Very few faults could be found in the text or in the excellent clear graphs and half-tone photographs, but a few points should be noted for the next edition (and I sincerely hope there is one!). On page 33, weight-lifting and throwing events are included with boxing and wrestling as 'contact sports', and on page 138 it is implied that lung damage can ensue from breathing air at depth from a snorkel tube.

Apart from these trivial faults, this is a very good and very readable book. I selected it to read to allay the tedium of a long flight, but found it as interesting as a good novel or travel book. I have learnt a lot from it.

H. E. Robson

REPORT ON A SECOND 'COLLOQUIUM ON CLINICAL PROBLEMS PECULIAR TO SPORT'

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This was held at Postgraduate Centre, King Edward VIIth Hospital, Windsor on 1st and 2nd March, 1978, with 31 participants as follows: Orthopaedics 8, Rheumatology and Rehabilitation 9, (including 2 Registrars) General Practice 9, others 5.

CLINICAL TRIALS IN SPORTS INJURIES

The opening session was devoted to a discussion of problems of clinical trials in the treatment of sports injuries. Mr. David Muckle, Consultant Orthopaedic Surgeon at Middlesbrough General Hospital presented his experiences with Drug Trials in the treatment of injuries in football. It was generally agreed in the discussion that followed that the use of placebos in double blind clinical trials of drugs in sport was unacceptable unless combined with other treatment e.g. physiotherapy which formed part of the control background of the trial. It was felt that sportsmen in general came seeking to find the quickest way back to their sporting activities, and this precluded the use of placebos in their treatment except under appropriate conditions. The question was then raised of the extent to which surgical procedures could be validated. This has become a matter of some importance with the development of aggressive surgery for the treatment of over-use injuries. Clearly any form of double blind trial was out of the question but matched pairs offered an approach in comparing one form of surgery with another, and surgery with conservative management. Other than that it appeared that individual experience with the careful follow-up and recording of results was the best that could be done to validate such surgical procedures.

THE FOOT

The afternoon was devoted to a symposium on 'The Foot in Sport' — the subject was introduced by Dr. John Williams, Medical Director, Farnham Park Rehabilitation Centre who presented a description of the foot as a biomechanical model. The function of the ankle and sub-talar complex as a torque converter could be deduced in part from the shape of the joint elements which gave a clue to the degrees of freedom of movement at each joint. The foot could be represented as a sprung tripod attached to the torque converter allowing considerable degree of freedom of movement of the body above the foot while the foot remained firmly planted on the ground. Study of the mechanics of running and walking showed that there were separate differently geared lever systems which were used in the foot in propulsion.

Mr. Howard Payne, Senior Lecturer in the Department of Physical Education in the University of Birmingham then discussed methods of analysing foot function with particular reference to the force plate. He described the construction of various types of force plate and indicated how they could be used to identify forces in the foot doing a wide variety of actions including not only running, walking and jogging but also such activities as hitting and throwing. Gait analysis using the force platform, stroboscopic filming or ultra-high-speed photography made possible a clearer understanding of the function of the foot and effect of pathological and other influences on it.

The clinical problems of the foot in sport were presented in profusely illustrated lectures by Mr. Leslie Klenerman, Consultant Orthopaedic Surgeon at Northwick Park Hospital and Mr. Basil Helal, Consultant Orthopaedic Surgeon at the London Hospital. The extraordinary variety of clinical abnormalities affecting the foot and influencing its performance was very apparent in these presentations. The general consensus agreed that remarkably little attention was paid to them in everyday clinical practice.

The podiatrist's contribution to the treatment of clinical problems of the foot was presented by Mr. David Bell from the Rheumatism Unit at the Canadian Red Cross Memorial Hospital, Taplow. Mr. Bell described the common mechanical disorders of the foot and indicated the various stabilising procedures which were available to correct them. In particular Mr. Bell described the use of insoles or orthoses to correct disturbances of gait. In the discussion which followed it was agreed that there was a need to identify precisely the pathological conditions responsible for the biomechanical peculiarities described. Although it was generally agreed that orthoses could be of considerable clinical value it had to be accepted that at the present time their prescription tended to be rather too empirical.

The last presentation on the Symposium on the Foot in Sport was a discussion of sports footwear presented by Dr. Peter Sperry, Consultant in Rheumatology in Hillingdon Hospital. He described the fundamental requirements of sports shoes, and mentioned the need to protect (or at least prevent injury to) the sportsman and other participants. He detailed a catalogue of common faults in footwear design, indicating the wide range of clinical problems which these caused. Generally it was agreed in the discussion which followed that there was a positive need for further research into foot function particularly in different types of shoes on different types of surfaces, to provide a more satisfactory range of footwear for sportsmen in general.

SHOULDER INJURIES

The third topic for discussion was 'Shoulder injuries in Sport' presented by Mr. John Buck, Consultant Orthopaedic Surgeon at the Brook Hospital. Mr. Buck discussed particularly the problems of acromio-clavicular dislocation and recurrent dislocation of the shoulder, and described and illustrated with slides, films and models surgical procedures for the reconstruction of these joints in chronic cases. In the former he advocated where possible the transference of the coraco-acromial ligament to replace the ruptured conoid and trapezoid ligaments. In the latter he said that wherever possible a modified Bankhart procedure which could readily be carried out with appropriate instruments gave very satisfactory results in terms of subsequent return to sport. The discussion which followed centered on the post-operative regime and it was agreed generally that the habit of the rigid enforcement of rest to the shoulder by strapping the arm to the side was probably counter-productive, and in general nothing more than a sling was required by way of immobilisation. The patient could be allowed (under controlled conditions) to start moving the shoulder much sooner post-operatively than was normally the custom provided stress was avoided and the arm was not abducted beyond 90°. It appeared that the possibilities of recurrence were extremely slight and early mobilisation certainly led to a much quicker resumption of normal function and sporting activity.

THE ELBOW

The final session was devoted to a discussion of the problems of the elbow in sport and was introduced by Mr. Roy Maudsley, Consultant Orthopaedic Surgeon, Wexham Park Hospital. Mr. Maudsley described a number of clinical problems relating to the elbow and paid particular attention to that very chronic and often problematic condition tennis elbow. He described the radial nerve entrapment syndrome associated with this condition and indicated that when present, surgical decompression of the radial nerve was the only effective treatment. Various other forms of treatment for chronic lateral epicondylitis were discussed and debated. It was agreed that in chronic cases surgical tenotomy was often required, if steroid injections failed to relieve symptoms.

Dr. Williams then showed two cases of elbow problems arising in young gymnasts and drew attention to the high injury rate affecting the elbow in this particular sport. One case had osteo-chondritis dissecans and there was much discussion as to the optimal method of treatment. It was agreed finally that where any semblance of loose body formation was present surgical removal was indicated but that otherwise an expectant policy had to be adopted. The other case involved a child with a dislocation of the head of the radius together with an old ulnar fracture associated with ectopic calcification. The interesting feature of this second case was the remarkably good function of the elbow in spite of the horrifying radiological appearances. It was agreed that in a situation of this type the important factor was the degree of function and that where function was good no interference should be considered. At the same time the significance of the possible development of cubitus valgus or cubitus varus in elbow injuries before the end of epiphyseal growth was recognised and therefore in cases of this type the child should remain under observation until growth was complete so that any developing deformity could be corrected as necessary.

The meeting was sponsored jointly by the British Association for Rheumatology and Rehabilitation and the British Association of Sport and Medicine and the programme was supported by Boots who provided most generous hospitality to all the participants.