Two recent reviews have concluded that little is known of the psychological effects (advantageous or otherwise) of wearing protective equipment in rugby.1 2 The most common reasons for wearing protective equipment given by participants in a New Zealand study were to prevent injury (57%), because of previous injury (53%), and because of medical advice (21%).3 Australian schoolboy rugby players also cited safety as the primary reason for using headgear and reported that they played more confidently when wearing headgear.1

On the basis of their conclusions regarding the impact of padded equipment on the incidence of injury, Garraway et al. recommend that the International Rugby Board “place a moratorium on the further development of protective equipment until it has been established that it is not contributing to the substantial increase in player morbidity associated with the introduction of professional rugby union.” In their abstract, they go further by recommending that the moratorium should be placed on the “use of protective equipment in competitive matches”.

There is at present little evidence to suggest that padded equipment modifies the risk of injury in rugby. We have no argument with the need to find explanations for the disturbing increase in injury reported by Garraway et al. What concerns us is that their recommendations have been made in the absence of supporting evidence, and that in making such recommendations attention is diverted from other explanations for the observed increase in injuries, such as law changes that affect the way in which rugby is played. Investigation of the effects of padded equipment on injury risk, through further epidemiological research, is required before recommendations about its use can be made. Placing a moratorium on the use of protective equipment may make it difficult to undertake such research!

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Proportions of activities in a climbing gym

EDITOR,—I refer to the paper on indoor rock climbing by Wright et al.1 Firstly, thanks to the authors for adding some valuable information to the under researched area of indoor climbing injuries (particularly given the popularity of this activity world wide).

While I have no doubt that many of your participants put leading or bouldering as the activity that they spent most time doing while in the gym, I would have significant doubts that it is actually the case, particularly in lower grade climbers. I suspect that the participants in the study may well have over-estimated the amount of time they spent in each activity, and that an analysis of actual time spent would reveal most time spent on a top rope than any other activity. This is a possible explanation for the otherwise unexpected findings when looking at the “preferred activity” as a predictor of overuse injury.

I do agree with the idea that many “committed” climbers will spend more time bouldering and leading than the non-committed, but this should logically be a factor to some extent related to grades climbed, not independent of skill level.

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Authors’ reply

Thanks to David Humphries for his comments on our paper. We agree that our respondents may have overestimated the time they spent leading and bouldering in comparison with top roping, although, if this is the case, we should ask why. Bravado, perhaps wishing to appear bolder than they actually are, or memory error, seem the most likely explanations. Memory error, resulting in this case in misclassification bias, is a potent source of error in epidemiological studies, a bias to which our study is no less susceptible than others reliant on memory based replies.

If the misclassification is all in one direction—that is, some people stated that their most common activity was leading and bouldering when it was in fact top roping, and no one made the opposite error—the true odds ratio for leading and bouldering in comparison with top roping would be lower than that which we found. We have not performed a sensitivity analysis to estimate the degree of misclassification that would reduce the coefficient of this variable to non-significance.

We have one further comment to make in relation to Humphries’ remarks about “committed” climbers. We have been careful to point out that we cannot regard our sample as a true cross sectional representation of the indoor climbing population. In particular, it seems unlikely that “team building” clients from the commercial sector would attend such an event, and possibly not school groups, or at least not in the proportions that they are believed to represent of a rapidly expanding market. In this sense, we suspect that almost all our respondents would be “committed” climbers, but the word has a different sense here from the way Humphries has used it.

DEBORAH WRIGHT
JAMES ROYLE
TIM MARSHALL

LETTERS TO THE EDITOR

Rapid responses

If you have a burning desire to respond to a paper published in Br J Sports Med, why not make use of our “rapid response” option?

Log on to our website (www.bjsportmed.com), find the paper that interests you, click on “full text” and send your response by email by clicking on “e Letters submit a response”.

Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “read eletters” on our homepage.

The editors will decide, as before, whether to also publish it in a future paper issue.

Impact of professionalism on injuries in rugby union

EDITOR,—We were concerned about the alarming increase in injury in Scottish rugby union football.1 In their article, Garraway et al report the results of a 1997–1998 survey on the Scottish club players, which, when compared with the findings of a 1993–1994 survey, indicate a substantial increase in the incidence of injury. The authors attribute this increase to factors associated with the advent of professionalism in rugby union football.

Garraway et al consider a number of possible explanations for their findings and then conclude that “the factor that is most likely to have contributed to the increased burden of injuries in competitive play and requires the most urgent attention is the almost universal adoption of protective equipment in rugby union between the 1993–1994 and 1997–1998 seasons.” The questions raised for us was: did the researchers question players about protective equipment in the two surveys and if so did they find an increase in the wearing of such equipment?

Later in the article, Garraway et al assert that “players at the professional level have turned to the use of this equipment during competitive matches in the expectation that it will minimise the consequences of bodily impact and may even give them a psychological edge when using their increasing physical presence to tackle opponents” and that “amateur players are already following their example.” These assertions raise further questions for us: were the participants in the surveys questioned about their motives for wearing padded equipment and/or their beliefs regarding its effects on their risk of being injured? How is the risk of injury modified for players who enter contact situations confidently compared with players who approach contact more tentatively? Are confident players more or less likely to use correct technique in contact situations?
Sports doctors' resuscitation skills

Editor,—I cannot resist the temptation to join the debate on sports doctors' resuscitation skills.1 The study by Thompson et al2 suggested that there is a perceived need among sports specialists for first aid skills. However, I received no response to my letter concerning this which indirectly posed the question, “should doctors who attend aquatic sports be able to deal with a suspected cervical spine fracture and recover the casualty?” Obviously, that is the task of a lifeguard in the same way that first aid at non-aquatic events is the task for a first aider, but perhaps doctors should be competent first aiders and/or lifeguards. This was never in the medical school curriculum and perhaps that should change. At least, first aid training is part of sports medicine courses, but I would like to suggest that lifeguarding should also be included. I would also suggest that all doctors at aquatic events should hold the NPLQ, NBLQ, or at least bronze medallion and bronze cross of the RLSS or overseas equivalent.

Should the organisers of any sports medicine course want advice on this, they should contact the RLSS at River House, High St, Brom, Akester, Warwickshire B50 4HN, UK. I would be happy to help out but would make two stipulations: everyone on the course should be obliged to join the RLSS and they should sponsor me for my next fund raising event for the RNLI.

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BOOK REVIEWS


This is the best book on the marathon that I have ever read. It is composed of a series of chapters based on lectures delivered at a British Heart Foundation symposium on marathon medicine held in London in 2000. The content includes a wide range of disciplines: history, sociology, psychology, medicine, physiology, and more.

It is noted in the introduction that the reader will be treated to the views of a veritable galaxy of experts. This is no false claim.

What a pleasure it was to read this book—comprehensive, direct, accessible, and practical are only a few relevant adjectives applicable to this text. It even kept me awake on a Sydney to London flight! Beautifully presented with clear figures, singular in its lack of waffle, and very well referenced, this is the ultimate guide to so many aspects of what many consider to be the greatest race. In addition to the weight of information contained in the chapters proper, I quite appreciated the inclusion of short sections of discussion between conference attendees and the experts which were included at the conclusion of some chapters.

Having personally struggled through a number of these events, I especially looked for practical information. Will it kill me? Probably not. Will I live forever if I complete one? No. What should I drink and eat? What about altitude training? Why do I fatigue? The answers, or our best current knowledge, are all there.

This is an excellent book. I am half way through it on the second reading. I would buy it myself and recommend it to all of those who care for participants in, or who are interested in, endurance sport. It is suitable for sophisticated athletes and both students and practitioners of sports science and sports medicine.

Analysis
Presentation 18/20
Comprehensiveness 18/20
Readability 18/20
Relevance 18/20
Evidence basis 18/20
Total 90/100

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“We have tried to strike a balance between being too academic on the one hand and competing with the pocket guides on high altitude emergencies on the other” proclaim Michael Ward, James Milledge, and John West, three internationally respected authors on the subject of high altitude medicine. Their third edition is an attractively covered book, its suprising weight giving suitable notice of the serious reading within.

Each chapter starts sensibly with a list of contents followed by a carefully worded summary. I found this increasingly useful as the majority of text favours the clinical specialist and high altitude physiologist. By chapter six I was struggling with M = ((P1 −P2)/Q)Q1(1−e−oωω). Those of you who recognise this as relating to the total transfer of a gas will be at one with this book. I suspect the majority of readers will silently thank the authors for providing those chapter summaries.

In the midst of this text I could sense John West’s influence predominate, with the profusion of scientific tables and graphs sprinkled with references to the pioneers of high altitude physiology, and it was in these scientific chapters that the authors seemed most at ease. As a GP with an interest in mountain rescue, I found the third part of the book much more relevant. The conditions of high altitude pulmonary oedema and cerebral oedema (HAPE and HACE), hypothermia, exhaustion, and fatigue are covered in workable detail, and there is useful information on how clinical conditions such as diabetes, COPD, and IHD are affected by high altitude.

So have the authors succeeded in their aim? On balance this is of more interest to the research scientist or high altitude specialist rather than readers like myself. There are cheaper (much) books that cover the clinical aspects at least as well, but none so logically laid out, beautifully presented, or as thoroughly researched (I counted 1537 references!). One for the serious high altitude buff who won’t even see the price tag.

Analysis
Presentation 17/20
Comprehensiveness 17/20
Readability 15/20
Relevance 10/20
Evidence basis 18/20
Total 77/100

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I was excited when I saw this book as the five authors are all well known to me as prominent in their respective fields. Nicola Maffulli of Stoke on Trent via Aberdeen and Hong Kong is an orthopaedic surgeon with a special interest in children’s injuries, Kai Ming Chan from Hong Kong is a widely published orthopaedic surgeon, Rose McDonald has been prominent in sports physiotherapy in the United Kingdom for many years, Bob Malina from Michigan State University is one of the foremost experts in children’s growth, and Tony Parker has been a leading FIMS official for many years.

Their stated aim is “to address in one volume the specific problems of different categories of individuals in sport.” The four groups considered were the young, the old, the female athlete, and the disabled athlete—all important subgroups with specific problems of their own. These four groups usually get a chapter each in general sports medicine books, so one would hope that these areas would be considered in significantly more detail in this publication.

The children’s section covers all the important issues such as growth and maturational, strength and endurance training, nutrition, and competitive stress. The sections on injuries have some inaccuracies—for example, in the section on pubertal stress fractures, describing the pain as “well localised to the apex of the foot” and prescribing rest only in the treatment, and the use of a rigid Boston brace in all cases of spondolesis—but they are generally well covered.

The female section also covers all the major issues but is quite repetitive, with three different chapters all covering menstrual irregularities. The section on ageing and master athletes (surely that should be masters...
Clinical risk management: enhancing patient safety


Clinical risk management is a strange subject which will perplex many readers. If this was a book about cricket, it would have chapters on no balls, wides, missed stumpings, and accuracy—rather than the disabled section. This smacks of careless editing. The other gripe is that there are a number of chapters that do not seem to bear any relation to any of the four major themes. They include a chapter by Jenny McConnell on "faulty alignment and posture" and one on "biomechanical problems of the lower limb—the key to overuse injury" by Australian podiatrist Simon Bartold. These two chapters are actually the best chapters in the book but seem to be thrown in for good measure rather than because of relevance to the topic.

All in all, this book covers important areas but suffers from too much repetition and poor editing. I am not sure that it covers the topics much better than some of the good sports medicine texts.

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Sports Injuries Management of the Shoulder
8 December 2001, School of Physiotherapy, Manchester, UK

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Competency Course in Musculoskeletal Ultrasound
7–9 January 2002, Oxford, UK
Further details: Alison Davies, Department of Radiology, Nuffield Orthopaedic Centre, Oxford OX3 7LD, UK; Tel: +44 (0)1865 227765; Fax +44 (0)1865 227347; email: alison.davies@noc.anglox.nhs.uk

II International Congress on Physical Education, Sports Medicine & Exercise Science
14–17 January 2002, Donapaula, Goa, India
Further details: Dr Jasraj Singh, Organising Secretary, LNPE Gwalior, India 21, Lakshmibai National Institute of Physical Education Shakti Nagar, Gwalior 474002 M.P

Fourth World Scientific Congress of Golf
23–26 July 2002, St Andrews, UK
Further details: World Scientific Congress of Golf Trust, The Scores, St Andrews KY16 9AT UK; Tel: +44 (0)1334 475560; Fax: +44 (0)1334 474322; email: golfscience@st-andrews.ac.uk
Website: www.golfscience.org.

Sports Medicine Course
3–10 August 2002, Vancouver, Canada
Further details: Cathy Means; Tel: +1 608 263 6637; Fax: +1 608 262 8421; email: cjmeans@facstaff.wisc.edu

XVI IEA World Congress of Epidemiology
18–22 August 2002, Montreal, Canada
Further details: Conference Secretariat, Events International Meeting Planners, 759 Square Victoria, Suite 300, Montreal, Quebec, H2Y 2J7, Canada; Tel: +1 514 286 0855; Fax: +1 514 286 6066; email: info@eventsintl.com
Website: www.iea2002.com

Sports Medicine of Australia 2002 Australian Conference
12–16 October 2002, Carlton Crest Hotel, Melbourne, Australia
Further details: Prue Robertson, Project Officer, Sports Medicine Australia, PO Box 237, Dickson ACT 2602; Tel: +02 6230 4650; Fax: +02 6230 5908; email: prue.robertson@sportnet.com.au

The 5th Asian Federation of Sports Medicine Congress
24–27 October 2002, Seoul, South Korea
Further details: AFSMC 2002 Seoul Secretariat, Hanjim Travel Service Co Ltd, (c/o Young CHANG) Marine Center New Bldg 5th Fl, #51, Sogong-dong, Chung-gu, Seoul 100–770, South Korea; Tel: +822 726 5555; Fax: +822 778 2514; email: ychang@kaltour.com
Website: http://www.afsmc2002.or.kr

Second World Congress of Science and Medicine in Cricket
4–7 February 2003, University of Port Elizabeth, South Africa
Further details: Dr Richard Stretch, University of Port Elizabeth, PO Box 1600, Port Elizabeth 6000, South Africa; Tel: +27 41 5042584; Fax: +27 41 5832605; email: sparas@upe.ac.za

Vth World Congress on Science & Football
April 2003, Lisbon, Portugal
Further details: Dr J Cabri; email: Jcabri@fmih.utl.pt
Website: http://www.fmih.utl.pt/wesf

The LTA Sports Science and Sports Medicine Conference

NOTES AND NEWS

www.basem.co.uk
The British Association of Sport and Exercise Medicine has launched its new website—www.basem.co.uk. The site provides information on the educational opportunities in sport and exercise medicine, and advice to those wishing to be involved in this area. BASEM members can also access the latest information of BASEM events.

www.UKSI.net
The UK Sports Institute (UKSI) is currently developing a password restricted website—www.UKSI.net—for the elite professional sporting community including athletes, coaches, and those in sport science and medicine. The site will be commissioning experts to write articles on a variety of topics. Each article will be aimed at the entire audience, promoting the integrated philosophy of the UKSI.

Bayesian statistics and evidence based medicine
Evidence based medicine is the buzzword of the day. But in fact, the standard statistics that are used in almost all studies do not answer the questions that are of interest to the clinician, even though they are misinterpreted as if they do. A new website www.physio.mcgill.ca/smcourse/bayesian is now available that compares the inferences that can be drawn from standard statistics with those that can be drawn from the Bayesian statistical approach. The authors welcome all questions and comments. This site is designed for both clinicians and epidemiologists.