EDITORIAL

And there we shall wallow...

Play in the young child and animal practises and develops specific adult life skills. So many sports have a special sociobiological function, that is, the preparation of individuals and societies for the advent of defensive and offensive conflict. Some sports like those representing the Martial Arts are clearly rehearsing person to person combat and they and many others promote cardiovascular fitness. A team sport such as Rugby allows this rehearsal to extend to the preparation of a group towards tactical objectives. A rugby player in a curving, tacking sidestepping run seems to me not unlike a foot soldier progressing under fire.

Altitude and water are well established environments into which sports medicine travels. What to some are adverse weather conditions have invited the promotion of winter sports. The technology of protection and sporting technique have evolved to match the vagaries of snow and ice. Such conditions are even artificially produced for training and events to further the development of these special sports.

Impact sports are generally defined in terms of player to player contact but additionally and equally as important is player to ground contact. Some sports like soccer can live more comfortably with artificial surfaces to prevent mud formation. In rugby, in which ground contact is more frequent and forceful, such surfaces have not been generally used perhaps at least because they have not been as kind as grass particularly to body sliding contact. This contrasts with American football in which off the ball blocking adds to the frequency of player to player impact. More protection is worn allowing for more use of prepared surfaces. In rugby the only change that is made on the day to meet the contingency of a water affected soil and grass surface is the length of the boot stud; the muddier the longer. This has sports' injury consequences.

Several weeks of the winter of 1994 were heavily and constantly wet. Being a club doctor for a professional Rugby League Club provided me with the opportunity to experience unique conditions for the practice of sports' medicine. It could almost be compared with trench warfare. The money involved, including television coverage, often tips the balance towards playing a match in atrocious conditions. This would not seem to have been the only incentive as both amateur Rugby Union and amateur Rugby League authorities had made similar decisions with presumably much less financial pressure.

Picture the scene. Days of rain have produced pools of water on the pitch. It is still raining. Surface markings are barely visible. Waterproofed groundsmen are trying to soak up the water sacking, draining with forks and filling in with sand. There is no undersoil heating and the base below one or two inches of mud is still hardened by recent frost. Even the best drainage system cannot keep up with the rate of rainfall. Gusts of cold wind drive the rain and temperatures down to low single figures. There is a separate doctor for the crowd that day. He wonders about the hardness of some of the older standing supporters.

The team doctor has learnt his lesson. He has left his formal club blazer and grey flannels in the dressing room. He has thermal underwear below a track suit, a waterproof coat and hat and rugby boots with long studs. He has abandoned his comfortable high level stand seat and sits with the physiotherapist, coach and, at that time, two substitutes, in a small dugout. The presence of the icebox appears superfluous.

Twenty minutes into the game it is becoming difficult for players and spectators to distinguish one side from the other. But not apparently too difficult for the referee. Indeed the man

in charge has been able to detect some blood on the face of a forward who by now is only recognisable to the dugout by his shape. The player is sent by the referee to the 'blood bin', (not the 'sin bin'), where his substitution will not count as one of the maximum four substitutions permitted at that time (1994). This allowance is dependant on the player being fit and free of visible blood within the following fifteen minutes. He is cursing his luck and is longing to get back on again. A water spray, not a sponge, clears some thick mud from his face revealing a laceration just above the eyebrow. A decision is made between physiotherapist and doctor that this should not be bound without wound toilet first, even if taping were satisfactory over an eyebrow. Coach and player are reinforcing each others' anxiety and impatience. No other sign of damage, including head injury, reassurance was given that the player will be ready in time. Back to the medical room feeling pleased to be a doctor enabling players to continue their sport rather than diagnosing disablement unnecessarily. Wound cleaned ready for a drop of local and some sutures. Eight minutes to go, the kitman enters hurriedly and concerned with a message from the physiotherapist. A player in the opposing team has gone down with a leg injury. He is reported conscious, not in pain, but cannot feel or move his leg. Recommend he is treated as a back injury and that the physiotherapist lead the procedure of mounting him on a scoop stretcher to be transported to the medical room. No time for local and sutures now so laceration closed with skin staples and back on field just in time. Wound covered with Iodine spray, vaseline and taped dressing to be reviewed and revised if necessary after the match.

The second injury brought in shivering, very wet and black with mud. Giving a history is affected by jaw trembling. Boot stuck in mud while tackled laterally. No pain, cannot move ankle nor foot and general numbness below both knees. Kit saturated in cold water. Skin colour difficult to assess locally and generally through the mud. Boots and kit off with difficulty. Ankles had not been bound with pre-match taping. Foot pulses barely palpable. After ten minutes of warming and drying further examination revealed no head, neck nor back injury and lower limb findings after return of sensation, movement and colour amounted to a small swelling over the lateral malleolus consistent with a sprain. He cannot resume playing but at least an ambulance and an A&E department have not been troubled and the player will not miss the coach back to Cumbria.

At half time there is a change of kit. Many players are showing several patchy signs of cold vasodilatation. Doctor did not think the players and coach would take kindly to the idea of rectal temperatures. (Tympanic thermometers not then widely available).

Play resumes as does the rain. An eyelid is everted with cotton wool bud on a stick. Washing out with contact lens saline spray proves difficult due to pain. Corneal abrasion provisionally diagnosed. Pain relief with amethocaine drops then successful irrigation. A spot of fluorescein strengthens the diagnosis. Chloramycetin and eye patch. A key player sidelined by a few grains of muddy sand! How many lacerations are now hidden even to the referee? How many of the away team have had adequate tetanus prophylaxis?

A recently signed Australian player is substituted. He has never seen snow and never played in such conditions. He is not apparently injured. He just slowed down to a stop on the field. Fortunately he did compensate with simple warming without any lasting effects of hypothermia or cold injury.

The after game bath-shower did reveal the inevitable bleeding long stud skin punctures. There should not have been a communal bath. Other lessons to be learnt. Weather affects presentation. The question arises as to whether the advantage of a better long stud boot grip maybe offset by the locking of a boot in glutinous mud with the risk of ankle and knee injuries and stud skin puncture. Is there research on this? The minimum medical team in attendance should be a qualified, experienced physiotherapist for each team and a club doctor experienced in the particular sport and willing to be dressed appropriately on the touch line.

Professional Rugby League is now mostly a Summer sport. Rugby Union, now all potentially professional, plus the British Amateur Rugby League Association, continue as winter sports. Rugby League now has four substitutes and six substitutions, (excluding the 'blood bin'), with no time limit for blood repairs.

If one of the socio-biological functions of certain sports is a nation's preparation for war then the environment of mud will provide a gentle peacetime introduction for a M.A.S.H. team. Some say sportsmen must be mad to play impact sports especially in cold-muddy conditions. Since sport, like war, is unlikely to become extinct in the near future we can only

continue to ensure that psychiatry is an important element of the sports' medicine syllabus.

B Miller

It has, over the last 7 years, been a most enjoyable duty to be Editor of the Journal of the Royal Army Medical Corps. In these days of 'super' specialization there is a great danger of us becoming very insular in our reading. The post of editor of a general medical journal however ensures exposure to a broad spectrum of medical work and I am grateful for the experience. The time however has come to move on and allow others to take over the reins.

The above editorial was written by Dr Barrie Miller, medical officer to the Salford 'Reds' professional rugby league team. I found the piece "atmospheric" and its relevance to a Regimental Officer in the field is obvious. I am grateful to Barrie for the article and having covered large sporting competitions myself fully understand the challenge of multiple adrenalin charged casualties, although I was fortunately spared the mud.

GO HOPKINS

ACADEMIC ACHIEVEMENTS

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DCH	Captain J Papworth RAMC
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