

THE FIRST AIDER[®]

Sports Medicine Information for the Athletic Department



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Ice Hockey Injuries

By Jeff Kreuser, ATC

Kansas City Blades Professional Hockey

It's getting colder out, the days are getting shorter, and the feeling of winter is in the air. This can only mean one thing: hockey season is here! Yes, it is that time of the year again where thousands of boys and girls across the country are lacing up their skates and hitting the ice to play hockey. Along with many outstanding goals and great saves come many sprains, strains, and other types of injuries. This article will describe some of the common hockey injuries and what we can do to prevent and treat them.

Hockey is a collision sport, meaning that one player makes physical contact with another player. With these collisions come many injuries. One body part that takes the brunt of these collisions is the shoulder complex. This can result in a shoulder separation. A shoulder separation is a sprain of the ligaments at the acromioclavicular (AC) joint. This is where the clavicle and the scapula meet in the shoulder complex. This injury is usually caused by being checked awkwardly into the boards or from trying to prevent yourself from falling with your arm. This injury can cause a player to miss anywhere from a few days of action (first-degree sprain), to a month or longer (second to third degree sprain). Pain is experienced over the AC joint caus-

ing limited shoulder movement, particularly shoulder flexion and internal rotation. Placing the arm in a sling may be required to make the athlete more comfortable. These injuries need to be x-rayed to rule out any fracture of the clavicle or scapula. The best way to treat a shoulder separation is



rest, ice, compression and elevation (RICE) and a referral to a physician. There are ways to prevent them as well. The best way is to make sure the player has a good pair of properly fitted shoulder pads. These pads should be comfortable, not inhibit any movement, and have a hard cap that fits directly over the entire shoulder joint.

All hockey injuries do not occur from body checks and collisions. Another

very common injury that occurs from just normal skating is the groin strain. While skating, the groin muscles are used much more than in running. Therefore, it is important to make sure that the groin is properly strengthened and stretched throughout the hockey season. Groin injuries can occur from forced hip flexion or from adducting and abducting the leg while skating. It is very important to keep these muscle groups flexible. Flexibility training should begin before the season and continue throughout the entire season, particularly for goalies. Care for a groin strain is RICE. Return depends on when the athlete is able to skate comfortably without any pain. This could be a few days or a few weeks depending on the severity of the strain. It is important to have the athlete skate in several different directions such as forward, backward, and turning before allowing the player to return to practice. This allows you to be sure that the muscles will not be re-aggravated.

With the return of hockey season also comes the return of sore feet due to new skates. Here are a couple of tips with skates in order to prevent some of those aches and pains. First, skates should provide good support for the ankle joint. If a player's ankle can

High School Head Injury Project Gears Up for Expansion

By Monique H. Olesniewicz, CRC / Project Coordinator

High School Head Injury Project

Nearly 100 years after President Theodore Roosevelt threatened to ban the sport of football because of the large number of serious injuries and deaths among players, the High School Head Injury Project begins a new phase of operations. Begun in 1997 as a San Diego-based consortium of health care professionals and research institutions, the Project's mission was to educate parents, coaches, school administrators and medical personnel about how to identify and evaluate concussions.

Working with local football players, the Project conducted baseline neurological test, post-trauma test among head-injured athletes and post-season tests of all athletes. Analysis of the data enabled researchers to learn more about risk factors for concussion, the recovery process and to begin to develop a standardized assessment tool for non-medical professionals.

In what amounts to a new phase of operations scheduled to stretch through 2004, the Project will broaden its operations geographically by expanding from one to four research centers, with new centers begin located in Washington, Florida and New Jersey. In addition, the Project will broaden its activities from testing and research to actively developing a standardized testing regimen for non-medical professionals, communicating its availability and training on-the-field personnel in its use.

The need for expanding the Project's mission was made clear as evidence was gathered suggesting that, while awareness of concussion and its attendant dangers was widespread, there existed significant and potentially dangerous discrepancies in the recog-

nition and evaluation among the various parties working with athletes with head injuries. Several instances were reported of differing evaluations of the same injury between emergency responders on the field and the follow-up evaluation by a physician. Discrepancies such as this create the possibility of further, potentially deadly head trauma.

The need to ensure continuity and consistency stems from the serious dangers posed by a allowing a player with an undiagnosed or under-diagnosed brain injury to return to activity



before he or she is completely free of the effects of that injury. It has been determined that an athlete with a single concussion has a fourfold risk of incurring a second. A repeat concussion occurring while the athlete is still suffering the effects of the first, the so-called "second impact syndrome," can lead to dangerous, often fatal, consequences. In a dramatic finding, the testing of football players mentioned above revealed 81% of the players tested had symptoms of concussion sometime during the season yet did not report them.

Currently, there are as many as 16 neurological assessments in use around the country to evaluate concussion. While most of these tests use common criteria for concussion, notably loss of consciousness and post-traumatic amnesia, all are based upon the opinion of experts rather than upon measurable and objective facts.

Further, each of these tests has a set of guidelines to help non-medical personnel "grade" a concussion and to help determine when an athlete may safely return to competition. While nearly all the tests classify concussion as "Grade 1," "Grade 2" and "Grade 3" (mild, moderate and severe), it is possible to reach different conclusions as to the grade, from the same set of symptoms. Since return to play is shorter for milder concussions, tests which look at the same set of symptoms and yield a more moderate grade 1 or 2 diagnosis provide less safety margin than tests which yield a grade 2 or 3 diagnosis.

Over the course of the next phase of the High School Head Injury Project, researchers will attempt to evaluate the strength and weaknesses of the various assessment methods and select one (or, perhaps, develop a hybrid of several). This selection will then be the focus of the Project's efforts to promulgate a common assessment tool among constituencies involved in preventing or treating athletic head injury.

Ice Hockey Injuries

Continued from page 1

wobble from side to side, a different pair of skates with stiffer ankle support may be needed. Skate must be broken in to prevent potential problems. Try to break in a new pair of skates slowly. Walk around in them and skate for short periods of time before you start wearing them full time. Another hint to break in new skates is to warm them up over a Hydrocollator® Unit so that the steam can loosen up the insides of the skate. It just takes a few minutes of steam to loosen up a skate. Another common problem that occurs while breaking in skates is lace bite. This is where the tendons on the dorsal aspect of the foot become inflamed from tying the skate too tight. Placing a small piece of foam or Ortho Gel™ padding material between the tongue of the skate and the foot can control this problem. Icing the injured site must also be done after practices and games. When breaking in skates, be prepared for the process to take anywhere from a few days to a couple of weeks.

These are just a few of the more common injuries that are seen in hockey. The best way to treat these injuries is to prevent them in the first place. The best method of prevention is to make sure the equipment is in good condition and fits properly. It is best to check equipment throughout the season for damage or breaking. By keeping the equipment in good condition, we will be more likely to keep our athletes healthy. Have an exciting and safe season.

Hydrocollator® is a registered trademark of the Chattanooga Group, Inc.

Cramer Announces Release Of New Injury Tracking Software

After a period of development and testing which has spanned six years, Cramer announces the introduction of AIM™ 2.0 injury tracking software. The program is available in both Windows and Macintosh-compatible versions.

According to Fran Larson, Cramer's Manager of Software Products, AIM™ 2.0 is a dramatic improvement over its predecessor. "AIM™ 2.0 lets you navigate through the program much more easily than the previous version. Now you can point and click any field and enter data directly into the field," Larson said.

We believe this new program will help athletic trainers save a great deal of time ordinarily devoted to keeping injury records by hand, said Larson. "Nearly all of the data entry is done with pick lists so there is very little typing required once all of the athlete's personal and physical data has been entered. Even the reports can be organized by just pointing and clicking," she said.

"Our research indicates a Certified Athletic Trainer spends up to 30% of his or her day on administrative tasks," said Tom Wealand, Cramer's vice president of marketing. "Using AIM™ software to keep track of injury and treatment data will not only free up time to spend elsewhere in the training room, it will also make the records more accessible and reports easier to generate."

AIM™ 2.0 software includes modules to develop an athlete roster, create injury reports and track injury treatments. AIM™ Plus contains the three basic modules but also adds modules for insurance reports, medication records and inventory management.



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5 Ways to Stop Your Next Cold

from Body Bulletin, January 1998

Buy Yourself Flowers

A purple member of the daisy family may just head off your next cold. Thirty-two clinical trails indicate that the herb echinacea boosts the immune system. "It activates the specialized white blood cells that help destroy invading cold viruses," says herb expert Varro E. Tyler, Ph.D.

Exercise, don't agonize

Moderate-not strenuous-exercise is the hero, when it comes to cold-stopping powers. Every time you take a brisk walk, it boosts the circulation of immune cells, increasing the chance that they'll meet up with and combat the cold virus. In three different studies, researchers found that women who walked moderately for 30 to 45 minutes, 5 days a week, had half the illness rate of inactive women.

Zinc Fast

Taken in lozenge form, zinc has pretty impressive power against colds. In a study at the Cleveland Clinic, 50 cold sufferers who sucked on lozenges packed with 13.3 mg of zinc every two

hours kissed their symptoms goodbye in half the time of their placebo-popping peers. Caution: Use zinc lozenges only when you have a cold, not on a regular basis.

Wash your hands of it

Cliché or not, washing your hands as often as possible is the first line of defense against colds. But we're not talking about just any kind of hand washing. According to new research from Purdue University, proper hand washing technique is equally important. Those who washed their hands thoroughly wound up getting fewer colds during during a 10-week, peak cold-season period than did a similar group who washed their hands in the usual hurried manner.

Keep your distance

Want to avoid a cold? Avoid

people with colds. Not likely, right? But you can reduce the chance of spreading germs: Make it a house rule that all coughs and sneezes get well buried in a tissue that then goes directly to the trash. Wipe off tables with disinfectant immediately before everyone congregates for meals. Shop when crowds are the smallest. And postpone your child's play date until his friend is over his cold.



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SPORTSMEDICINE SOLUTIONS

Taping for Medial Epicondylitis

By Richard "Butch" Ortiz, PT and Sherry Williams MEd, ATC, PTA

Restorative Health Care Services, Inc. Chino, CA

Materials:

Tuf Skin

PF Tape

Strapping Tape

1. Strip A- 3-4 inches long

2. Strip B- 4-5 inches long

Position:

Athlete should be lying supine with the arm in 60° abduction

Forearm supinated and elbow flexed at 45°

Step 1

Spray the medial elbow with Tuf Skin-tape adherent from the flexor/pronator muscle mass to just superior and posterior to the medial epicondyle.

Step 2

Apply 1 strip of PF Tape over the flexor/pronator muscle mass, starting 3-4 inches below the medial epicondyle and pulling to about 2 inches superior and posterior to the medial epicondyle.

Step 3

Apply Strip A (Strapping Tape) starting 1 inch proximal to the medial epicondyle to 1 inch distal to the medial epicondyle. The left over tape is folded back onto itself, forming a 1 inch area of tape "sticky side up" just below the medial epicondyle. Attach the lower end of Strip A to itself by "dog-earing" a corner and lightly securing it down.

Step 4

Apply Strip B (Strapping Tape) across the flexor/pronator mass from distal to the medial epicondyle, moving proximally over the sticky part of Strip A and securing it to this sticky segment. There should be at least 1 inch of Strip B extending past its attachment to Strip A.

Step 5

Holding the end of Strip B with one hand, pull and hold the flexor/pronator mass upward (proximally) with the fingers of the other hand. Pull the end of Strip B upward, over and along the path of Strip A. Strip B should be firmly attached proximal and slightly posterior to the medial epicondyle.

- * Avoid crossing the tape over the epicondylar groove, to avoid impairment of the ulnar groove.
- * Don't be afraid to pull the flexor/pronator mass or Strip B upward rather forcefully. The resulting "tug" of the tape must be significant to be effective.

Step 6

Apply a small amount of baby powder over the tape and rub lightly to cover the entire medial area. This takes away any remaining tackiness left by the tape adherent and reduces the tendency for the tape to snag on clothing or other gear.

Taping for Medial Epicondylitis

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Taping for Medial Epicondylitis

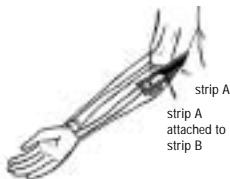
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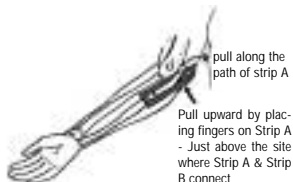
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