www.sasma.org.za

Nov/Dec 2016

SASMA

SOUTH AFRICAN SPORTS MEDICINE ASSOCIATION

The Voice of South African Sports Medicine

The South African Sports Medicine Association is an internationally recognised, a-political, non-profit, multidisciplinary professional and scientific society dedicated to co-ordinating and integrating a high standard of medical, scientific and educational services in sport, exercise and health in South Africa

The Ironman that was 2016

Roll on 2017

Terror attacks, Zika, Brexit, police shootings, Syria, Trump, Springboks, racial tension, State Capture, Shaun Abrahams, Fidel Castro and for some, personal tragedy....much like the roughest ironman, 2016 was extra long, incredibly tough and, in this last stretch, the legs have lost all feeling and we plod along on autopilot counting steps until the finish line. Of course, every marathon has its highlights: Rio 2017, Sundowns, Proteas (mostly), small personal victories – they are what make us come back to do it again. December is here and we near the finish line feeling the same type of exhaustion one feels after a gruelling marathon – a different level of tired accompanied by an enormous sense of relief. As we wind down 2016, let's take time to celebrate the small victories and learn from the mistakes. Be kind to yourself. Dust yourself off and get ready to rise up and take charge of 2017 – it *will* be a beautiful destination with everything to look forward to including the SASMA Congress in October. Goodbye 2016, roll on 2017. Here's wishing our SASMA members a relaxing, refreshing and joyful Festive season. Happy holidays from all of us on the SASMA Exco!

Contents

Sundowns Rise to Glory!

It is not everyday that one of the PSL football clubs can elevate South African football to the level Mamelodi Sundowns have done this last season in the CAF Champions League. The last time a South African club had earned these honours was in 1995 with Orlando Pirates. This, of course, comes with several challenges especially from the medical, fitness and conditioning aspect. Dr Lee Pillay interviewed Dr Carl Tabane, the team physician for Mamelodi Sundowns, about the challenges of travelling through Africa for sport. The hunt for the elusive "star" on the club logo is always a great achievement and very often the medical team is not given deserved accolades for this. Here's what our medical "star" had to say about his experience.

Lee Pillay (LP): Dr Tabane, thank you for taking the time to answer these questions. What was the experience like for the medical staff from a general perspective?

Carl Tabane (CT): Thanks for affording me the opportunity to give an account of this long journey that started when I joined the club in the 2012/13 PSL Season. Having worked with Coach Pitso Mosimane at National Team level, I have always known that this tournament was one among many that he envisaged winning. Although the dream was only realised now, the preparations started a few years back. These included training camps away from South Africa to countries like Ghana, Zambia, Zimbabwe just to name a few. This was purely meant to prepare everyone for what was "to come" when travelling to other parts of Africa. From a medical staff perspective, one was faced with the daunting task of having to move away from the comfort of their own facilities and equipment to places where there were limited or even no facilities or medical support. When travelling one needs to be thoroughly prepared. We created a check list for the medical team to make sure we were prepared for whatever might come our way. There were tough challenges we faced as a Medical Team, but at the same time an enormous amount of experience was gained, something I always refer to as "paying our school fees". Nothing prepares you like being hands-on.

Mamelodi Sundowns celebrate after winning the CAF Champions League final match against Zamalek at the Borg El Arab Stadium on October 23, 2016. Source www.timeslive.co.za

LP: Coming off as winners in the Absa Premiership 2015/2016 season, there must have been challenges in getting players to focus on the agenda of doing well in CAF. While other teams had an off season period, Mamelodi Sundowns were still travelling and playing. During the entire campaign, were the medical staff challenged in dealing with the psychological aspects of travelling? The mental fatigue in combination with the travelling fatigue?

CT: As mentioned previously, the preparations started 2 to 3 years back. Orlando Pirates participated in the 2013/4 Final, and their schedule in terms of number of games played in a season, including all local tournaments and national call ups, gave us an idea of what to expect. To make matters worse, our players had to come back few days after the off-season having learned about the disqualification of As Vita. Some even had to abandon families whilst on Holiday to come resume training. Admittedly, this was a strain on players and staff. Fortunately, the players had been prepared well in advance for this eventuality. The Coach had made it clear season in and out that the Club's desire and ambition was to participate and triumph in this tournament. The fatigue was there all the time but what drove the players and everyone else was the idea of being the best in Africa and playing with the best in the World; an opportunity to make history; being the team that generations to come will always talk about; doing it for their families and of course the financial reward - that kept the boys going. The dream and motivation was bigger than any mental fatigue and it worked for us.

LEFT: Dr Lee Pillay (Guest Writer) – twitter: @Levarson
RIGHT: Dr Carl Tabane (Team Doctor Mamelodi Sundowns)

LP: What range of injuries were prevalent?

CT: The most prevalent injuries were muscle strains, specifically Adductor and Hamstring. We also had a lot of contusions and only 2 long-term injuries, a High Ankle sprain and Meniscus Tear. The Coaches also helped by rotating the team, and that helped us in having a bit of time to manage the injuries.

LP: What illnesses were observed?

CT: We had a few cases of Travellers Diarrhea and Common Cold. Fortunately nothing severe and no cases warranting hospital admission or player withdrawal.

LP: Did the medical staff work together with the rest of the technical staff to tailor make recovery protocols? If so, what were the most commonly used and effective strategies that worked for the team?

CT: When we started working together in the latter part 2012/13 and 2013/14, towards the end of the season we suffered a lot of injuries, especially muscle strains. Although we won the league that season (2013/14), we had to take a look at the causative factors. For the better part of that season, we were training twice a day, mostly 4-5 days per week including match days - we were clearly overtraining our players and not allowing them enough time to rest. Our pre-season training and subsequent periodization was tailor made to suit the team. This included training once a day (max of 60 minutes), adequate nutrition (pre/post workout), ice baths after all games, 20-30 minutes training after each match for players that played less than 60-min or were on the bench as substitutes, 20-30minutes recovery training after each game with a full body massage and a day off the following day to allow the players to rest.

LP: How did you find the support from the medical staff in countries that you visited? Were they equipped to handle any on field incidents like sudden cardiac arrest?

CT: The Team Doctors from the opposition teams have always been helpful, and we have exchanged contact details with some and have became friends. We travel with our defibrillator and a fairly equipped emergency bag with drugs as these are not always present on-field. Our hosting of the Confederations/World Cup has given us an upper hand with Stadia, which are well equipped to deal with such cases, and this equipment is generally adequately maintained throughout South Africa. Unfortunately, most of our sister/brother countries are not at that level yet.

LP: How does the medical team feel to be such a vital part of such a historic South African achievement?

CT: It's obviously a great feeling and a mammoth achievement as a Medical Team! Most importantly though, we acknowledge and embrace the fact that we must pay it forward by sharing our knowledge and experience so that colleagues and aspiring Sports Medicine Practitioners can learn from our mistakes and victories. END

SASMA 2020 Vision

1. Grow and diversify membership
2. Build a strong brand
3. Grow participation in the regions
4. Achieve multi-discipline integration

2016 Priorities

1. Rebranding
2. Website face-lift
3. Secure sponsors
4. Review accreditation policy and membership registration process for implementation in 2017

Sports doctors should not report to team management –Harvard report

There are "significant legal and ethical quandaries" to the existing system where medical staff are charged with treating sportsmen but report to team management and coaches, found a 493-page **Harvard University** report. It outlines a new system to end the "inherent conflicts of interest" in the **US's National Football League** (NFL) but with impications for contact sports worldwide.

The **Football Players Health Study** at Harvard University has released a set of recommendations on issues affecting the health of NFL players. Among its major recommendations, the study said that club medical staffs should not have divided loyalties between players and clubs. The study also suggested further research into the health effects of playing football, and said that health care improvements should never be a bargaining chip in negotiating sessions between the NFL and the players union.

A research initiative composed of data from several ongoing studies, the report, which is nearly 500 pages long, is based on an analysis performed over two years by researchers from The **Petrie-Flom Centre** at **Harvard Law School.** It's the first comprehensive analysis of the legal and ethical obligations of groups influencing NFL players' health.

The report reviewed and evaluated the roles of 20 relevant stakeholders, including the NFL, the **NFL Players Association (NFLPA),** players, and team doctors. The report made 10 major recommendations, and 76 in all.

Its highlight findings addressed these key issues:

Conflicts of interest: The current arrangement under which a team's medical staff, including doctors and athletic trainers, have responsibility both to the players and to the club presents an inherent structural conflict of interest. A division of responsibilities between two groups of medical professionals is needed to minimise such conflict and ensure that players receive medical care that is as unbiased and uninfluenced by competing interests as possible. Care and treatment should be provided by one set of medical professionals, called the "players' medical staff," appointed by a joint committee with representation from both the NFL and NFLPA. The evaluation of players for business purposes should be conducted by a separate set of medical personnel, known as the "club evaluation doctors."

Player health and adversarial collective bargaining: The NFL and NFLPA should refrain from making improvements to player health policies a bargaining chip in labor negotiations, to the extent that this is not already the case. Players should never be asked to trade their health care for other benefits in the collective bargaining process.

Ethical guidelines: Various stakeholders — including club doctors, athletic trainers, coaches, contract advisers, and financial advisers — should adopt, improve, and enforce codes of ethics specific to the environment of the NFL.

Ongoing research into the health effects of the game: The NFL and NFLPA should continue to initiate and support efforts to scientifically and reliably identify the health risks and benefits of playing pro football.

Access to data: The NFL and, to the extent possible, the NFLPA should make aggregate injury data publicly available for independent reanalysis. They should also continue to improve their data collection and offer it to qualified professionals for analysis.

Meaningful penalties: The collective bargaining agreement should be amended to impose meaningful fines on any club or person found to have violated players' rights to medical care and treatment.

Investing in players' health and care: The NFLPA should consider investing greater resources to investigate and enforce player health issues and enforce player rights. This report recommends that responsibility for player health should fall upon a diverse but interconnected web of the groups involved.

"Our report shows how the various stakeholders might work together to protect and support NFL players who give so much of themselves – not without benefit, but sometimes with serious personal consequences – to one of America's favourite sports," said Glenn Cohen, professor of law at Harvard Law School and co-lead of the law and ethics initiative as part of the health study.

"We are committed to addressing the needs of 'the whole player, the whole life,'" said Alvaro Pascual-Leone, professor of neurology at **Harvard Medical School** and research director of the study. "As a physician, I know we must take an interdisciplinary approach to address important ethical and structural factors. This report elucidates many valuable points that we hope will lead to productive dialogue."

"This report offers vital recommendations to improve player health," said Ed Reynolds, a former linebacker with the **New England Patriots** and **New York Giants** and an adviser on the study. "Many individuals and groups are involved, and we must continue this important dialogue to help keep NFL athletes healthy on the field and long after."

The NFL strongly took issue with the methodology and conclusions drawn by the Harvard researchers, reports ***The Washington Post.*** On 1 November, Jeffrey Miller, the NFL's executive vice president of health and safety, sent the researchers a 33-page response in which he rejected any suggestion that NFL doctors have conflicts of interest and called the proposed change "untenable and impractical." He said researchers have called for "several unrealistic recommendations that would not improve player care."

The report "cites no evidence that a conflict of interest actually exists," Miller wrote. "... the report identified no incident in which team physicians were alleged to have ignored the health status of players, failed to adhere to patient confidentiality consent procedures, or made recommendations to clubs that were contrary to the health of players."

Though funded by the NFLPA, the research is independent, and Harvard officials stress that neither the union nor the league has any control over the studies. And, the report says, an NFLPA spokesperson declined to comment on the study's conclusions, and the union also declined an offer by researchers to submit a written response, similar to the NFL's.

In interviews, the Harvard researchers say they were surprised by the league's response.

"I had expected we'd maybe be quibbling around the margins of how it would actually be implemented," said Holly Fernandez Lynch, the executive director of the Petrie-Flom Centre and one of the report's authors. "I did not expect that we would have to have this conversation about whether there is, in fact, a conflict because it's so obvious on its face."

"Admitting you have a problem is the first step to get over," added Cohen, another of the report's authors, "and while we think many of the people who serve as club medical staff are wonderful doctors and excellent people – this is not to besmirch them or their reputation – it is not going to produce a good system if you're operating under an inherent structural conflict of interest and one that is corrosive to player trust."

The report says that since the league's inception, players have been treated by doctors and trainers hired, fired and paid by the teams. They consult with coaches and team management about all manners of player health. The Harvard report suggests players instead should be treated by a doctor and staff that is selected by a neutral committee. Though still paid by the team, the medical staff would serve solely the players' interests, deciding whether the players should participate in practices or games.

In its response, the league said the proposed change would "unnecessarily complicate the patient-physician relationship to the detriment of the player's health." The league said relying on a written report "would lead to confusion, errors and ultimately failure … particularly with respect to complex medical situations."

The NFL contends its wide array of doctors are in no way conflicted and points out that the players' union hasn't called for such a drastic overhaul to the medical structure. "We think the standard of care offered to our players really is top of the line," said one league official who had read the report.

League officials point out that the collective bargaining agreement between owners and the players' union states in Article 39, Section 1 that "each club physician's primary duty in providing player medical care shall be not to the club but instead to the player-patient."

The NFL's response outlined many of the measures undertaken in recent years to address player health, noting that the league has committed tens of millions of dollars to research, have as many as 29 medical professionals on hand at most NFL games and has made 42 rule changes since 2002 to improve player safety. League officials point out that myriad protections are in place for players: They're allowed to seek second opinions from doctors of their choice, can choose their own surgeons at the club's expense and utilize union resources and employ agents to serve as advocates on health-related issues.

In its response, the report says the NFL complained that Harvard researchers failed to cite specific instances in which a conflict of interest was apparent or players might have received compromised treatment. "At some point, policy changes need to be based on fact," said one NFL official who has reviewed the report.

The NFL also took issue with what it called "deeply flawed methodology," criticising the report for relying too heavily on the 10 current NFL players and three former players who were interviewed by researchers. The NFL said the sample size was too small considering more than 2,000 players will suit up in an NFL game this year, while researchers pointed out the report is not a clinical study and the player comments were intended to illustrate certain points, not necessarily be representative of all players.

The report says despite two attempts, researchers were denied access to team employees, including coaches, doctors and trainers.

The report says two years ago, the NFLPA contracted with Harvard to create the Football Players Health Study. This is the 14th report to date from the study.

Link:
http://www.medicalbrief.co.za/archives/sports-doctors-not-report-team-management-harvard-report/

The hidden costs of breast cancer and the financial impact on a family

Preparing for the financial impact on a family is crucial

New research by the Independent Clinical Oncology Network (ICON) reports that four out of five South African women working in the private sector who are diagnosed with breast cancer are likely to survive the disease, due to access to medical aid.[1] While continued medical advances and increased breast cancer awareness has resulted in more women being able to identify and successfully treat the disease, the overall *financial impact* on patients and their *families can be sizeable*.

This is according to Soré Cloete, senior legal manager at Old Mutual, who says that a cancer diagnosis comes with a range of additional expenses that can be mitigated with sound income protection and risk cover. When a mother or carer is diagnosed with cancer, it causes considerable distress - particularly in teenagers and young adults – even inhibiting many of them from reaching financial independence. This is backed up by a recent study[1] of 255 young Australians between the ages of 12 and 24 years, suggesting that the diagnosis of a caregiver disrupts the normal transition of young people into self-sufficient adults.

Cloete says, "This body of research suggests that, apart from the emotional and psychological impact of dealing with the possible loss of a parent, children often take on an over-extended sense of responsibility, causing many to delay moving out of home, or seeking full-time employment, ultimately impacting their transition to adulthood. The reality is that developing a disease like breast cancer has far-ranging financial implications.

"The loss of a mother's income can severely undermine a family's ability to maintain its standard of living. particularly if the mother is the sole breadwinner," says Cloete.

According to the Old Mutual Savings and Investment Monitor, one in two mothers in South Africa describe themselves as single parents. Compounding this problem, only 12% of these receive regular financial support from the father of their children[1]."While a comprehensive medical aid plan will cover the cost of care associated with the diagnosis, treatment and recovery of breast or cervical cancer, there will always be additional, unexpected and indirect costs that even the best medical aid plan won't cover.

"The hidden costs of cancer could include additional home care or maintaining child-related fees such as college or university tuition. At the same time, because of the demands of a treatment schedule, cancer patients may need to work less, which could potentially result in lower earnings."

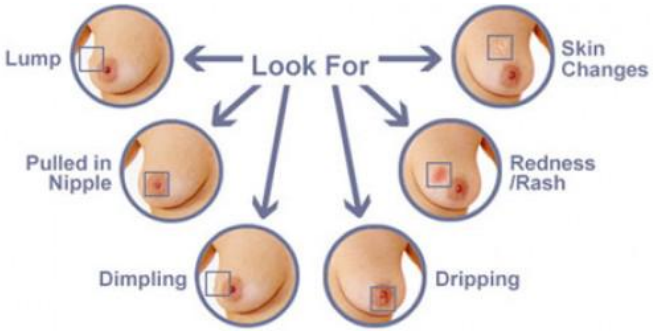
Old Mutual's claim statistics for 2015 further support the necessity to have severe illness cover in place: 34% of cancer claims were for breast cancer - the highest of all cancer claims -and overall 49% of all severe illness claims were cancer related.

Cloete believes that income protection and risk cover should be the cornerstone of every financial plan. "For women, battling a disease such as breast cancer is hard enough without worrying about co-payments, personal finances and other day-to-day expenses. Income protection will ensure that a patient is never in a financial position that impacts on her family's wellbeing and financial goals."

Ends

[1] ICON SA. (2016). *Big (breast) data informs quality, cost-effective breast cancer treatment in SA - ICON SA*. [online] Available at: http://iconsa.co.za/patient_news/quality-cost-effective-cancer-treatment-sa/

[1] McDonald, F., Patterson, P., White, K., Butow, P., Costa, D. and Kerridge, I. (2015). *Correlates of unmet needs and psychological distress in adolescent and young adults who have a parent diagnosed with cancer*. Psycho-Oncology, 25(4), pp.447-454.



http://www.chemobrainfog.com/2015/10/inflammatory-breast-cancer.html

If you need financial advice, send an email to ***advice@oldmutual.com*** *or call* ***0860 60 60 60***

SASMA Notice Board
Highlighted this month

SASMA 2017 Congress: SAVE THE DATE!

SASMA
SOUTH AFRICAN SPORTS MEDICINE ASSOCIATION

Date: 24 – 27 October 2017

Venue: Century City Convention Centre, Cape Town

Theme: Integrate. Accelerate. Elevate.

Website: www.sasma2017.co.za

VACANCY

VARSITY CUP PHYSIOTHERAPIST

We are seeking options on a physio to join our Varsity Cup 1st team for our 2017 season. We used Chris Hopwood who is moving on to a next job.

The duration of the duties with the team will be from 1 December 2016 – 31 August 2017.

Requirements: Experience with a sports team, preferably rugby: Attending weekly training sessions in the afternoon from 16:00, game days with the team(which can include travels from a Sunday – Tuesday) and also once a week in the morning between 8:00 – 9:30)

For more information, contact:

WERNER JANSE VAN RENSBURG

wernerjvr@uj.ac.za

2017 Conference Calendar

9 – 12 Feb 2017	South African Rheumatism & Arthritis Congress, Sandton
16 – 18 Mar 2017	IOC World Conference on Prevention of Injury & Illness in Sport, Monaco
8 – 13 May 2017	AMSSM, San Diego, CA
25 – 26 May 2017	3rd International SA Society for Hip Arthroscopy Meeting 2017 Cape Town, RSA
30 May – 3 Jun 2017	ACSM, Denver Colorado
23 – 26 August 2017	ASPC, Xth International Forum on Elite Sport Durban, RSA
24 – 27 October 2017	**SASMA Congress, Cape Town**

Will training load modification reduce the incidence of anterior cruciate ligament ruptures in netball?

30Nov, 16 | by BJSM

Laura Geitz jumping. Photo: Matt King / Getty Images

By Zoe Rippon

Netball is the most common female team sport played in Australia and New Zealand. The elite professional netball league (ANZ championship) includes 10 teams across Australia and New Zealand. The high physical demands of the sport from sprinting, maximal jump landing (often with contact), change of direction and the rules only allowing one step after landing with the ball causes a significant risk of knee injuries to athletes. Between 2008 and 2015 Stuelcken et al, [1] found 21 athletes tore their anterior cruciate ligament (ACL) despite multiple screening tools and prevention measures in place to reduce the risk of these injuries. These injuries were sustained by either indirect contact (landing following a collision), non-contact (landing with no contact) or changing directions.

ACL ruptures are still happening at an alarming rate with five female athletes nameable from the 2015/2016

Could this be a training load issue? [2]

Training load is important to consider due to the competitive mentality of athletes to be the best; training harder and longer will enable them to perform better. This training mentality often pushes athletes to extreme physical limits. Overloading does not only cause overuse injuries; it is thought to contribute to acute soft tissue injuries as well. [2] Gabbett 2016, [2] describes the 'Training-Injury Prevention Paradox' established from current evidence that non-contact soft tissues injuries are a result of an incorrect training regimes. His research states that consistent loading from training has a reduced risk of injury of less than 10% (based on extrinsic factors (GPS) or intrinsic factors (rateable perceived value)) if training load was 5% less or 10% more than the previous week. Injury risk increased rapidly to between 21% and 49% If the load increased by 15% or more.

The non-contact nature of these injuries leads to the questions: does overloading of the ACL in netball via the sudden deceleration mechanism during a running, jump, land and stop add to the high incident of ACL ruptures? Is there micro trauma/weakening or even previous partial tears that are undetected that make individuals prone to the ACL rupture? Does inappropriate loading lead to fatigue of the hip muscles, trunk muscles and/or hamstrings and then cause a high strain on the ACL? [1,3,4]

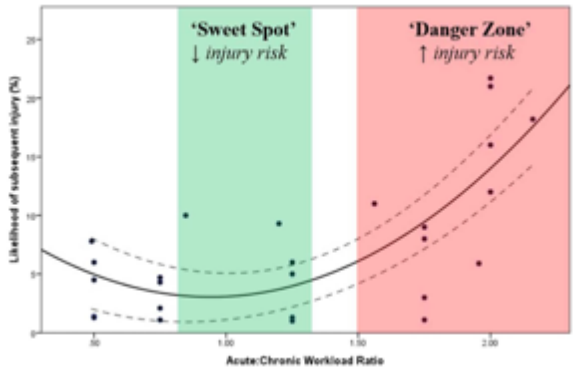


Figure 1: Ratio of acute:chronic training load. Acute = is recent training load. Chronic = moderate-term training load. Green area where reduced injury risk where acute training load is graduated at 0.8-1.3 of the chronic training load. [2]

Does mental fatigue have an effect on neuromuscular control? [5] It's not as if we can pre-scan the ACL or do testing just before the injury to answer our questions and therefore we rely on documentation of the injuries including their mechanism. There are plenty of questions and not many clear answers. What we can establish from the literature is that the contributing factors are multifactorial. [1]

For minimising ACL injury risk we also need to take into account other factors that affect load on the netball athletes: [6]

- Age of the athlete
- Individual factors – biomechanics, neuromuscular control, BMI, physiological systems, psychological factors (confidence, determination)
- Equipment – netball shoes, floor surface (grip and shock absorption)
- Position on the netball court – requires different amounts of jumping, landing and running
- Level of the athlete e.g. development, experienced, length of time in team
- Athletes who play more than one sport
- Nutrition and recovery methods

The million-dollar question – what is the optimal training load for our netball athletes?

Optimal training loads are challenging to research and compare. Athletes or Coaches at the elite level do not want to share their information as possibly this is what gives them the edge over their competitors. Getting the load of training right not only reduces the athlete's injury risk it also maximises their ability to perform. Reduction in injuries allows for maximal training and game time and more athletes available for competition. [2]

ACL injuries don't just happen at the elite level, this is right through from juniors, recreational players, up (but aren't well documented at these other levels). From my experience playing at a premier club level, the focus is on movement patterns and strength, but based on the Training-Injury Prevention Paradox model we need to start educating coaches and players on load management and appropriate training principles if we want to minimise non-contact injury risk further. [2] This training principle not only applies to preseason training and in season training and games, we can also use it to guide rehabilitation and a safe return to sport.

****

Zoe Rippon is a Postgraduate student in sports physiotherapy at the University of Otago. She has an interest in netball injuries and prevention being a player herself. She also works in Private Practice at Muscle People Physiotherapy, Christchurch, New Zealand.
E-mail: zoerippon@gmail.com

References available at http://blogs.bmj.com/bjsm/

Happy Holidays!

Please contact us with comments or suggestions.

Best Wishes!

Phatho Zondi
SASMA President

Connect With Us:

SASMA President: president@sasma.org.za
Enquiries: info@sasma.org.za

SA Sports Medicine Association

@sasmadiscuss

Contact your Region:

Gauteng Central:	gautengcentral@sasma.org.za
Gauteng North:	gautengnorth@sasma.org.za
KZN:	kzn@sasma.org.za
Western Cape:	westerncape@sasma.org.za
Boland:	boland@sasma.org.za
Eastern London:	eastlondon@sasma.org.za
Port Elizabeth:	pe@sasma.org.za
Free State:	rudi@fsrugby.co.za

If you are located in an area too remote from these established chapters but with a growing/large number of sports practitioners, contact us on president@sasma.org.za and we may be able to help you set up your own chapter for CPD activities.