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Bone Injuries **FAQs**

Common Questions
Parents Want to
Ask but Never Do

By
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Q Which is better Heat or Ice?

A For an acute (that is a recent) injury, always use cold therapy—ice bags, styrofoam ice cups or even frozen peas. One doesn't have to place the ice directly on the skin. It is important to keep the ice on the injury for 20-30 minutes then remove for 30-60 minutes and repeat throughout the day especially the first 2-3 days. Ice helps constrict blood vessels and helps reduce swelling to the injured area. Ice also acts as a very good analgesic and can help reduce the pain as well. Unlike ice, heat causes more blood to flow to the injured area and thus can increase swelling. Just to note after the acute stages, when the athlete is trying to return to activity heat is often used prior to therapy to loosen up the joints and increase the range of motion. Ice is then applied after therapy is completed.

An easy mnemonic to remember when dealing with an acute injury is **PRICES**:

Protection to prevent further injury

Rest

Ice

Compression such as an ace bandage

Elevation

Support such as a splint or brace as well as crutches if needed

Q *When is it necessary to seek medical attention after an injury?*

A Going along with the prior question, any injury that alters the athlete's performance or function on the field or in practice should be evaluated. An injury that causes swelling especially within a joint needs an evaluation to rule out any bone or ligament damage. Recurrent pain or constant soreness to a body area may indicate an overuse injury that may need to be checked out. Often a child or adolescent will not tell their coach or family of their injury, so it is important to observe them on the field and determine if they may have a problem. Unfortunately, unless the child is in high school the athlete usually doesn't have access to an athletic trainer and should be evaluated by a properly trained physician.

Q *"His bell was only rung..." Isn't it safe to return to play?*

A This is a very common misconception. Many parents and coaches feel that a minor ding to the head is nothing to be concerned about. The sports medicine community often hears a response "...when I was younger and playing I had my bell rung plenty of times and nothing happened to me."

Even a minor head ding can be a concussion. A concussion is a mild traumatic brain injury that can be from a direct force to the head face or neck or indirectly transmitted from a force from the chest and body.

Nationally, there are over 300,000 concussions in sports each year most commonly occurring in football, lacrosse, soccer, wrestling, hockey and gymnastics. There is a wide array of signs and symptoms of a concussion and

each individual may present differently. The more common signs and symptoms seen are:

- Headache
- Dizziness
- Nausea and vomiting
- Visual Changes
- Amnesia/Confusion
- Difficulty with memory
- Loss of Balance
- Fatigue
- Slurred speech
- Brief Loss of Consciousness
“head in a fog”

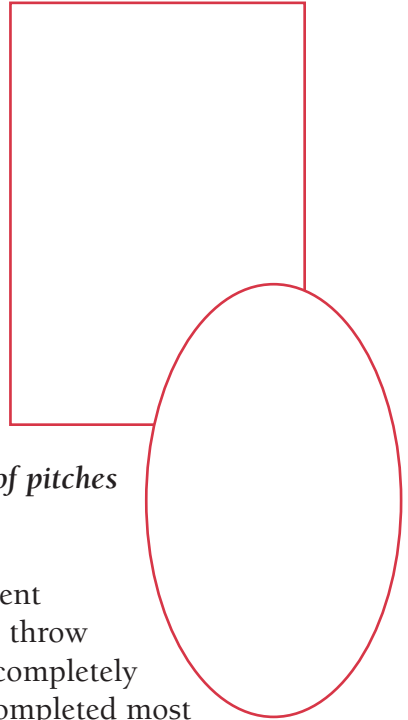
Other symptoms that may not be noticeable immediately are personality changes, trouble concentrating, sleeping problems and irritability.

When someone is believed to have a concussion, it is essential to be properly evaluated medically. The physician should assess the athlete for physical and neurological signs as well as check their cognitive function such as memory, recall and attention. The latest international sports medicine meeting on concussion has made a standardized assessment tool to incorporate these areas, which is simple to implement even on the sidelines by properly trained personnel. In some cases, if the physician feels there may be a more serious injury, a CT or MRI will be ordered.

Early detection and serial evaluations are essential towards the management of sports related concussion. Be aware of any deterioration mentally or physically and look for an increase in the symptoms, which may be an ominous sign and not to be taken lightly. Avoid giving the concussed athlete any medication such as aspirin or ibuprofen for their headache symptoms unless “ok’d” by

the treating physician. The medication can disguise pertinent symptoms or even worsen the injury especially if there is bleeding within the brain.

Only recently has the sports medical community begun to establish a classification and protocol for returning someone to play. Presently there is a step-wise process in advancing the individual back to competition. No one is to start this protocol until he or she is completely symptom free. No one is to be rushed through the healing. His or her treating physician must clear each athlete before returning to play. Every athlete must be individualized in their treatment because each is different in their time to heal. “When in doubt, sit them out!”



Q *Are there limitations in the types of pitches to throw?*

A Yes, for young and adolescent throwers only allow the athlete to throw overhead pitches until they have completely gone through puberty and have completed most of their growth spurt. Sliders and curve balls may cause a drop in the elbow and place extra stress on the elbow joint itself which can cause ligament and bone damage. A good benchmark would be to reserve these special pitches until the athlete’s junior year of high school. It is also especially important to teach proper technique so that bad habits are not started early.

Q *How many pitches are safe to throw in order to avoid injury?*

A Pitching is not a “no pain, no gain” activity. It is very important for coaches and parents to be on the same page and be aware. Pitch counts exist to prevent elbow and shoulder overuse injuries especially in the adolescent. Pitch count guidelines range from 90-120 per week and include practice. Some guidelines also break it down by innings/week limiting to no more than 6 innings/week with rest at least three days in between games. Proper warm-up strengthening and stretching programs should begin at least 6 weeks prior to the season and continue during the season.

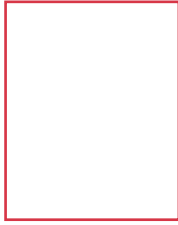
Overuse injuries are becoming a more frequent problem due to the fact many baseball teams are now playing year round including exhaustive weekend tournaments where one team may play up to 6 or 7 times in that three day period. If possible it would be beneficial to allow the young throwing athlete a period of rest during the year (or play another sport) as well as try and avoid the three day tournaments every weekend throughout the season.

**Helpful websites on
Patient Education for reference:**

www.nlm.nih.gov/medlineplus/sportsinjuries.html

www.sportsmed.org/sml/edlit.asp

www.sportsmed.buffalo.edu/info.html



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A member of the American Osteopathic Academy of Sports Medicine and the American Medical Society for Sports Medicine along with the American Osteopathic Association. He has lectured at several regional and national conferences on sports medicine topics including his research involving concussion in the school athlete. He has served as team physician for several South Jersey and Cleveland high schools and has worked with Cleveland's minor league ice hockey team and the Cleveland Indians baseball organization.

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