Steven Bruce
We did have a question earlier on which I don't think I mentioned somebody asked David asked whether there is always bruising with Gilmore's growing.

Simon Marsh
That's actually really uncommon. And if I do see I take pictures I've only got three pictures that's really rare. And actually right it's just that's quite a dramatic injury. When that happens we can usually get that settled down so most people don't notice anything you more commonly will get bruising with your doctor tears. And I suspect a lot of people watching will have seen the quietcontrol rooting you get down in the thigh when you tell your adopted muscle. And again, there's no reason to do anything about that because what those patients have done, they've done their own adapter release the tight tendon tears, it will heal back longer and it will take the tension off itself but that's where you get the really dramatic bruising more commonly is with the tears.

Steven Bruce
Yeah, I'm sorry I dragged you away from hernias back to Gilmore's groyne. Again. Before we went on air, you said you could perhaps spend a couple of minutes talking to us about the modern approach to repairing hernias.

Simon Marsh
Yes, and this all comes from the fact there's been about whether mesh hernia repairs cause chronic pain. Now there are about 80 1000 hernia repairs I mean pre pandemic repairs in the country obviously there are less now and lots of CCGs and NHS are now trying to restrict hernia repairs. And previously it was all the new people learn how to do this if you like with a modified what's called shoulder dice technique, the Sol dice clinic in Canada, Edward L. Sharm el shango is founded it and they learned they repaired hernias anatomically with stitches. And that was how we will add to it. That's how I learned to do it as what was called a surgical registrar in the late 1980s. Now in the mid 90s, this technique that some people heard about called Alicia and Stein technique aimed after lessons dying, if not from the country, it's the man. And what he did was just put a plastic patch over the hernia and stick it on top of the muscles. And this became the standard way of doing it in the NHS because it was felt to be easy for an inexperienced surgeon to have low complication rates, low pain and so on. None of the other bits are true. It perhaps is easier for an experienced surgeon because you don't have to understand the anatomy. And this is one of the problems I think we're now seeing. But then you're getting the problem of does it cause chronic pain. And it's the same with the laparoscopic repairs where they just put a very large mesh patch on the inside gamma. And I've seen all sorts of complications from that. And there are a whole long list of complications of laparoscopic surgery which you don't get with surgery from front. They're rare, but you don't get them from the front.

Steven Bruce
It's still being done these mesh repair.

Simon Marsh
They are and they're still being done about 15% of hernia repairs are laparoscopic, the vast majority in this country mesh repairs now. Now I haven't done a mesh patch repair for over 20 years, I don't like them. I have used a thing called a mesh plug. And the thing about the plug is it sits behind the muscle Not in front because it's the front where the nerves are being put a plug behind. But I always repair the muscles over the front in an anatomical fashion. And I'm increasingly getting people coming to see me sounded like a hole in your pay. I want no mesh at all. That's fine. That's how I learned to do it. I don't mind. And I wonder whether I perhaps is not even using the plug. But some people with a really big hernias. You just think with a plug behind not the mesh patch in front, but the plug behind it just gives you that reduced risk of it coming back. So I think it's a compromise. But I think the thing is people need to be aware of potential risks and have a choice of which way they have it done.

Steven Bruce
Final question for you, Simon. We've got about one minute left. what point would you say I don't who sent this in At what point would you say someone needs surgery for hernia, one of those criteria

Simon Marsh
for a hernia? I think it's causing if it's always getting bigger if it's causing them symptoms or pain it needs to be done. The NHS tries not to do hernias, what we call minimally symptomatic hernias. Now the trouble with that is if you have a 75 year old jet with a minimally symptomatic only when he's at it could be quite symptomatic, and by which time you might have a heart attack, so I have a low threshold for repairing them. But what I like to see is a definite lump you can push back, if it's just pain or even if an ultrasound scan says all those little fatty hernia just be a bit careful because it's probably not the hernia causing the pain.

Steven Bruce
Simon Thank you. There's a couple of other questions which have come in but we are at the end of our time, and we're very grateful for you giving up your time. I hope you got some teacup audiences

Simon Marsh
and certainly no problem. I'm very grateful and I enjoy doing things on it. It helps us let people know what we do and hopefully dispel some of the myths and confusions about what goes on surrounding Gilmore's going particularly and also

Steven Bruce
helps us to distinguish who we need to refer to people like yourself and I know you've got to rush off for surgery this afternoon. So we're doubly grateful. You're joining us today.