EDITORIAL

In this issue of the Journal we are again reminded of the serious nature of eye injuries which may be sustained in sport. Nicholas Jones presents a clear account, pointing out that eye injuries in sport represented a quarter of all severe eye injuries during the six month period of study with 57% of these severe injuries being due to racquet sports. Interestingly, those with severe injuries tended to be experienced sports people. It is probable that this data is representative of the country as a whole and alerts us to extend our education to the players themselves and to sports halls personnel in the hope that, at least for racquet sports, eye protection might be introduced, as is commonly the case in North America. The study by Chard and Lachmann again alerts us to the hazards of racquet sports with demographic information being provided for the less serious injuries that occur, with those needing immediate casualty attendance, including those to the eye, not being seen. This case selection might be the reason for finding, in the detailed part of their study, more inexperienced players. The finding that 20% of the injuries occurred in the first few minutes suggests the importance of warm-up, although it would be necessary to analyse which players performed warm-up and the exact nature of that warm-up. They noted a much greater number of injuries in squash than in tennis or badminton and this may be because of the risk of contact injury with the opponent and with the walls of the court.

The paper by Maffulli and colleagues provides some interesting information about the diagnosis of Achilles tendon lesions. Of more importance is the need to assess whether this additional information alters patient management and in so doing provides greater benefit to the patient. This area is sadly rarely explored in the clinical manuscripts that we receive, these mainly providing details of numbers relating to injuries and medical problems.

The paper by Paliczka and colleagues provides a potentially useful shuttle-run test as an assessment of maximum oxygen uptake. If their findings relating shuttle-run performance to $\dot{V}O_2$ max and race time can be confirmed with larger numbers this could provide a very useful field test which could be undertaken on large numbers without elaborate equipment and for low cost.

Clough and co-workers give an account of reasons for individuals failing to run in a marathon that they have entered. The response rate to their questionnaire was low making their conclusions (as they honestly point out) speculative. Although they suggest that it is a good idea to include a half marathon within a main marathon to obtain a lower drop out this would not seem a good idea when it is considered that most competitors who fail to run were injured, since the effects of even a half marathon on an injured runner could have long-lasting consequences.

The study of law enforcement officers who might not be considered sportsmen in the normal sense of the word does at least utilise the methodology frequently used in exercise physiology. Of surprise is the high body fat calculated from body density. More disconcerting is the great discrepancy between the high body fat from this assessment when compared to the measurements calculated from skin fold measurements which were some 30% less. The discussion comments on the musculoskeletal integrity based on Cybex analysis which is hardly justified for such a small group of subjects bearing in mind the individual variation which may be seen on repeated testing with this method.

A letter to the Editor alerting us to an unusual injury in Aikido reminds us of the interesting anecdotes that we may encounter as a result of our involvement with sport.

Wendy N. Dodds

BRITISH ASSOCIATION OF SPORT AND MEDICINE

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