LETTERS TO
THE EDITOR

Editor,—I read with interest the leader by Billat VL. 

Oxygen uptake kinetics in general, and the 

aetiology of the VO2 slow component phenome-

nomenon in particular, are certainly topics of 
great conceptual and practical importance. 

However, there were several points of conten-
tion within Dr Billat's article that should be 
brought to the attention of readers so that an 
informed and balanced debate can take place. 

Dr Billat states that “A high range of work (rates) can be identified at which there is a sustained increase in blood lactate . . . with maximal lactate recruited before a baseline value.” These two sentences, which are applied to a description of the physiologi-
cal responses to moderate intensity exercise, are clearly inconsistent. It is also stated that 
during high intensity exercise “only lactate levels of about 80% in high level marathon runners”. This suggests that VO2 will reach a steady state close to 80% VO2MAX irrespective of the absolute work rate within the moderate exercise intensity domain. However, it should be remembered that moderate intensity exer-
cise is, by definition, any exercise that is per-
formed below the lactate threshold. There-
fore constant load moderate exercise can lead to 

the lactate steady state if it exceeds the rate of disac-
car-ance . . . VO2 reaches a steady state that is higher than the VO2 requirement” and “(time to exhaustion at) critical velocity is reduced to less than 30 minutes”. If Dr Billat believes that critical velocity occurs at a higher intensity than the maximal lactate steady state, then she should support this position with references. 

I am aware of any studies that have compared the 
directly determined critical velocity and 

maximal lactate steady state in runners, and the 

more thorough studies in cycling suggest that 
the two may be viewed synonymously. 

Dr Billat also states that time to exhaustion is lim-

ited above the critical velocity “because of rapid exhaustion”. To my knowledge, there is no evidence to support this assertion, and it would be safe to say that fatigue at these 

exercise intensities may result from a number of different mechanisms. 

In the mechanism for the VO2 slow component, Dr Billat states that “. . . is mainly due to the recruitment of fast fibre type II fibres (sic) with fatigue”. This is something of an oversimplification. Although it is true that the relative amplitude of the slow component is well correlated with the proportion of type II fibres in the vastus lateralis, a great deal of additional work must be carried out before the recruitment of type II fibres during heavy exercise can be unequivocally accepted as the mechanism for the slow component phenomenon. Dr Billat also states that the reduction in the slow component observed at the same absolute exercise intensity after endurance training occurs “. . . because of an increase in the dis-

tribution of type I fibres”. Again, to my knowledge, there is no evidence that changes in the proportion of type I muscle fibres will occur as the result of a short term training programme. It is also difficult to understand Dr Billat's assertion that “. . . the amplitude of the slow component is not linked to endurance at all”. It seems implausible that a phenomenon that is causing VO2 to rise inexorably towards its maximum, and that is generally associated with a profound and increasing metabolic acidosis, is not related to 

endurance exercise performance. Indeed, in her own article, Dr Billat reports that, after a training programme that increased the slow component, the time to exhaustion at the high intensity training pace was doubled. 

Of greatest concern to me is Dr Billat's statement that “. . . fit endurance athletes . . . have no VO2 slow component”. In several years of work in this field, I have yet to observe a single person (elite, well trained, recreationally active, or sedentary) in whom a VO2 slow component has not been shown during high intensity treadmill running. Dr Billat's reports of minimal slow components in highly trained runners can be explained by methodological problems in her studies. The subjects in these studies were not exposed to “square wave” exercise functions as is con-
vventional in the serious study of VO2 kinetics but, rather, the treadmill belt velocity was increased gradually until the subjects reached the required exercise velocity which is not appreci-
ably greater than the critical velocity) before timing was started. The VO2 slow component was then defined simply as the difference in VO2 between the value at three minutes and the value at the end of exercise. Given the 

faster VO2 on-kinetics in fit subjects, the reduced slow component in subjects who are aerobically fit or who have a high proportion of type I muscle fibres, and the fact that the slow component typically emerges at two minutes into heavy treadmill exercise, it is possible that Dr Billat's methods lacked the sensitivity to detect the slow component. 

Dr Billat's work in identifying the type of training session that maximises the time spent at VO2MAX may well be of some conceptual value. However, I feel that it should be acknowledged that there is no evidence that this type of training is more effective than other types in improving VO2MAX or any other physi-
ological correlate of endurance performance. 

In conclusion, Dr Billat's observations and ideas are interesting and deserving of further study but I feel strongly that they should not be presented as fact (as they were in her article) until they can be confirmed by other groups. An over-reliance on unpublished observations is not helpful, and uncorroborated studies in review articles is unscientific and potentially misleading.

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2. Poole DC, Ward SA, Gardner GW, et al. Metabo-


4. Billat V, Bonnaud M. Influence of running on 


Impact of professionalism on injuries in rugby

Editor,—Garraway and colleagues have re-
cently written an important follow up study1 to their 1995 survey on rugby injuries in sen-
ior rugby clubs in the Scottish Borders.2 This 
comprehensive review of rugby injuries and their implications set standards in injury defi-
nition and information gathering. They have 
now studied the same model and population 
to assess the changes over the last four years and to define increased injury rates, which 
have caused some concern. The authors con-
clude that this increase in injuries has resulted from the introduction of profes-
sionals, which has been the major change in the 


game during the period before their 1995 study and the follow up. The emergence of 

paid players and the marketing of the sport has undoubtedly accelerated changes in the 

game. However, it is important to look at what professionalism means. A professional player is financially rewarded for what he does, which increases the imperatives of 

pay, the pressure of his employers, the oppor-
tunity for increased fitness, and the desire to return to sport too soon after injury. All of these factors are understandable and were to be expected. 

However, hand in hand with the payment of top players has come a much broader pro-
fessionalism. There are changing attitudes 
towards rugby, and indeed throughout sport in general. The growth in sports science, which has led to increased and available information concerning nutrition, fitness, strength, and training techniques, has 

fuelled the desire for sportsmen and women, professional or amateur, to be better and more competitive. This ‘professional’ approach to sport, and the increasing emphasis on winning, is further driven by the general commercialisation of sport as a pastime. 

Rugby union is an evolving game. Changes to the Laws of play and style of play have been intro-
duced to make the game faster and more attractive, and must continue to be closely monitored to define the emergence of new injury patterns. The dramatic increase in injuries shown in this study are likely to focus attention on the tackle and so called protective equipment, as the authors rightly suggest, but also on the increasing intensity and frequency of training and playing.

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Hormones, offspring sex ratios, and weekly training distances of male runners: implications for overtreatment

Editor,—Mackelvie et al report that, within a group of male runners, free testosterone levels correlate negatively and highly significantly with the weekly training distance (p<0.005). Crawford et al reported that the offspring sex ratio (proportion male) of a sample of male runners varied significantly by their weekly training distance (table 1). Inspection of these data suggests that the regression of sex ratio on training mileage is U shaped (χ²=16.7, df 4, p<0.005).

<table>
<thead>
<tr>
<th>Weekly training mileage</th>
<th>Sons</th>
<th>Daughters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>112</td>
<td>69</td>
</tr>
<tr>
<td>0–30</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>30–50</td>
<td>46</td>
<td>70</td>
</tr>
<tr>
<td>50–70</td>
<td>35</td>
<td>25</td>
</tr>
<tr>
<td>70+</td>
<td>19</td>
<td>17</td>
</tr>
</tbody>
</table>

There is now abundant evidence that the sex ratio of offspring of mammalian (including human) parents is partially dependent on the hormone levels of both parents around the time of conception.1 The relevant hormones almost certainly comprise testosterone, oestrogen, and the gonadotrophins, and probably progesterone. However, others—for example, growth hormone and thyroid hormones—may be implicated. These data on sex ratios need confirmation, but, if confirmed, they would suggest endocrine involvement in overtraining. While the right arm of the U of the regression does not imply pathology, it is certainly suggestive of a process that is associated with pathology. So I suggest that hormone assays should be performed on male runners, particularly those who run more than 50 miles a week. One may wonder whether their established testosterone deficit is accompanied by an even more extreme gonadotrophin deficit.

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What is a sports medicine specialist?

Editor,—I feel that I must respond to the recent article on sports medicine specialists.1 After an editorial and several papers on the recognition of sports medicine as a specialty, this paper listed the 18 attributes considered necessary to be a sports medicine specialist. Of these only four (items 5, 10, 12, and 16) seem to me to be specialist. The others items are either attributes of all doctors (items 3, 4, 8, 9, and 11, possibly 12, 13, 14, 17, and 18) or firstaiders (items 1, 2, 6, and 7). Surely sports doctors and specialists should be more than that? They should be able to discuss the pros and cons of exercise, should have detailed knowledge of the risks and benefits of different sports, and should be promoting the concepts of wellness and injury prevention. I think it would be useful to know the original background of the selected group of sports specialists who drew up this list although I suspect it will be they will be part of the orthopaedics specialty or that of accident and emergency. If any doctor can do what they suggest is “special”, and that you get free at point of contact in the NHS, I would question the validity of the concept of sports medicine as a specialty.

As an aside, if stabilisation of the cervical spine is the second most important attribute of a sports medicine specialist, how many sports specialists attending aquatic events know how to effect that in water and recover the casualty?

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Authors’ reply

We welcome Dr Schur’s letter and are glad that this small pilot study has stimulated his response. Indeed, his thoughts on the matter really bring one back to the title of the article—"What is a sports medicine specialist?"

The choice of Delphi methodology was specifically to allow a wide range of input to reach an initial consensus. We attempted to maximise the breadth of the study by offering both examples of similar studies and inviting as many responses as possible. Those involved in the pilot study had all shown their commitment and expertise in sports medicine by holding the Diploma in Sports Medicine. Their backgrounds were varied: nine are general practitioners, two are sports physicians, one is an orthopaedic surgeon, and one an accident and emergency specialist. Seven of the GPs also run sports medicine clinics. The sporting backgrounds of those contributing to the study were also diverse, covering many major and minor sports. Every person involved in sports medicine will have their own viewpoint based on personal experience, qualifications, sporting background, age, and outlook and a full study involving many of the cross section of members of BASEM (British Association of Sport and Exercise Medicine) in a greater number of rounds to get a more specific consensus.

By completing studies such as this, it should be possible to convince the sceptics that sports medicine is indeed a specialty which requires recognition rather than something which any doctor or first aider can provide competently.

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This well presented paperback contains true/false and short answer questions based on recent articles from the British Medical Journal and the British Journal of General Practice. Chapters cover specialties, diseases, or treatment areas. Sports medicine is pitifully represented by only five questions (one less than the HIV section!); however, at least the GP reader is reminded thereby of the implications of prescribing for sportsmen.

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Never one to plough through weighty texts when studying, I preferred to use books of this kind to test areas of strength or highlight deficiencies. Somehow MCQs in exams were always worded slightly differently from those seen previously in a quiz book making them difficult to revise verbatim. The author admits that this book is not intended as a definitive text, and the subjects discussed are open ended with the aim of stimulating further reading. I would dispute the author’s claim that the book can be used as an aide memoir in the consulting room; although it contains many facts and figures, it would be difficult to extract them quickly in view of the lack of a subject index.

The book was enjoyable and it highlighted one’s tendency to study disproportionately on subjects in which one is already knowledgeable. However, the evidence base is very restricted and the British Journal of General Practice has recently received criticism from the profession for lacking flair and relevance to mainstream general practice.

This book could persuade GPs to begin their personal development plans, thereby avoiding accusations from postgraduate tutors of becoming overspecialised in certain areas (in my case sports medicine) while neglecting others of less personal interest but no less importance to everyday practice.

Analysis
Presentation 16/20
Comprehensiveness 10/20
Readability 14/20
Relevance 15/20
Evidence basis 8/20
Total 63/100

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NOTES AND NEWS

Sport and Exercise Working Group of the Royal College of General Practitioners
The Sport and Exercise Medicine Working Group of the Royal College of General Practitioners have elected a new chairman, Dr Paul Jackson, medical officer for English Rugby, who has a particular interest in medical education. This group has been very active in recent years and has organised a number of meetings, including the successful joint meeting with the BMA on the benefits and hazards of sport and exercise. Sport and exercise medicine will also feature on the main programme of the 2001 spring meeting of the Royal College of General Practitioners.

Olympic success for Great Britain
Many members of BASEM were involved in the preparation of the Great British team for the 2000 Olympics. This was the most successful games in recent memory, with British athletes winning medals in many sports and many other remarkable performances outside the medals. The success of this team was greatly assisted by medical and scientific support. Lottery funding aided athletes in training but was also important in financing medical and scientific support. The UK Sports Institute will play an important part in the continuing success of British sport and the development of sport and exercise medicine.

A journey through sports medicine, ethics, and the law
The Institute of Sports Medicine held a very successful meeting in association with the Section of Sports Medicine of the Royal Society of Medicine in November. It was entitled “A journey through Sports Medicine, Ethics and the Law” and it addressed some very difficult topics. Sport and medicine have a complex relationship and, while medicine can help athletes recover from injury and return to top level, medicine also has the potential to aid performance through illegal and unethical means. The participation of high profile members of the legal profession and media in this meeting reflects the major changes in sport and has implication for all those involved with high level sport.

Sports medicine and the Royal Society of Medicine
Dr John Lloyd Parry is President of the Section of Sports Medicine, of the Royal Society of Medicine, which was founded in 1994 with Sir Roger Bannister as its first President. Dr Parry has put together a very exciting programme for 2001 which, in addition to the academic programme, includes away days to Burghley Horse Trials, Wimbledon All England Tennis and Croquet Club, and a golf tournament at The Belfry. Further details are available from the RSM (tel: 020 7290 2987; email: Sports@Rocsmed.ac.uk).

Diploma in Sport and Exercise Medicine, Great Britain and Ireland
This two part diploma examination will be held twice a year. Part 1 of the examination, consisting of a multiple choice question and short essay paper will be held in April and September in London, Glasgows, or Dublin. Successful candidates will proceed to part 2 of the examination in either June or November. This consists of an oral and a clinical, based on two OSCEs, and will be held at a single centre which will rotate every six months.

Further details: Examinations Department, Royal College of Surgeons in Edinburgh, Nicolson Street, Edinburgh EH8 9DW. Website: www.rcsed.ac.uk

20th national congress of the Société Française de Médecine de Sport:
Physical activity, sport and health
6–8 December 2000; Paris, France
Topics include:
- Physical activity and fertility
- Sport and aging
- Rehabilitation

Further details: Pranacom, 40 rue des Blancs Manteaux, 75004 Paris, France. Email: pranacom@ifrance.com
Website: www.sfms.asso.fr

NSMI/BASEM Current concepts meeting on tendinopathies
8–9 December 2000; Cambridge, UK
Subjects covered include:
- Tendon science
- Achilles tendon
- Rotator cuff

Further details: Barry Hill, NSMI Medical Education, Medical College of St Bartholomew’s Hospital, Charterhouse Square, London EC1M 6BQ. Tel: 020 7251 0583; fax: 020 7251 0774; email: barry.hill@nsmi.org.uk
Website: www.nsmi.org.uk

UK Radiological Congress
21–23 May 2001; London, UK
Further details: UKRC Secretariat, PO Box 2895, London W1A 5RS, UK. Tel: 020 7307 1410/1420; fax: 020 7307 1414; email: ukrc@dial.pipex.com
Website: www.ukrc.org.uk

True or false—answers
(T = true; F = false)
(T) p 415: Standaert CJ, Herring SA. Spondylolysis: a critical review

Multiple choice—answers
(T) p 415: Standaert CJ, Herring SA. Spondylolysis: a critical review

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V̇O₂ slow component and performance in endurance sports

Andrew Jones

doi: 10.1136/bjsm.34.6.473