

The Editor attended two International Conferences – in a private capacity, and reports are included on the 5th Balkan Congress of Sports Medicine, held at Izmir, Turkey, and an interesting interdisciplinary meeting on medicine for horses and their riders at the centre of equestrian activities in France, Saumur, in the Loire valley. BASM's Secretary, Dr. Peter Sperryn, meanwhile attended a meeting in Rome of the International Federation of Sports Medicine together with representatives of national sports medicine bodies and the International Olympic Committee. One main object of this convention was to attempt to standardise rules governing dope control in various sporting events, and to develop detection techniques. The constant battle between dope detection laboratories and unscrupulous "sportsmen" and their advisers resembles the armaments race, where increasingly powerful weapons lead to increasingly effective defence, starting with palaeolithic flints up to the hydrogen bomb. Like the armaments race, we hope that doping would also be controlled by international understanding and agreements, to reinforce legislation.

Wearing his other cap of Treasurer of BASM, the Editor is dismayed at the very small number of members and external library subscribers who have co-operated in updating Banker's Orders in time for the subscription rise in January 1982. An important notice about this appears in the Bulletin section of this Journal.

### NEWS OF MEMBERS

**Dr. NUALA DWYER** of Exeter whose father and brother are also members of BASM, won the BMA National Tennis Championship doubles, partnered by Dr. Graham Appleton, in July at Bournemouth.

**Dr. REX SALISBURY WOODS**, a founder member of BASM has recently celebrated his ninetieth birthday, and we send him our sincere good wishes.

He qualified in 1916, MB, BCh, University of Cambridge and studied at St. George's Hospital, London. In 1919 he gained his MD, and was elected FRCS of England in 1922. He served with distinction in both World Wars, was mentioned in despatches in the First World War, and was a surgical specialist in the East Africa Command in World War 2. Until the advent of the National Health Service he was able to combine general practice with surgery, but recently has had to let his NHS practice list decrease, though is still active.

He was, or rather is, an outstanding sportsman, representing Great Britain in the Shot in the 1924 (Paris) and 1928 (Amsterdam) Olympic Games, and only two years ago he succeeded in his third hole-in-one on the golf course. He was specialising in the treatment of athletes long before there were any official sports medicine organisations, is the author of "Cambridge Doctor", his autobiography devoted largely to his sports medical experience (1962) and contributed to Brit.J.Sports Med. in 1969 (Vol. 4, pp. 218-221). He was made an honorary life member of BASM in 1963. We can find no better advertisement for the long-term benefits of exercise than Dr. Salisbury Woods, and no better rebuttal of the view that all doctors should retire at 65.

We reprint his article on injuries to the knee.

SOME PERSONAL EXPERIENCES OF CHANGING FASHIONS IN THE TREATMENT

OF INJURIES TO THE KNEE

R. Salisbury Woods, M.D., F.R.C.S.  
Cambridge

---

A sprained ankle one summer, and 'water-on-the-knee' the next, blighted my cricketing ambition at school, thanks to the archaic treatment of those days when Hilton's classic, *Essays on Rest and Pain*, of 1896 had already held up progress for years. So that, when I came to practise at Cambridge, I developed a natural interest in sports injuries, and rejoiced in enabling others, in defiance of the teaching of that time, to get their jeopardised Blue or 'International' before it was too late.

The urgent problem was to restore full function and fitness to withstand fresh stresses far more quickly than the existing regime could possibly achieve. As early as 1923 Romer, was advocating firm strapping, followed by immediate and increasing natural use for sprained ankles, and discarding the usual treatment of masterly inactivity and, at the most, passive massage and electrical stimulation. By modifying his method it was soon found that undergraduates could train within a few days and play in about a week. "Beating the clock" became, indeed, a worthwhile job.

These relatively minor conditions escaped the notice of many in the busy Teaching Hospitals; and old methods were perpetuated in the text books. Yet these ordinary sprains may vitally affect a man's whole career.

Injuries of the knee joint in general disable games-players more frequently than any others, and are responsible for more errors in diagnosis than injuries of any other part of the body. A torn semi-lunar cartilage, a strained medial or lateral ligament, a ruptured cruciate ligament, a nipped infra-patellar fat pad, or even simple bruising, will all produce a synovial effusion; so 'water-on-the-knee' is a totally inadequate diagnosis. A case thus labelled was sent walking to St George's Hospital, where X-ray examination showed a fissure-fracture of the lower end of the femur involving the knee-joint. Clinical experience alone is often not enough to eliminate serious organic damage to the knee; radiological examination and repeated observations are frequently essential to achieve a correct diagnosis, so necessary before treatment is started.

1. Simple sprain of the collateral ligaments: The medial ligament is injured five times as frequently as the lateral and, even when the injury was an uncomplicated sprain followed inevitably by some synovial effusion, the knee has been considered so sacrosanct that, as in my own case, over two weeks rest in bed was considered advisable, although this ensured maximal muscular wasting, particularly of the quadriceps muscles on which the stability of the joint depends. So, it seemed reasonable to expect knee injuries to respond to the same active treatment as those of the ankle. This was first tried out in 1932 (Woods, 1935) on a wing-threequarter with a painful ballooned knee due to a simple sprain. After 24 hours of rest, the knee was firmly supported by interlocking non-elastic strapping over a layer of Elastoplast, with padding over the hamstring muscles, and immediate walking exercise given. Massage and Faradism were needed for the almost paralysed quadriceps muscles and active natural movements encouraged. The effusion subsided far more rapidly than usual, and in eight days he walked five miles, resumed training on the eleventh day and, sixteen days after injury played an outstanding game for Cambridge,

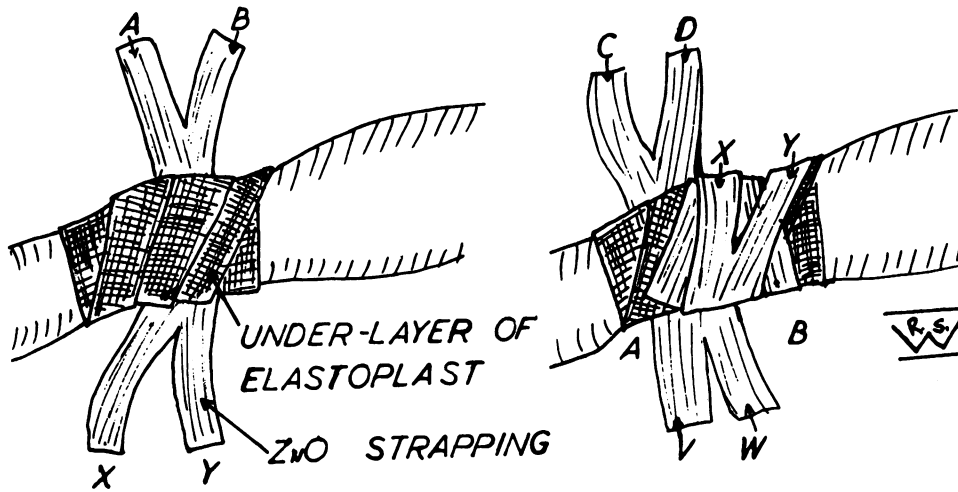


Fig. 1. Strapping for a simple sprain of the knee joint. An under-layer of elastoplast is applied first, then three or four split-tailed pieces of non-elastic strapping are put on, their tails interlocking.

for which he was awarded his Blue. A month later he played for Scotland, and thereafter for several seasons. Return to play has been hastened similarly in all subsequent cases, and quadriceps insufficiency does not develop.

Yet, in that same year, Romanis and Mitchiner (1932) still advised bed rest and a pressure bandage, combined with a posterior gutter splint. Electric treatment of quadriceps and massage were recommended, Scott's Dressing after 48 hours, and only non-weight-bearing active exercises after 14-21 days, depending on severity of the sprain! At the earliest, weight might be borne after three weeks, but ionisation or a blister could be used if the effusion proved indolent. Even eight years later, Rose and Carless (1940) were still recommending bed rest and a back splint until the effusion had disappeared, and only then applying strapping or firm bandaging. Modern advocates of early mobilisation may be unaware that their present principles have been applied to the knee-joint for nearly forty years.

2. Haemarthrosis: Even when a rapid, soggy distension indicated copious haemorrhage into the joint, the principles of Romer still apply (Woods, 1956), though in this case, the bloody effusion is first dealt with under sterile condition by stab-puncture, evacuation and suture. A sterile dressing is applied and the knee strapped as before. Walking is resumed in 2-4 days, when there will be no further oozing in the joint.
3. Torn semi-lunar cartilages: The medial meniscus is injured eleven times as frequently as the lateral, and meniscectomy is essential if the knee has locked on more than one occasion. Here the principles of early operation and vigorous rehabilitation had already been accepted (though often not practised) for many years. Nine servicemen with cartilage tears were operated on in Madagascar in 1943. All had returned to full duty and were playing hockey months long before the 5-monthly Hospital ship called at Diego Suarez - and before orders were issued preventing routine orthopaedic surgery in tropical conditions where hygiene and facilities were not considered good. (Woods 1962). But I had an excellent (Guy's) Theatre Sister.

4. Fracture of the Patella: In my early days good results followed wiring of the fragments, but recently complete removal of the bone has been usual. This has prevented the frequent sequel of osteoarthritis from fractures involving an articular surface.
5. Dislocation of the Patella: Treatment has required little change in the past forty years. This condition may follow over-vigorous ("un-qualified") attempts to "manipulate" a sprained knee; probably because of damage to the lower fibres of the vastus medialis muscle. One such case of iatrogenic trauma necessitated reduction of the ensuing dislocation under a general anaesthetic before the patient could be removed from a taxi-cab.
6. Some recent therapeutic procedures for knee injuries: In recent years, further efforts have been made to expedite the return of an athlete to his sport by the injection of a local anaesthetic to reduce pain, together with a cortisone preparation to accelerate the healing of congested peri-articular tissues and to hasten synovial re-absorption; sometimes aspirating the effusion first. This might be regarded as a short term policy, reserved for a critical event. Nevertheless, if an athlete is not fit to compete without an analgesic, he is likely to do more harm than good by undertaking violent stress from which he cannot feel any warning pain. (Woods, 1963).

Physiotherapy - usually massage, radiant heat or diathermy, and Faradism when necessary - of course has its place as an ancillary form of treatment in loosening up the joint, and especially in strengthening the vastus medialis following meniscectomy when it is often paralysed temporarily.

Although recently ultrasonic therapy has been advocated for resolving the absorption of bruising and effusions, its use is still uncertain, and many feel that it has few advantages over the more traditional techniques.

Moreover, Bohler stated (in 1935) that the best massage of all is that of natural function. In fact, there has been no significant advance on the high standard of treatment available, but little known and seldom used, over thirty-five years ago. Fortunately it has now been widely adopted and the athlete of today has a far better expectation of rapid recovery than when I was a competitor.

#### References

- |   |                                   |      |
|---|-----------------------------------|------|
| 1. Hilton, John: <u>Essays on Rest and Pain.</u>  | Bell, London.                     | 1896 |
| 2. Romer, Frank: <u>Sports Injuries.</u>  | Practitioner                      | 1923 |
| 3. Woods, R. Salisbury: <u>Treatment of Athletic Injuries in C.P.G. Wakeley's Modern Treatment in General Practice.</u> | Bailliere, Tindall & Cox. London. | 1935 |
| 4. Romanis & Mitchiner: <u>Science and Practice of Surgery.</u>   | Churchill, London.                | 1940 |
| 5. Rose & Carless: <u>Manual of Surgery.</u>  | Bailliere, Tindall & Cox. London. | 1940 |
| 6. Woods, R. Salisbury: <u>Reflection on the Treatment of Sports Injuries.</u>  | Camb.Univ.Med.Soc.Mag.            | 1956 |
| 7. Woods, R. Salisbury: <u>Cambridge Doctor.</u>  | Robert Hale, London               | 1962 |
| 8. Woods, R. Salisbury: <u>Cambridge Doctoring - Old and New</u>  | Camb.Univ.Med.Soc.Mag.            | 1963 |
| 9. Bohler, <u>Treatment of Fractures.</u> (Trans. by E.W.Hey Groves)  | John Wright, Bristol.             | 1935 |