[ Editorial ]

# Getting Back on the Field

Returning an injured or ill athlete safely to practice and, eventually, competition is a crucial role of the team physician. This process usually relies on the daily care and monitoring of athletic trainers and/or physical therapists. Individual athletes all have their strengths and weaknesses. Some tolerate pain and discomfort without a hint of a problem, all in an effort to return to their sport. These individuals are often fun to treat but require the utmost caution and care because they are capable of hurting themselves, and sometimes do. They can be their own biggest threat because of their blinding motivation and often "bulletproof" self-image. They can be young or old, male or female. Their love of sport can overcome significant pain and ill feeling. It is best for clinicians to identify these athletes and monitor them closely.

On the other side of the spectrum are low-pain-threshold athletes who can't or won't participate until they're convinced that they are 100%. Through no fault of their own, their physical and mental perception of injury and/or illness is much more sensitive and sometimes safer. Clinicians usually do not have to be concerned about these athletes returning too soon because they won't let it happen. These athletes know that they are not "bulletproof" and are often concerned about every minor element of their care.

A wise old football coach often talked about the track athlete who played football and the football player who ran track. The former views himself as a fine-tuned machine and needs every stiffness or soreness addressed to play. They know that "well-tuned" feeling and won't/can't compete unless they're there. The latter is used to being bruised and sore, doesn't expect to feel perfect, and drives himself to compete despite the maladies he faces. Astute clinicians recognize the full spectrum of these competitors and what each will need in the injury/illness situation. They recognize who needs their concern and protection and who will require prodding and encouragement. It is interesting how coaches fit into this scenario: some help and some don't. Some coaches can read athlete personalities like a book and know just when to light the fire. Other coaches should never be allowed in the training room and create "Extra-Strength Tylenol" headaches for those treating athletes. Team physicians are best off recognizing these coaching personalities also.

Athletic caregivers have an easier course to follow when the injury or illness is a common one: an ankle sprain, a muscle strain, or the like. Not that these are trivial or can't cause issues, especially with greater degrees of injury, but we are best with problems that we see regularly. We grow accustomed to what is required from different athletes, and there are treatment guidelines to fall back on. Where things get tough is when the injury or illness is unusual—the one that hasn't been seen in a long time, if ever. These require sharper clinical skills in diagnoses and treatment to yield optimal results.

Looking back, I remember standing on the sidelines during a spring practice-ending football scrimmage a few years back. The weather was pleasant and everyone was upbeat as the 20-session spring was about to come to a close. We had a track-star tailback who hit the line hard after taking the hand-off. The hit that took him down wasn't that impressive, yet he failed to bounce back up quickly. The athletic trainer was first out to attend to him, and he didn't appear particularly concerned as I got out to that area of the field. The player was holding his abdomen but had gotten to his feet before I could examine him. As we walked off the field, I wondered if he'd just had enough for the day. He remained on the sidelines for a few minutes before saying he felt a little light-headed. At that point, as a precaution, he was taken up to the locker room. I got concerned when I realized his left upper quadrant was quite tender and his pulse was rapidly increasing. Subsequently, the emergency medical technicians whisked him off to the emergency room where a splenic rupture was diagnosed. Thankfully, his condition stabilized, and nonoperative treatment was appropriate. He spent the rest of that spring and summer recovering, and his medical team was pleased that fall's double sessions were months away. During that summer, we searched for guidelines for athletes to return to activity after splenic rupture. Unfortunately, there wasn't much to go on other than what could be gleaned from the trauma literature. That is no longer the case. No, we don't have evidence-based guidelines yet on return to intense contact sports. But, as the article by Rushad Juyia and Hamish Kerr[3] in this issue of *Sports Health* emphasizes, we're getting better! Several key facts are worth emphasizing about spleen and liver injuries from this

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publication: Ultrasound is ideal in the unstable athlete, while intravenous contrast-enhanced computed tomography is the imaging modality of choice in the stable athlete. Nonoperative treatment is the norm for hemodynamically stable athletes. Routine reimaging is not recommended, but close clinical follow-up is useful.[3]

Besides blunt abdominal trauma, this issue of *Sports Health* is of value to those clinicians on the bench or sidelines for several more reasons. The reviews of infectious mononucleosis[1] and febrile illness[2] are insightful and concise. These represent 2 areas where clinicians no longer have to guess at best treatment guidelines. These were very informative for me; I hope they are for you also!

—Edward M. Wojtys, MD
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## REFERENCES

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2. Dick NA, Diehl JJ. Febrile illness in the athlete. *Sports Health*. 2014;6:225-231.
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