

PostScript

LETTERS

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Football blades: a cause for concern

Sporting injuries have always contributed a significant proportion of the workload of the emergency department.¹ The number is increasing considerably² for several reasons. A burgeoning range of sporting activities combined with increased disposable income and leisure time has led to greater participation.² Consequently research and development aimed at enhancing performance has escalated.

One such development is the use of "blades" instead of the more traditional studs on football boots. Unlike the traditional round peg-like studs, the new blades measure up to 3 cm long and are shaped to contour the foot (fig 1), providing enhanced stability to the standing foot when kicking. Since they were first endorsed by high profile figures such as David Beckham, the appeal to the younger generations has increased to the extent that many junior players use such footwear.

The traditional studs can cause a range of injuries, from minor lacerations (the most common) to more complex punched out soft tissue injuries. The cases described below highlight the potential severity of injuries sustained as a result of direct contact with a football blade.

The first case involved a 14 year old boy with a laceration to the medial aspect of the



Figure 1 Football boot with blades.



Figure 2 Laceration to left leg.

left knee sustained after a tackle. The laceration was 8 cm in length and extended down to muscle but had not involved the knee capsule (fig 2). The wound was thoroughly irrigated, debrided, and closed with sutures.

The second involved a 28 year old man who was involved in a tackle with a player wearing football blades; as a result of the tackle the leather uppers of the football boot were torn with a ragged laceration measuring 5 cm over the dorsum of the foot. The laceration was irrigated, debrided, and sutured.

Sporting injuries presenting to the emergency department are common, and, over the last decade more interest has focused on prevention. One aspect of this is footwear design. Chan *et al*³ showed a direct correlation between footwear and both performance and rates of injury. A similar study showed that boots with a greater number of studs were associated with poorer performance compared with those with fewer, primarily because of inferior traction with the ground.⁴ A large proportion of football injuries are ligamentous and involve either the knee or the ankle,⁵ thus shoe-surface traction is the specific variable most likely to correlate with injury incidence.⁶ These theories led directly to the development of the blade to replace the traditional stud on football boots to improve shoe-surface traction. For this reason a large number of professional footballers use blades, and as a result the appeal to amateur players of all ages is high. As the number of players using such footwear increases, the number of injuries resulting directly from blades is increasing also. Concerns are now being raised in the media as to the safety of such blades, especially in more junior grades of football.⁷ In certain countries there are moves to ban such blades because of safety concerns.⁷

These cases highlight the severity of lacerations that can result from tackles with boots fitted with blades. In the second case report, the blade was actually sharp enough to penetrate the leather uppers of the boot before lacerating the skin. Although stud injuries have presented to the emergency department for many years, we should be increasingly aware of the potential dangers of this design of stud, especially in junior levels of competition.

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References

- 1 Abernethy L, McNally O, MacAuley D, *et al*. Sports medicine and the accident and emergency specialist. *Emerg Med J* 2002;19:239-41.
- 2 Changes in sports injuries to children between 1983 and 1998: comparison of case series. *J Public Health Med* 2001;23:268-71.
- 3 Chan KM, Yuan Y, Li CK, *et al*. Sports causing most injuries in Hong Kong. *J Sports Med* 1993;27:263-7.
- 4 Brizuela G, Llana S, Ferrandis R, *et al*. Biomechanical design of football boots: effect of studs on performance and injury prevention. www.isb98.uni-konstanz.de/topic5.html.
- 5 Watson AW. Sports injuries in school gaelic football: a study over a season. *Ir J Med Sci* 1996;165:12-16.
- 6 Orchard J. Is there a relationship between ground and climatic conditions and injuries in football? *Sports Med* 2002;32:419-32.
- 7 Sawdon-Smith R. Is it time to give blades the boot? www.readingrefs.org.uk.

Recidivism in sports related injuries in primary care

Involvement in top sports challenges the body's physical faculties to the limit. Surpassing these limits may cause sports related injuries. However, these injuries occur among participants of all sports at large. Once a sports related injury has manifested itself, subsequent recovery incorporates a real probability of future relapse.

The expansion of an aging population participating in non-organised sports is likely to produce an increase in the number of patients presenting to the family doctor with sports related injuries and possible relapses.¹ To gain a better understanding of the concept of recidivism, a Medline literature search on relapses of sports related injuries in primary care was performed. This general search produced no references, but a sports specific search yielded two publications on relapse in sports related injuries. Sports related injuries are known to recur in equestrian sports² and in soccer players (strains and sprains).³

Information about the prevalence of recidivism was obtained from a randomised controlled trial conducted to study the care provided by family and sports doctors in 230 patients with non-acute sports related injuries to the lower extremity. This study took place in three northern regions in the Netherlands between September 2000 and May 2002 and involved the participation of 83 family doctors. A non-acute sports related injury was diagnosed as an injury that originated at least two weeks before consultation of the family doctor. Data on all participating patients contained in the primary care data base were scrutinised to determine if these patients consulted the doctor again for a new or other sports related injury in the year after inclusion.

In 7.4%, a new sports related injury prompted patients to revisit their doctor in the year after inclusion. In 4.5% of the cases, the injury was related to the original one but not considered a relapse, which was found to occur in 2.2% of the cases. In this cohort, it

was found that relapses of non-acute sports related injuries to the lower extremity do not often occur.

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References

- 1 **SociaalCultuureelPlanbureau.** Rapportage Sport 2003. The Hague, 2003.
- 2 **Frankel HL, Haskell R, Digiacoia JC, et al.** Recidivism in equestrian trauma. *Am Surg* 1998;**64**:151–4.
- 3 **Arnason A, Gudmundsson A, Dahl HA, et al.** Soccer injuries in Iceland. *Scand J Med Sci Sports* 1996;**6**:40–5.

Charity runners should be warned of dangers of consuming alcohol after the race

A healthy 38 year old man finished the 2004 London marathon in just over five hours. During the evening celebrations, he had “two gins” and collapsed to the floor hitting his face on the pavement (fig 1).

Despite regular fluids during the race and food afterwards, five hours of continuous exercise would have caused hypovolaemia, hypoglycaemia, and reactive insensitivity of the leg veins to the shifts in blood volume which occur on standing. These changes combined with the vasodilatory effects of alcohol would cause orthostatic intolerance. He fainted.

The London marathon attracts thousands of amateur runners who should be warned of the dangers of post-race celebrations.

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Figure 1 Results of the patient hitting his face on the pavement.

BOOK REVIEWS

Low back disorders: evidence-based prevention and rehabilitation

S McGill. Champaign, IL: Human Kinetics (www.HumanKinetics.com), 2002, £34.00, pp 312. ISBN 0736042415

There are many ways in which rehabilitative exercise, postural correction, ergonomics, as well as vast numbers of pain relieving techniques can assist in the prevention and treatment of low back pain. Research teams throughout the world are beginning to provide evidence for effective management strategies within their areas of expertise. This research often relies on development of valid and reliable measurement techniques. Some research teams focus on clinical trials, in which validated pain and disability measures are used to provide evidence for efficacy of a particular method of treatment. Other back pain research teams (as that of McGill) focus on the development of management approaches, based on an understanding of how muscles function to provide spinal stability and load transfer through the spine and pelvis. These management strategies have been developed through a focus on either biomechanical or neurophysiological models of muscle function. McGill has developed exercises for prevention and rehabilitation of low back pain based on biomechanical models.

The strength of McGill's text lies in his anatomical and biomechanical research evidence on how injury develops in specific anatomical structures (including an excellent depth of understanding of “tissue creep”) and the methods through which tissue loading can be reduced to minimise the risk of injury. This important information can direct strategies for the prevention (and rehabilitation) of low back pain, which involve postural correction and adherence to sound ergonomic principles. We would highly recommend this text for these essential aspects of low back pain management.

However, the rehabilitative exercise regimen described by McGill in this text differs markedly from many other evidence based exercise programmes devised for the treatment and prevention of low back pain. Other approaches, which have been based more on neurophysiological research on the joint protection mechanisms, base their exercise treatment on a problem solving approach and, more importantly, on the impairments that develop in these mechanisms, in low back pain patients. These impairments are different in each patient, and depend on issues such as the specific location of the injury, lifestyle factors, and pain. The impairments in muscle recruitment patterns result in some muscles becoming less active or inhibited and others becoming more active, less fatigable, and tight. These factors are used to direct exercise treatment.

Thus McGill's text is ideal for gaining an understanding of how to prevent and treat low back pain using some important principles of postural correction and ergonomic management. Future clinical trials will be required to estimate the efficacy of the rehabilitative exercise programme.

The book is targeted mainly at health practitioners dealing with ergonomics and occupational health.

The author is well known, well published, and well respected in his area of research.

The book definitely has a “feel good factor” and we would buy it. The only issues we found slightly irritating in the book were the rather simplistic explanations of theories of motor control.

Rating

● Presentation	15/20
● Comprehensiveness	15/20
● Readability	15/20
● Relevance	16/20
● Evidence basis	16/20
● Total	77/100

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Atlas of uncommon pain syndromes

S D Waldman. Saunders, 2002, £74.99, hardcover, pp 224. ISBN 0721693725

This title arouses interest, and immediately brings to mind the aphorism “when you hear hoof beats, think of horses, not zebras.” Indeed, the preface begins with just that advice. However, a dip into the book soon reveals that this is a mixed collection of conditions under the broad heading of “uncommon.” Of course, uncommon depends on one's field—within any sports medicine practice, such conditions as supraspinatus tendinitis (sic), iliotibial band friction, and talofibular pain are very much everyday horses. However, omohyoid syndrome, Parsonage-Turner syndrome, quadriceps expansion syndrome, and many others are more intriguing.

The text is arranged regionally, with 71 conditions dealt with in individual chapters, with accompanying illustrations. The term syndrome is loosely applied to a variety of causes of pain of predominantly musculoskeletal and neural origin. A particular condition or area of pain is very easily located, and each chapter describes the condition in detail, and offers sections on symptoms, signs, tests, differential diagnoses, treatment, complications, and clinical pearls. The illustrations are large, colourful, and well executed, and immediately help the reader to localise the potential diagnosis. Thus far this appears to be an accessible and useful text for all who treat musculoskeletal conditions. Unfortunately, closer examination soon reveals deficiencies that detract from its value.

When looking at the conditions covered in a particular region, it rapidly becomes apparent that it is also necessary to consult the author's companion volume *Atlas of common pain syndromes* if all likely diagnoses are to be considered. A cross reference to conditions covered in that book would be invaluable, but is absent. The text has been word processed in such a way that paragraphs are often

identical from one condition to another. The text has been inadequately proofread, with paragraphs sometimes copied repetitively, and other paragraphs apparently left out. For a number of conditions the text refers to the success of "this injection technique", yet fails to describe the technique. Investigation advice is too often non-specific. MRI is usually offered as the investigation of first choice, when in many cases other modalities are undoubtedly superior and cheaper. Characteristic investigation findings are rarely mentioned, and the few diagnostic images reproduced are of little value. There is a defensive approach throughout, which encourages more tests to exclude other diagnoses, but rarely helps to pinpoint the condition in question.

The author is an anaesthesiologist, and the focus of treatment is on injection techniques to block pain. Some injection techniques are described and illustrated clearly, but, for many, either direct instruction or more companion volumes, *Atlas of pain management techniques* and *Atlas of interventional pain management*, are essential to safe conduct. Again, there are no cross references to the companion texts. For most conditions the treatment proposed is non-steroidal anti-inflammatories, heat and cold application, and if those measures fail, injection. Rest is invariably offered for activity related conditions. For conditions such as ankle sprain, these measures can hardly be called best practice. Physiotherapy is rarely mentioned, and rehabilitation and biomechanical correction are virtually ignored. Guided injection techniques, using ultrasound, fluoroscopy, and computed tomography, which are ideal for some of the conditions covered, are not mentioned.

There are several major omissions. Evidence based practice is not considered, and the treatments offered for several conditions are clearly counter to well established guidelines. There are no references, and no recommendations for further reading. For many of the conditions less familiar to me, I would welcome the chance to do some additional reading before making a diagnosis.

Overall, this text has a role as an easy guide to unusual conditions that may not otherwise be considered. The illustrations are evocative, but in many cases are more like cartoons than diagnostic tools. Diagnostic information is inadequate, and treatment options one dimensional. The author's companion volumes would enhance the value of this text, but at a price perhaps too high to recommend them. Handy for the library, worth looking through, but not a must buy for most practitioners.

Rating

• Presentation	18/20
• Comprehensiveness	14/20
• Readability	14/20
• Relevance	12/20
• Evidence basis	0/20
• Total	58/100

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Exploring sport and exercise psychology

Edited by J L van Raalte, B W Brewer.
Washington, DC: The Eurospan Group, 2002,
£33.95, softcover, pp 561. ISBN 1557988862

The days when psychology was referred to as "the art of pulling habits out of rats" are quite rightly now behind us. Indeed, the foreword eloquently describes the rapid and continued growth of psychology and its important role in aiding individuals involved in exercise and sport at any level, which the book explores in detail.

The previous edition (published in 1996) was highly regarded because it provided a sound basis for both student learning and clinical practice. This second edition aims to provide an update of the developments in the field that have occurred since 1996 and to address important topics that were not previously included. This worthy objective is more than adequately met.

The authors, contributors, and editors are all credible authorities in the field of sport and exercise psychology, and this is reflected in the standard of the text. I particularly enjoyed the chapter on hypnosis (chapter 8).

Multi-author books of this type can result in a stilted or disjointed flow for the reader; however, the editors have done a fine job with a readable, well referenced, well organised addition to the sport psychology literature the ultimate result of their efforts. The book features up to date references (2002), case examples, and three new chapters. It progresses in a logical fashion and each chapter includes a summary and the book a detailed index.

Students and professionals interested in the ever diversifying field of sport and exercise psychology will appreciate this resource.

Rating

• Presentation	16/20
• Comprehensiveness	17/20
• Readability	18/20
• Relevance	17/20
• Evidence basis	19/20
• Total	87/100

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CALENDAR OF EVENTS

2004 APS Intersociety Meeting – Integrative Biology of Exercise

October 6–9 2004, Austin, TX, USA

Abstracts due May 12, 2004

Further details: Email: meetings@the-aps.org; website: www.the-aps.org

Australian Conference of Science and Medicine in Sport

October 7–9 2004, Alice Springs, Northern Territory, Australia

Further details: website: <http://www.sma.org.au/ACSMS/2004/>

BASEM Conference 2004

14–17 October 2004, Belfast, UK

Main themes: Overuse Sports Injuries and Muscle Injuries. Keynote speakers include: Chris Bradshaw, Medical Director, Olympic Park Medical Centre, Melbourne and Kim Bennell, Assistant Professor, School of Physiotherapy, Melbourne University.

Further details: Email: fionnuala.sayers@greenpark.n-i.nhs.uk

2nd International Ankle Symposium

15–16 October 2004, Newark, DE, USA

The meeting will examine ankle instability and other related ankle pathologies from a multidisciplinary perspective. Attendees will include clinicians and scholars from the disciplines of orthopedics, podiatry, physical therapy, athletic training, biomechanics, and sports medicine. This conference aims to build on the success of the inaugural symposium held in Ulm, Germany in December 2000. Emphasis will be on oral and poster presentations of original research along with selected plenary presentations.

The deadline for abstract submissions is July 1 2004.

Further details: Jay Hertel, PhD, ATC, FACSM, Conference Co-Chair, Penn State University, email: jnh3@psu.edu, or Thomas Kaminski, PhD, ATC, FACSM, Conference Co-Chair and Host, University of Delaware, email: kaminski@udel.edu. Website: <http://www.udel.edu/ias/>

The 23rd Congress of Sports Medicine of the AZ Sint-Jan AV

15–16 October 2004, Brugge (Belgium)

Further details: tel: +32 (0)50 45 29 00; 45 22 30; fax: +32 (0)50 45 22 31

1st World Congress on Sports Injury Prevention

23–25 June 2005, Oslo, Norway

This congress will provide the world's leading sports medicine experts with an opportunity to present their work to an international audience made up of physicians, therapists, scientists, and coaches. The congress will present scientific information on sports injury epidemiology, risk factors, injury mechanisms and injury prevention methods with a multidisciplinary perspective. Panel discussions will conclude symposia in key areas providing recommendations to address the prevention issue in relation to particular injuries and sports.

Further details: Oslo Sports Trauma Research Centre and Department of Sports Medicine, University of Sport and Physical Education, Sognsveien 220, 0806 Oslo, Norway. Email: 2005congress@nih.no; website: www.ostrc.no

4th European Sports Medicine Congress

13–15 October 2005, Lemesos, Cyprus

Further details: Email: pyrgos.com@cytanet.com.cy

BASEM Conference 2005

10–12 November 2005, Edinburgh, Scotland

Further details: Email: BASEMinfo@aol.com

BASEM Conference 2006

5–7 October 2006, Oxford, UK

Further details: Email: BASEMinfo@aol.com