

WINNING *at* Russian Roulette

By Dr. J

I'm writing this column as the doctor of a premiership-winning NRL team, so it gives me the chance to pen an entirely self-indulgent wank. In other words, it won't be any different from any of the previous Dr. J. columns. I think that – as opposed to the players – the year you win the premiership as a doctor, the most significant observation is that you don't feel as though you have done the job any differently than in any other year when your team might have come 8th instead of 1st. You still crap yourself on the sidelines knowing you have players out there with ridiculous injuries that shouldn't be playing, the only difference being that the players are out on the field scoring tries and kicking goals instead of letting them in.

To give self-credit where it might be due, the Roosters had a good year medically because almost all of our major medical gambles – in retrospect – seemed to pay off. For AFL fans, we had a year like the Adelaide Crows did in their premiership years of being struck by a huge early-season injury toll but regaining most key players towards the finals. To be realistic, our medical gambles were all still gambles and could have blown up in our face and had the administration thinking that poor injury decisions contributed to the team not winning the premiership yet

again. In the likely event that the Roosters don't win the comp in 2003, it won't be because the medical team has been of any worse quality than it was in 2002, it will only look that way to everyone who casts a critical eye in our direction.

Local anaesthetic complications

This year I published a paper that was somewhat risqué in that I detailed to the world multiple episodes of local anaesthetic injections that had not led to the desired outcome [1]. I won't pretend that this sort of publication is borne totally from altruism, as obviously being the first paper of its kind it will pick me up a few handy impact factor points. I hope it also serves as an example that we have to be honest that in professional sports medicine, it is actually good medicine in professional football to be skating on thin ice a lot of the time. My big local anaesthetic complication from 2002 – which didn't make it into the *British Journal of Sports Medicine* series – occurred during the State of Origin rather than at the Roosters. I won't publish names in any of the following cases, although some readers in the northern states may have a good idea of the cases I am talking about. One of my Origin players

(who wasn't a Rooster) went into an Origin match with a fairly mild rib cartilage injury that I injected with a touch of local before the game. When I say a touch I mean it, as I have in the past in finals matches given players up to 40ml of Marcaine to try to get rid of pain from bad rib injuries. This player didn't have any problems after the injection until about 20 minutes into the game when his ribs managed to find a stray opponent's boot at full swing and he consequently picked up a pneumothorax. I wouldn't shy away from the fact that his pre-existing problem was almost certainly a predisposing factor in his second injury, and also that he was on the field carrying his first problem with the help of my pre-game injection.

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picking up a pneumothorax and despite sections of the rumour mill suggesting otherwise, I know that he didn't get this injury directly from my injection technique.

There is another well-known NRL player that recently managed to win his team a premiership and get a pneumothorax within

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a week of each other due to insisting on playing with broken ribs. I am passionate about the concept that it is definitely good medicine to keep doing these procedures for players in important professional matches, and it is a prime example of why sports medicine is a specialty area that needs its own specific knowledge base. And I'm equally passionate that whilst it might be good "risk management" (in Dr. Evil quotation marks) to warn players when you are injecting their ribs that the procedure might lead to a punctured lung, it

is totally shoddy sports medicine practice in the real world to be emphasising punctured lungs when they are preparing for an important match and trying to play well carrying a rib injury.

Reasonable risk

At the end of the Origin series, which finished in a tie that most Queenslanders thought was a win to them, it is easy to be critical about injuries such as the one above and say that they cost New South Wales the series, but the greater reality is that Queensland had some bloody good players

that cost New South Wales the series. This year in the NRL final series we also took risks with a few of our injuries that after a Grand Final win appear to have paid off. One of our most valuable players went into the Grand Final in 2002 carrying a hamstring strain and had a solid but unspectacular game and the decision to play him seemed like a major triumph. In season 2000, he played a very similar game with a very similar injury in a losing side, and he looked like he was a passenger incapable of providing the spark that the team was lacking. The difference was other players in 2002 who had great games that made the whole team – including the medical team – look good. Some of the other players who had very good games were getting injected for injuries that entailed a fair degree of risk – including punctured lungs amongst other things. But none of these possible complications happened. Winning makes geniuses out of everyone.

The issue of what represents a reasonable risk in a professional football game is not going to go away. There is obviously a line somewhere over which aggressive sports medicine suddenly becomes genuine negligence. There is a case from the US where a team doctor apparently injected a player's knee joint for a season after he had suffered a torn ACL [2], and this sort of case history makes me recoil in horror probably as much as a lay person recoils at the thought of a football player risking a punctured lung. The football codes could attempt to 'solve' the problem of local anaesthetic

injections by banning the practice as rugby union has done. It would decrease the frequency of the practice, but would doctors really abstain from injecting fingers and ribs of key players in finals and Test matches when they knew they wouldn't get caught? These risks are never going to go away, and so I believe we need to keep discussing them publicly so they are better understood by all parties.

Two contrasting decisions we made during the season to injured Roosters front rowers are also worth mentioning. One of them involved a prop who had a very nasty disc prolapse with severe nerve impingement who had mid-season surgery. His recovery exceeded our best expectations and perhaps this type of surgery is improving to the extent that it needs to be considered more often mid-season in high-level players who want a rapid return. One of our other front rowers had a chronic patellar tendinopathy and missed the first two months of the season. He looked as though he might miss the whole year, and the question of surgery was put on the table. In this case we went for another specialist opinion and by specialist I don't mean surgeon. Because he had patellar tendinopathy we flew him down to Jill Cook in Melbourne, who most readers will know as a world expert on this condition. Even though the player was to discover at this visit that the physiotherapy treatment he was already getting back home from Liz Steet was very good, the psychological impact of meeting someone who had done a PhD in his condition

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and who could reassure him that he shouldn't necessarily be looking to surgery to cure him was a key factor in him turning the corner and getting back on the field. He also went on to become a key player in the finals.

It goes to show that the real meaning of specialist is someone who is very good at treating a particular subset of patients with similar conditions. Medicare doesn't get this, and unfortunately neither does the AMA and these two bodies can sometimes dupe the general public. However, patients who aren't getting good opinions from 'so-called' medical specialists will notice the difference when they see practitioners who are real experts in the relevant areas. I don't know of any orthopaedic surgeons in Australia who specialise in patellar tendinopathy remotely as well as Jill Cook, for example. As sports physicians, physiotherapists and the like, we need to just hang in their with specialist-level practice and the official recognition will belatedly come.

Real estate

After being part of a premierships team when it seemed for a minute there that life couldn't get

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any better, I entered the Sydney real estate market as both a vendor and purchaser. Just about everything that could go wrong with these transactions did. I thought I had bought and sold at about the same time, only to have my purchaser pull out 3 weeks after we reached an agreement on terms of the sale. I then found out holding deposits weren't worth the paper they are written on and that real estate agents aren't the only people in the property game who tell bare-faced

lies. I also had bank hassles and was rescued by none other than my State of Origin team sponsors Wizard. Since then there have been hassles with the state of the property I have just bought, which had a major defect that was hidden from me by the vendors and strata managers. It all goes to prove that you never get too many good things happening in a row in life, although it is always worth remembering the opposite applies whenever you are having a bad run. No matter how bad your

football team did this year, they almost always will bounce back and you can almost always find an opposition supporter in a worse situation (unless you barrack for Carlton or are a member of the Barmy Army).

References

- [1] Orchard JW. Benefits and risks of using local anaesthetic for pain relief to allow early return to play in professional football. *British Journal of Sports Medicine* 2002, 36:209-213.
- [2] Gallup E. Law and the team physician. Champaign, IL, USA: *Human Kinetics*, 1995.

Sports injury prevention research – what is happening internationally? *continued from page 15*

session on “Water related injuries: boating, swimming, diving and others”; a five-poster session on “Ski and snowboarding injuries”; a seven-poster session on the “Use of protective equipment in sports and recreational activities”; a five-poster session on “Studies and risk factors in sport and leisure injuries”; and a six-poster session on “Playground safety”. The quality of these sports injury posters was highlighted in the positive evaluations from conference attendees.

Research quality improving

Taken together, this conference highlighted a range of sports injury prevention activities from across the world. It was also clear from the general quality of the work presented that the quality of sports injury research is continuing to improve.

Importantly, there were many instances of studies that did not just present descriptive statistics of injury occurrences.

The seventh meeting will take place in Vienna, Austria, from 6-9 June 2004 (for further information see www.safety2004.info).

It is also worth noting that this regular international conference has recently changed its name to introduce the concept of safety promotion: the World Conference on Injury Prevention and Safety Promotion. We believe that there is potential for Australian activities in this area to be more widely promoted to the international injury prevention community, through this conference and other avenues, as well as the international sports medicine and sports science communities.

Copies of the abstracts can be obtained from the English section of the website of the Institut National de Santé Publique du Québec (National Public Health Institute of Québec). The address is www.inspq.qc.ca/English and “click” on the conference logo to find the abstracts. They will be available on this website from December 2002 until May 2004.

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