

Show courage!

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We are proud to present to you the annual *Norwegian Sports and Exercise Medicine Society's* issue of *BJSM*.

MOT means courage in Norwegian. MOT is also the name of the organisation and life skill programme established 25 years ago after the 1994 Winter Olympics at Lillehammer, with the main aim to help robust youth who include all and help youth to show courage. Using top athletes as ambassadors and role models (Olympic champion Birk Ruud on the cover photo), MOT promotes the message to show the courage to care, the courage to say no and the courage to live. This also includes to accept yourself and feel valuable as you are. You can read more about MOT and their work in the service spotlight.

In the spirit of MOT, we would like to encourage health personnel working in the field of sports and exercise medicine to show more courage! Racism in sports has been, and still is, a prevalent issue. Recently, the first professional male football player in England since 1990 came out publicly as gay. We believe that medical personnel are in a position within sport to use their position to influence the cultures from the dressing room to the boardroom to make it easier for people to be themselves.

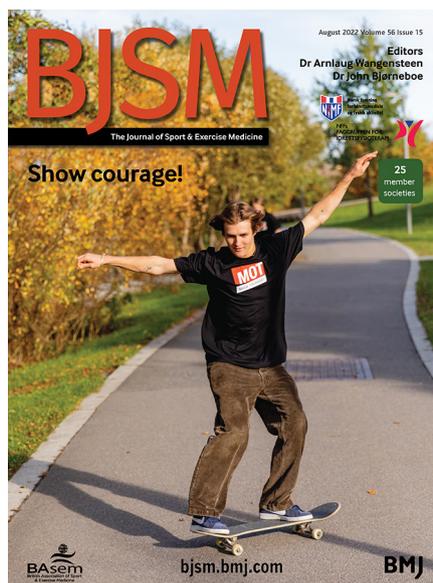
Talking about Norway, we are happy to announce that the Norwegian SEM conference will be held physically in Sandefjord from 29 to 31 October 2022. The conference will also be broadcasted digitally, and you are more than welcome to join us!

An example where researchers really show courage is the relationship between smoking and health problems. The first smoking ban in Norway was put in place in 1632 by Christian IV, but was later overturned, until it was prohibited from 2004 in public places. During the Norwegian SEM conference, professor Geir Kåre Resaland will discuss whether physical activity in school is the most important public health activity since the smoking ban. Thus, we have included two interesting original articles highlighting that

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the young adulthood is an important time period for interventions to increase and begin the maintenance of moderate-to-vigorous intensity physical activity (see page 847), and that long-term physical activity about three times the guidelines or more is independently associated with coronary artery calcium progression, although no additional risk of incident cardiovascular disease (CVD) events could be detected (see page 854).

Physical activity and exercise also play an important role for people with osteoporosis, which is summarised in the consensus statement (see page 837). In short, Brooke-Wavell *et al* recommend 'strong, steady and straight'! Meaning that people with osteoporosis should undertake resistance and impact exercise to maximise bone strength. In addition, implement activities to improve strength and balance to reduce falls and undertake spinal extension exercise to improve posture, and potentially reduce pain levels caused by vertebral fractures and risk of falls. Thus, importantly, they highlight that inactivity should be avoided!

Moving on to the young athlete, there has been a widespread belief that arthroscopic surgery is needed after acute traumatic meniscal tears. However, results from the first high-level trial comparing arthroscopic partial meniscectomy with non-operative treatment suggest that physical therapy with optional delayed arthroscopic partial meniscectomy is a reasonable alternative to early

arthroscopic partial meniscectomy in patients with a traumatic meniscal tear. Read these interesting findings (see page 870)! Talking about knees, a 10-year follow-up from the Swedish National Knee Ligament Registry just recently found that a greater proportion of patients report an acceptable symptom state after ACL reconstruction compared with non-surgical treatment (see page 862). In this study, they used a patient-acceptable threshold value to interpret the results of the patient-reported outcomes, and whether this difference is clinically relevant seems to remain unknown.

The choice of surgical or non-surgical treatment should be reached via a shared decision-making process. The same also applies to the return to sport (RTS) process, of which the Strategic Assessment of Risk and Risk Tolerance (StARRT) framework has been instrumental in the way practitioners view RTS decision-making. However, in the editorial by Taberner *et al*, the authors interestingly pointed out the lack of considering the athlete's sports-specific training capacity in the RTS decision-making process, thus, proposing a revised StARRT framework including sports-specific training capacity in step 2 (Assessment of Activity Risk) (see page 832).

Unfortunately, many athletes with breathing problems are treated as having asthma. However, some of them may have exercise-induced laryngeal obstruction (EILO). As you will read in the patient voice, Madeleine Rubinstein was one of those (see page 890). After realising that neither asthma medication nor harder cardio training solved her problem, she was diagnosed with EILO. After 8 weeks of treatment, she gained better control over her larynx during high-intensity exertion and returned to full Judo activity.

Finally, we hope to see you in Sandefjord, either physically or digitally. And we hope you all find your way to somehow show courage in your sports medicine community.

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Contributors Both authors were responsible in writing and editing the manuscript and final approval of the submission.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval Not applicable.

Provenance and peer review Commissioned; internally peer reviewed.

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To cite Bjørneboe J, Wangensteen A. *Br J Sports Med* 2022;**56**:829–830.

Accepted 29 June 2022
Br J Sports Med 2022;**56**:829–830.

doi:10.1136/bjsports-2022-106026

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