Rugby union is a highly competitive sport. Since the advent of professionalism the players are becoming bigger, fitter, and faster. Injuries are therefore inevitable, though some are preventable. To help prevent injury it is important for players to warm up thoroughly before taking part. The correct technique is also of vital importance, particularly in the tackle. In an attempt to protect themselves, more and more players are wearing head guards (scrum caps), and shoulder pads also seem to be increasingly common, though not always allowed within the laws of the game.

One of the attractions of rugby union is the opportunity offered to players of different sizes in different positions. However, players are increasing in size and even those playing at scrum half, traditionally the position for the smallest player on the field, are getting bigger, with many tall international scrum halves—for example, Joost van De Westhuizen of South Africa. Countries now favour bigger players and this puts smaller players' places in jeopardy.

Injury associated with the scrum is still a controversial facet of the game. This season the back row has to stay bound until the ball is out of the scrum to allow the opposing three quarters more room to run. Also, despite stricter refereeing the collapsed scrum is still far too common. Different laws for younger players require less intensive scrumming to reduce the potential danger of spinal injuries, particularly to the neck! Tackling has changed too with players tackling higher, which is a technique favoured in rugby league. This puts the tackler at greater risk from neck injury.

Obstruction is also very common and referees are under increasing pressure, despite help from touch judges. The two areas of the game in which there are particular problems are in the killing of the ball on the floor and off-side play by the three quarters. With so many difficult refereeing decisions, we may be approaching an era of action replay as has happened in American football.

The number of personnel who coach the team has increased considerably. Nutritional experts, fitness advisers, and psychologists are an integral part of most top teams. Top level rugby now demands the support of medical and scientific experts, and a highly professional approach exists on and off the pitch.

The forthcoming British Lions tour of South Africa poses some interesting questions. The British players will be playing for the most part on bony hard grounds. Friction or grass burns are likely. Once a player has sustained one of these injuries, it is very difficult for it to heal, owing to repeated trauma. Liberal application of Vaseline plus protective wear may be used in an attempt to prevent these types of injury.

The big difference with playing in South Africa is the effect of altitude (High Veld). Acclimatisation is thought to be important, though it is interesting that provincial teams in South Africa fly up from sea level to altitude on the day of the game and then fly back home, the altitude apparently causing them little problem. The South African players will certainly be bigger than their British counterparts. This has always been the case with the Afrikaans nation.

There are many rumours about anabolic steroid use among rugby players in the southern hemisphere, though there are similar rumours in the United Kingdom. Drug testing is spasmodic at present, and I believe that anabolic steroid use is more widespread than is generally thought by the authorities in the United Kingdom. The Lions tour to South Africa is the first British tour to take place under the new professional laws and it will be interesting to see how the players react.

There is much conjecture about the future of British Lions tours. Personally, I feel that they are the pinnacle of a British player's rugby career, and I certainly valued them greatly on my two trips to New Zealand in 1971 and South Africa in 1974.

There is still a considerable difference in the entertainment value between the northern and southern hemisphere teams. The Super Twelve tournament in the southern hemisphere encourages points scoring and the game is much faster flowing. The refereeing is much looser and encourages free flow. It behoves the players and referees in the northern hemisphere to make the game a better spectacle. After all, professional sport is all about entertainment and the paying public deserves enjoyment.

J P R WILLIAMS
Bridgend and District NHS Trust
Princess of Wales Hospital
Coity Road
Bridgend
Mid-Glamorgan CF31 1RQ

Sports injury clinics

Sports related injuries form a significant part of the workload of the National Health Service. Patients with acute injuries account for between 3.9% and 7.1% of total attendances at casualty departments, and a higher proportion of attendances—28% by children. An unknown proportion of these injuries go on to become chronic or recurrent problems which later involve orthopaedic clinics or general practitioners. Cohort studies of GP populations provide evidence that in the under 65 age group about 7% of all consultations (excluding those for back problems) are for symptoms relating to strains and sprains, tendinitis, and enthesopathies. Not all of these can be due to sport, but many are, accounting for a significant proportion of the workload in primary care.

There is at least one other significant group of people with sequelae from sports related injury. These are individuals who for a number of reasons seek out and pay for assessment and treatment in sports injury clinics. A large recent study of the use of a network of these clinics in Scotland shows that most find their own way to the clinics as few are directly referred by their GPs. The majority have chronic or recurrent injuries. Why do they take their injuries to non-NHS providers? Maybe access to services is difficult because of the rationing imposed by waiting lists, and the timing of NHS clinics during the working hours of the relatively young and working population. Patchiness of expert advice and level of interest at a primary care level is probably another reason. Clearly, there is an unmet need
for expert advice and treatment for which, for whatever reason, NHS resources are unavailable. This might reflect widespread belief that injury occurring as a result of sporting activity is "self inflicted", leading to an implicit denial of an NHS responsibility for its treatment. However, health boards and other national organisations actively promote exercise as a component of attempts to improve the public health. The injured follower of this advice might well ask why the NHS fails to follow up the consequences of its own health promotion campaigns.

The clinics in Scotland which provide physiotherapy, and often podiatry services, are open at more user-friendly hours than regular NHS outpatient clinics. The sports clinics may be attached to general practice or, rarely, hospitals. More usually they are situated in local authority premises. The network in Scotland was set up with some initial funding for equipment provided by the Scottish Sports Council, and there is a process of regular accreditation and review every three years. One requirement is that chartered physiotherapists only are involved, and there needs to be medical participation. The number of clinics varies over time, the maximum being 38, of which 28 are currently accredited. Provision of services by private physiotherapists is not included.

Now that a large descriptive study has been completed, further such studies are not going to add much, at least in the near future. What is the next stage? The normal process in epidemiology is to go on to undertake prospective studies of injury. Descriptive studies have many limitations, the absence of suitable denominators—hours of participation, numbers of events, training sessions—being the most obvious. To make an impact numerous sports need to participate, particularly at the recreational/club level. The elite are not the problem from a public health perspective, though their own good (and unfortunately also their bad) practices can serve as models for the much larger majority of active participants. Prospective studies imply setting up monitoring systems for injury, which, once in place, should be maintained. Thus any strategy to reduce injury by appropriate attention to rules and to coaching practice can have its effects closely watched. This has worked for hurling in Ireland. It needs to be undertaken for many other sporting activities.

Suggesting the above is of course easy, but doing it is quite another matter. Funding is an issue. It is available in a few of the larger sports. As for the 150 or so other sports with national associations there clearly needs to be a coherent overall national strategy put in place by the sports councils.

Using an evidence based approach for the reduction of injury needs to become a priority for all associations, not just for those with foresight. Go for it!

ROBIN KNILL-JONES

Department of Public Health
University of Glasgow, G12 8QQ

Sports injury clinics.

R Knill-Jones

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