the enforcement of eye protection. This method is used in North America although the game there is slightly different with a higher risk of eye injury.

Obviously such an enforcement programme would be controversial (as with the recent seat belt legislation) and in practical terms it is unlikely that any further action will ensue until a legal case from such an injury forces the issue.

The serious nature of these injuries make it essential that Governing Bodies publicise the risks involved in their particular sport and encourage the development of more effective forms of protection. The individuals can then make their own decisions. It may be wise for the Governing Body to circularise members of their own Association and all

professional players (who are the trend setters) regarding the idea of enforced use of eye protection. This will certainly help the education process as it is sure to provoke strong feelings and would also give some insight into the support for such an idea. Without the players' support it would be a difficult rule to enforce.

Incidentally, in the same issue a similar problem is presented with regard to mouth protection for hockey players! Should it be the player or the Governing Body who decides on protection?

Yours faithfully

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Dear Editors,

CLOSED INTRAMEDULLARY NAILING OF TIBIAL FRACTURES IN SPORTSMEN

Fractures of the tibial shaft are not uncommon among sportsmen. The treatment is controversial between conservative and operative. We have employed closed intramedullary nailing as the method of choice that offers anatomic reduction with rapid mobilisation, enhancing return to sport.

We would like to report two typical cases.

A 22-year-old professional football player sustained a fracture of his left leg as a result of being kicked. X-rays showed a mid-shaft fracture of tibia and fibula. He was operated upon the same day and the fracture stabilised and fixed with a Kuntcher-Hertzog intramedullary nail by the closed technique. Two days post-operatively, physiotherapy was initiated, consisting of passive, then active knee and ankle exercises. Full weight-bearing was resumed within one week. Three months post-operatively clinical and radiological union was evident. The patient returned to light training within 6 months and resumed full activity with negligible functional deficit within 13 months.

A 27-year-old basketball player sustained a fracture of his left tibia and fibula as a result of a fall of team mates onto his leg. A "butterfly" mid-shaft tibial fracture was seen on X-ray. At operation the fracture was reduced, stabilised and fixed by a Kuntcher-Hertzog intramedullary nail, employing the closed technique. Physiotherapy was initiated on the third day post-operatively, aimed at preventing muscle wasting and loss of joint movement. He resumed full weight-bearing within 10 days. Fifteen weeks post-operatively, clinical and radiological signs of union were evident. He returned to light training five months post-operatively and resumed unlimited sports activities at the beginning of the next season twelve months later.

The treatment of tibial shaft fractures poses a therapeutic challenge to the orthopaedic surgeon. Operative risks, such as wound infection, delayed union, or non-union, may "raise the price" one may pay for anatomic reduction, early mobilisation and preservation of functional capacity obtained by surgical treatment. On the other hand, the immobilisation associated with conservative treatment, has

its own risks and disadvantages, such as: muscle wasting, loss of joint movement, shortening of the leg, malunion, or "compartment syndrome" of the leg. These risks still exist, even with "cast-bracing" which is currently the most popular conservative method of treating tibial fractures.

When these complications are considered, the advantages of surgical treatment are quite attractive. Of all the surgical options, closed intramedullary nailing seems most appropriate for sportsmen.

The major advantages of this method are:

1. It offers a limited, short surgical procedure, resulting in minimal soft tissue damage and low infection rate.
2. This modality offers anatomic reduction, associated with minimal shortening of the leg, which may be encountered with conservative treatment.
3. The rigid fixation of the fractures by an intramedullary nail permits early weight-bearing.
4. This technique preserves the blood supply to the fracture site and retains the reamed bone fragments to produce a bone graft at the fracture site. This enhances fracture healing and reduces the rate of delayed or non-union that occurs with other surgical methods to a minimum.

Therefore, closed intramedullary nailing of tibial shaft fractures should be considered as the treatment of choice for high performance sportsmen, since it preserves their precious functional capacity.

Yours faithfully,

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