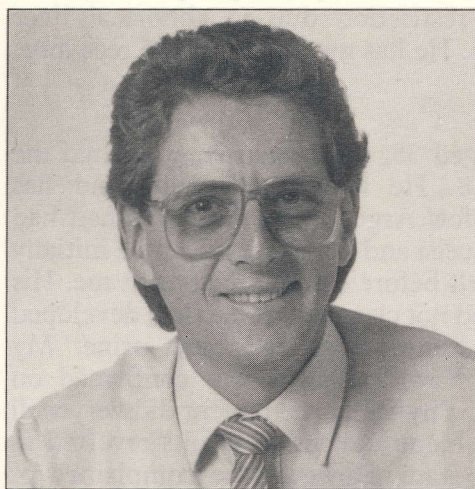


# Dilemmas in the Primary Health Care of Sportsmen

— S Furman



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## Curriculum vitae

Saville Furman graduated from UCT in 1973 and entered general practice in December 1974. He obtained the MFGP (SA) in 1977. He has a wide field of interest in medicine, the main being 'Doctor-Patient Relationship' and 'Sports Medicine'. He is Chairman of the Western Cape Region of the SA Academy of Family Practice/Primary Care, a member of the Academy Council, part-time lecturer in the Dept of Community Med (UCT) and is very active on the Editorial Board of *SA Family Practice*. Dr Furman received the Louis Leipoldt Award for the best GP paper published in the *S Afr Med J* in 1980, has run many marathons and a few ultra-marathons since 1982. Saville is also a keen photographer and an avid reader. He is married to Shelly and they have 2 children: Donna and Graham.

Primary Health Care doctors face many dilemmas in treating sportsmen. Firstly medicine in general has not kept pace with sports medicine in the last decade.<sup>1</sup> Secondly, General Practitioners are not perceived as having enough knowledge, expertise, qualifications or experience to treat sports injuries.<sup>2</sup> In fact most

## Summary

*Sportsmen tend to experience GPs as not really taking an interest in them, and GPs have not been trained effectively in sports medicine. A few case reports illustrate this, and the author identifies a few areas in which doctors need specialized training.*

S Afr Fam Pract 1989; 10: 333-8

**KEYWORDS:** Sports Medicine; Physicians, family; Education, medical

GPs are seen as not to be interested in sports medicine. Sportsmen have the impression that their treatment is a diversion of the doctor's precious time and resources that could otherwise be spent on the "seriously ill". Doctors are being faced by a variety of illnesses induced by sports activities and conversely, many common and not so common illnesses influence performance.

Being a sportman with an injury is also a dilemma. This dilemma is not unique to South Africa as illustrated by an article that recently appeared in the weekend magazine of the London Telegraph of 8 October 1988 entitled "The Ouch Trip". This is the story of a keen runner who acquired a minor injury. He rested it himself for a few weeks until it felt better and then started running again. However, this did not help him and he took what he called the unprecedented step of visiting his doctor. He comments: "Most GPs are not interested in sports medicine. They aren't even trained in it. As far as they are concerned, anyone who can walk and talk and go to work without

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constant pain is doing pretty well. Certainly, such injuries do not justify a diversion of precious time and resources that could otherwise be spent on the seriously ill." His GP waved his leg around for a few minutes, then said it seemed perfectly all right to him. However, a few months later the leg seized up entirely. The GP reluctantly conceded there might be something wrong and referred him to a Physiotherapist who said "I don't hold out much hope. You should have brought this in straight away". Diagnosing a chronically inflamed hamstring, the Physiotherapist attempted to treat him with massage and ultrasound, but a dozen sessions failed to help. He then sought help from other health care persons.

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### *The GP needs additional training to function better in sports medicine*

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His Osteopath diagnosed a highly inflamed iliotibial tract and recommended a course of 20 sessions. The Podiatrist thought it was a strained iliotibial tract and recommended his own brand of custom-made 'orthotic insoles'. The Natural Therapist muttered 'repetitive strain injury' and recommended a course of herbal therapy.

The total costs so far of the recommended therapy amounted to £410.00 (R1 790.00). He felt that any one of them may have been right, but it was up to him and not a medically qualified practitioner to pick a diagnosis and choose a treatment.

I'd now like to present some sick and injured sportsmen who have recently consulted me.

#### **Patient 1**

Dr RA, a Veterinary Surgeon, aged 35, consulted me on Christmas Day 1988. He had performed a mini-triathlon, including a swim, cycle and run 2 days previously. He maintained he had never felt better or fitter in his life before this, but during the triathlon he started feeling muscular aches and weakness. He then developed incredible tiredness, became sweaty and ran fluctuating fevers. On examination there was clinically nothing to find.

The patient sent off a blood count which just suggested a viral illness. Later during the week he consulted me again and said he was having

night sweats, tiredness, and could not even get up to go to work. Being a Veterinary Surgeon one had to bear in mind occupationally related illnesses like Toxoplasmosis and Brucellosis. A later blood count, liver function tests and Paul Bumel were requested, by myself this time! These results now showed inconclusively that the patient had Infectious Mononucleosis (Glandular Fever). He obviously performed the triathlon during the incubation period of this illness. He was recommended to have a prolonged period of rest and alcohol restriction due to abnormal liver function tests. He has made a complete recovery.

#### **Patient 2**

Mr RL — aged 38, a Pharmacist, consulted me in June 1988. He is a keen cyclist and has completed a few Argus cycle tours. He had had diarrhoea, nausea and vomiting which he initially treated himself before coming to consult me. His bowel pain did not clear up and he then developed a persistent temperature and dark urine. My diagnosis of Viral Hepatitis was confirmed on blood testing. Physically the patient did very well and soon his blood chemistry results reverted to their normal state. However, he complained of many non-specific symptoms including light headaches, insomnia, feelings of claustrophobia, tightness in his throat, shortness of breath and gross fatigueability. He went to a physician for a full check-up. The physician commented that the patient had recovered very well from his recent Hepatitis. He could not explain the numerous somatic symptoms. He felt the patient came across as being fairly anxious, and thought all the above symptoms could be explained on this basis. There was no evidence of chronic liver disease and the patient was reassured. However, it took the patient a long time to recover and this year he successfully completed the Argus cycle tour, but not without getting severe cramps.

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### *...the special effect of illnesses on sportsmen*

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#### **Patient 3**

Mr PG — age 33, has been running 50 - 100 kms per week for the past 6 years. He recently received a bear hug around the chest by a friend which resulted in some pain for which he consulted me. A chest X-ray was taken but it did not show any rib injury or pneumothorax.

However, the report stated that the heart appeared prominent and an ECG was performed. This revealed asymmetrical T-wave inversion in the infrolateral leads. The patient was sent to a Cardiologist who performed a resting and effort ECG as well as echo-cardiography which were all within normal limits. He commented that the changes observed by me were a normal variant pattern.

### Patient 4

Mr FS — aged 37, had been complaining that his left knee had been troubling him when he ran long distances. He had a medial menisectomy after a soccer injury fifteen years previously and

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### *The emotional effects on the patient if he cannot continue his favourite sport*

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two years ago had a lateral menisectomy performed after a twisting injury whilst playing soccer. The examination suggested the presence of degenerative changes and loose bodies in the knee and the presence of swelling and giving way was an indication for arthroscopic examination. At arthroscopy a tag was found on the lateral meniscal rim posteriorly which was impinging on the joint surface and this was trimmed arthroscopically. It was also noted his medial meniscus had only been partially removed and a further tag on this remnant could also be smoothed arthroscopically. Numerous loose bodies were aspirated from the joint via the arthroscope. Unfortunately, in addition, there was a full thickness articular surface defect on the medial femoral condyle. The edges of this were smoothed and spongiolisation using a fine K wire was performed. Post operatively he was encouraged to cycle and perform other non-impact type rehabilitation exercises. When seen for follow up the swelling had almost completely abated but he was still experiencing discomfort in the joint. Because of the absence of his meniscus the Orthopaedic Surgeon felt he was a prime candidate for the development of degenerative arthritis at a fairly early stage. Four months later he was doing very well and he was running up to 5 kms without significant discomfort or swelling of his knee. It was noted by the orthopaedic specialist that his running was tremendously important to him as he found it was the only

form of exercise which helped him to keep his weight within acceptable limits. The orthopaedic specialist felt he would rather the patient did not run long distances, but as it was so important he felt he should be allowed to run as long as he takes care never to use analgesics for discomfort, or if he felt increasing pain or swelling after his run that he immediately consult me. He also felt that he would probably require to have his joint washed out at yearly intervals to remove accumulating debris. The patient was feeling so much better, that four months later he decided to run the Kellerprinz Marathon. Up to that stage he had been running up to 70 kms each week without major discomfort. However, at the 27 km mark he developed severe discomfort over the medial aspect of his knee and he had to stop running. Further arthroscopy was indicated which revealed a worsening of the previous pathology.

There was an articular surface defect on the lateral femoral condyle and a full thickness-defect on the tibial plateau. The patient was advised to have an osteotomy (the wedge taken from the outer tibia to change the weight distribution in the knee to prevent further damage to the joint.) This was carried out successfully by the surgeon with myself assisting. The patient is at present undergoing rehabilitation exercises. He is receiving ongoing support for the psychological effect his inability to run has caused him.

### Discussion

There is a need for the Primary Care Physician to be well trained to function effectively as a sports medicine doctor. There are areas in which he should be especially well trained.<sup>3</sup> These include:—

#### 1. Musculo-skeletal systems

Soft tissue injuries such as sprains, strains, contusions, subluxations, dislocations, bursitis and tendonitis are the most common musculo-

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### *Special advice to the female athlete*

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skeletal problems. Most sports injuries can be treated by the Primary Care doctor. However, it is important to identify at the right time the athlete who needs referral. Both doctor and patient will benefit from association with a Physiotherapist. Maintaining a close working relationship with an Orthopaedic Surgeon prac-

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ting the state of the art techniques in sports medicine is essential and also helps in keeping current in this area.

### 2. Exercise sciences

A basic knowledge of exercise physiology, biomechanics and kinesiology is essential to communicate with and guide today's athletes.

### 3. Nutrition

This has been one of the most neglected areas in medicine. A knowledge of nutrition is necessary to guide the athlete through the maze of fads and fallacies. Therefore association with a registered dietician is essential.

### 4. Pharmacology

In the case of athletes, effects on performance should be discussed along with the problem and contra-indications and adverse effects before choosing a medication. There are three basic types

of drugs used in sports:

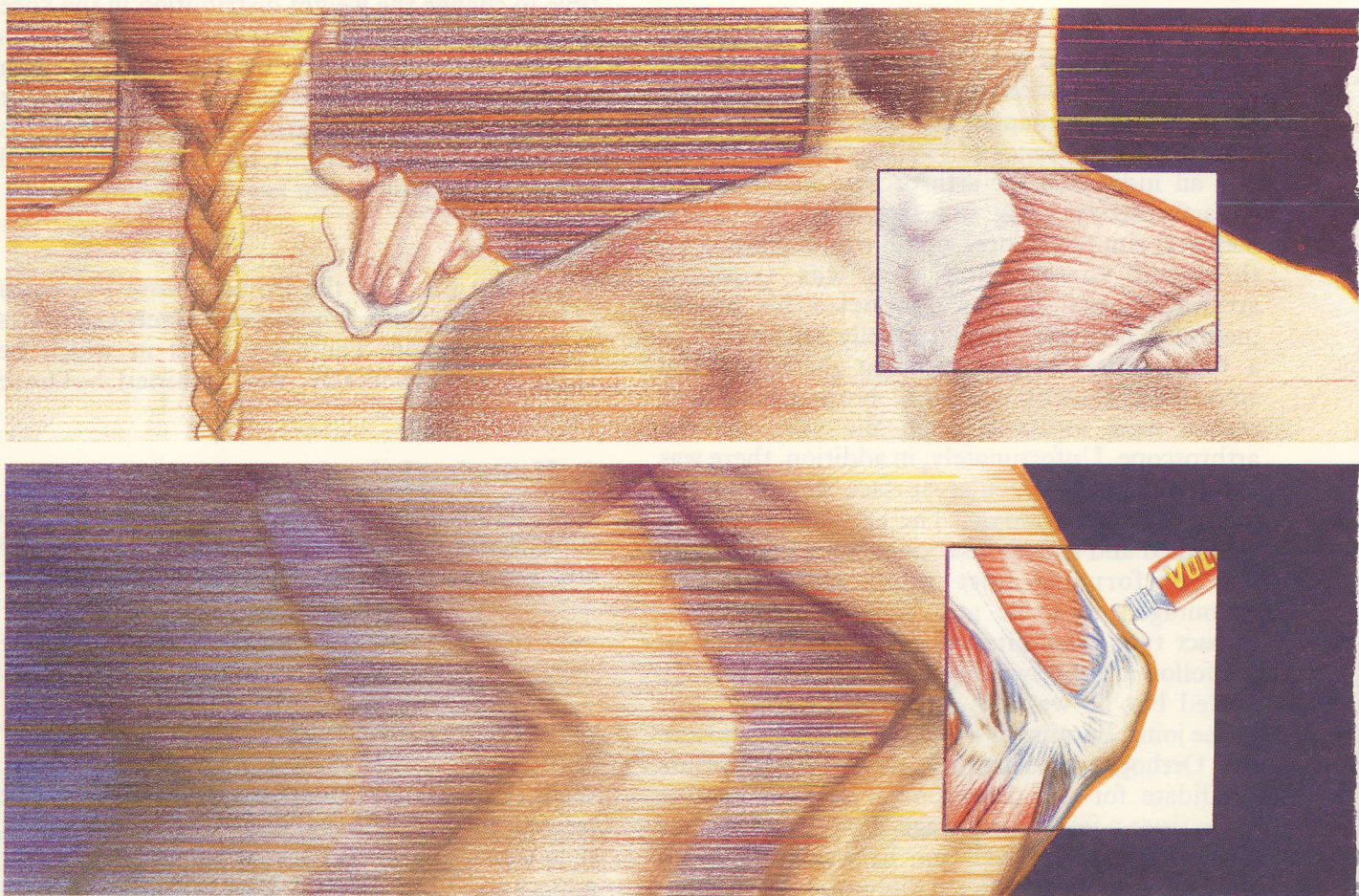
- (a) Therapeutic, which includes anti-inflammatories, analgesics and beta-sympathomimetics. The health and safety of the athlete must be our primary concern.

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### *... when to stop sporting activities*

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- (b) Performance aid. Athletes have reportedly used many drugs to enhance their performances. The Primary Care doctor should be able to inform the athlete of the facts and intelligently discuss the pros and cons of these substances.
- (c) Entertainment escape. Most frequently abused substances are alcohol, marijuana, stimulants, depressants and cocaine.



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### 5. Behavioural Science.

It is important to identify potentially harmful situations and teach athletes how to work towards optimum performance and help through emotional control. Psychologists and Psychiatrists familiar with athlete's problems can help investigate problems and provide treatment

6. *The female athlete* requires special attention in areas of exercise and menstrual function and exercise during pregnancy.

### 7. Cardiovascular and pulmonary systems

The physician must understand the physiology, pathology and diagnosis of these symptoms.

### 8. Dermatology

Certain dermatological problems, for example herpes, impetigo, scabies and lice are contraindications to contact sports because of probable infection.

There are many other important areas in sports medicine; however, the ones above form a foundation on which a Primary Care doctor must build to practise sports medicine successfully.

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### *To whom to refer the injured sportsman*

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Keeping current is difficult in all areas of medicine. Advances in technology, both diagnostic and therapeutic, as well as the ever expanding data base from which information is drawn, require ongoing continuing education.

### Conclusion

The above cases illustrate many important principles, the main one being that the Primary

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### Pharmacological action

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### Indications

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### Contra-indications

Hypersensitivity to diclofenac, acetylsalicylic acid and other non-steroidal anti-inflammatory drugs, as well as to isopropanol or propylene glycol.

### Dosage and directions for use

Depending on the size of the painful site to be treated, apply 2 to 4 g VOLTAREN EMULGEL 3 to 4 times daily to the affected parts and rub in gently.

### Children

Confine use to adults only, as safety and efficacy have not yet been established in children.

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Side-effects as experienced with systemically absorbed diclofenac sodium include the following:

Epigastric pain, eructation, nausea and diarrhoea, headache or slight dizziness. If they persist or are troublesome, the preparation must be discontinued.

There have been reports of skin rash, peripheral oedema, gastro-intestinal ulceration or haemorrhage, hypersensitivity reactions (e.g. bronchospasm, anaphylactic/anaphylactoid systemic reactions), elevated transaminase levels, jaundice, hepatitis, renal failure and nephrotic syndrome.

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### Precautions

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Not to be taken by mouth.

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### Pregnancy

The safety of VOLTAREN in pregnancy has not been established.

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Care doctor has a knowledge of many illnesses and must understand how they can affect sportsmen. He also has to know how sporting activities can influence the course of medical illnesses and biochemical tests. Not only must he be able to diagnose and treat, but most important of all, he has to understand what the effects of advising the patient to stop exercising or to change from a sport which he dearly loves, to another one which he may not feel comfortable with — which could be necessary to recover from a sport-induced illness. Thus the primary care sports doctor has a vital role to play in the health care team. If he feels he is not adequately equipped for this role he should know to whom he should refer the sick and injured sportsmen.

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## From the Journals

### The "I-Never-Took-Pills-Before" Syndrome and the Treatment of Hypertension

Martin G Myers, MD

Can Fam Physician 1989; 35: 65-7.

**Summary:** A new condition called the "I-never-took-pills-before" syndrome has been developed to describe hypertensive patients who react adversely to a variety of medications with different side-effect profiles. The typical individual who manifests this syndrome readily admits to a dislike of taking medication in general, has rarely taken drugs before a diagnosis of hypertension was made, and tends to develop the same constellation of side-effects in response to completely different classes of drugs. Various features of this syndrome are outlined and suggestions offered to help physicians identify and treat patients with this condition.