



Wantirna South Junior Football Club

Trainers Information Package

2022 Season

Prepared by Head Trainer

First of all and most importantly, thanks for taking on this role. It is vitally important that all teams have a trainer that has access to as much information as possible that is handy to them to enable them to help our kids whilst playing football. During the Trainers course you would have been informed of many resources that can assist you. This package is designed to give you a ready reckoner if you chose to have it with you at games. All trainers need to be qualified in First Aid, CPR and the registered Emergency Response

coordinator (ERC) or Level 1 Trainers Course. The club will reimburse trainers for completing the Trainers Course. The EFNL preferred provider is First Aid Management, located in Forest Hill. They can bill the club directly.

Club Contacts-	President	Paul MONTGOMERY 0413 888 395
	Operations	Damian Taylor 0431 175 445
	Trainers Admin-	Travis Geary 0451 301 607

YOUR ROLE

We need you to be across your team and their pre-existing injuries and illnesses and work with players and parents to manage these. It is not your responsibility to be the main responder to a player that has an ongoing illness that requires maintenance. Work with the parents.

Ensure you have been given a list of these illness/injuries at the start of the season from the club. This information is taken directly from the player registration forms. Use this to touch base with parents and players and implement a management plan. Ensure parents supply appropriate epi-pens, puffer etc or are present with them. Make sure you or the Team Manager has a contact list for parents on game day.

Ensure you have been given the team sheet with an injury record on the back. Please make sure all new injuries are noted on this form. This form goes back to the club to enable us to keep a record of injuries.

Please ensure you are at every game and there to assist players in their preparation. This may include massage to warmup a muscle or break up a bruise or strapping injuries. We would expect players to bring the appropriate strapping and ointments for ongoing use.

Be present on the boundary and ready to respond to any on field incident including injury. Make sure you have a fully stocked “trainers kit” with you. Liaise with your coach in relation to the player being able to continue playing, but in the end, it is your call as to whether the player can continue. Ongoing player welfare is the key.

Parents have been informed of their responsibilities and what will occur in case of injury. This is;

- The trainer will attend to the player on the field. (No parents are allowed on the ground). The trainer will assess the injury and whether the player can continue or needs to come off.
- If you are present, you will be updated.
- If you are not present and the child is removed from play you will be notified at the earliest opportunity.
- If your child is assessed by the trainer as requiring an ambulance and you are not present 000 will be called without your consent. WSJFC will not be liable any costs incurred.
- At the completion of the game the trainer will liaise with you about the injury.
- Before training or playing again the player’s injury will be assessed.

Remember to complete the Injury Record on the team sheet at the end of the game.

All stock for the kits is kept at Templeton Reserve and can be obtained by contacting the one of the Trainer Management team or committee.

CONCUSSION is a hot topic and a real risk in this sport. Make sure you are aware of the concussion policy (attached) and respond accordingly. After a concussion, if in doubt sit it out.

RESOURCES/ GAME DAY DUTIES

Trainers Kit – each kit is different and made according to the age group.

Uniform – Black plain pants and white top or a WSJFC top and spray jacket if required.

Trainers arm band or bib.

Check for access to a stretcher prior to the start of the game.

If you have a smart phone, the Elastoplast App is a fantastic resource as well.

Save the club contact numbers above into your phone.

Check the grounds are safe – no obvious glass, cricket pitch adequately covered, post padding etc.

TRAINING NIGHTS

To ensure the safety of your children, the club will require the Trainer or designated parent to be present at trainings to assist with injuries. If you offer to perform the role, please ensure you are there or arrange someone else. If not, please ensure the Manager rosters a Parent Helper where possible to be there each training. Remember, the coach has to continue training up to 24 kids whilst your child's injury is being attended to.

The attached material specific to injuries and management are taken from sma.org.au . This is not an exhaustive list of the available material rather relevant injuries to the sport.

**Jason Stone from Wantirna Osteo located in Stud Road, Wantirna provides a free assessment of more serious injuries (that occurred during football) on a Monday night at the clinic generally after 7pm.
Please contact the clinic to make an appointment. Ph 9800 0388.**

Sportsmed Biologic are leaders in Concussion recognition, recording, reporting and treating. They are located near Box Hill Hospital at 116-118 Thames St, Box Hill 1300 858 860. You will end up approx. \$300 out of pocket.

Vermont Urgent Care are a specialised Fracture management clinic and have x-rays on site. If you chose not to go to a hospital these guys can and will help. They remain open on Sundays until approx 4pm. If they do not answer on 9874 3344 contact the Specialist Doctor directly on 0412 007 170.

Knox Private Hospital is closest to our fields and offers a discount to children as members of the EFNL.

CONCUSSION POLICY AND RECOGNITION TOOL

If a player receives a bump to the head and the trainer is called on to assess the player and you have concerns the player may be concussed please refer to the recognition tool below. The following will apply to any WSJFC player;

A player with suspected concussion must be withdrawn from playing or training until fully evaluated by a medical practitioner and cleared to play.

Any player with a suspected concussion should (where practicable) be assessed by a qualified medical practitioner on the day of the incident or as soon as possible after.

Any player who is suspected of having a concussion will be excluded from any type of physical activity, training or a match until evaluated by a medical practitioner. If the player is not evaluated by a medical practitioner and they had a suspected concussion, the player will be required to follow the attached 12 day return to play guidelines (from the date of concussion or suspected concussion) and therefore miss one match.

Coaching Staff and Trainers will not be swayed by the opinions of players and or parents suggesting a premature return to play. Decisions regarding return to play after a concussive injury (a disturbance of brain function) should only be made by a medical practitioner. Or trainers can assist at the game and can help guide parents through the AFL Return to Sport policy.

Our overriding responsibility to all of our players under our care is to their long-term health and wellbeing. It is our duty of care to always act in the best interests of all our players as is the case with any injury.

If as a trainer you are having issues with any coaches, players or family please speak to a member of the Trainer Management Team.

The club continues to look at various apps and motor function testing systems to assist trainers and will keep you posted when we adopt something.

Quick reference taken from the Concussion tool.

Refer to the observable signs- Lying

motionless or slow to get up

Disorientated, confused or a blank look on their face

Their balance or stance is effected

They have a facial injury or head trauma. **Use**

this easy memory assessment to assist -

Where are we playing footy today?

Which half is it now?

Which team scored the last point or goal of this game?

What team did you play last week?

Did we win the last game?

IF IN DOUBT, SIT IT OUT.

CONCUSSION RECOGNITION TOOL 5®

To help identify concussion in children, adolescents and adults



FIFA®

Supported by



FEI

RECOGNISE & REMOVE

Head impacts can be associated with serious and potentially fatal brain injuries. The Concussion Recognition Tool 5 (CRTS) is to be used for the identification of suspected concussion. It is not designed to diagnose concussion.

STEP 1: RED FLAGS – CALL AN AMBULANCE

If there is concern after an injury including whether ANY of the following signs are observed or complaints are reported then the player should be safely and immediately removed from play/game/activity. If no licensed healthcare professional is available, call an ambulance for urgent medical assessment:

- Neck pain or tenderness
- Severe or increasing headache
- Deteriorating conscious state
- Double vision
- Seizure or convulsion
- Vomiting
- Weakness or tingling/burning in arms or legs
- Loss of consciousness
- Increasingly restless, agitated or combative

Remember:

- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Assessment for a spinal cord injury is critical.
- Do not attempt to move the player (other than required for airway support) unless trained to do so.
- Do not remove a helmet or any other equipment unless trained to do so safely.

If there are no Red Flags, identification of possible concussion should proceed to the following steps:

STEP 2: OBSERVABLE SIGNS

Visual clues that suggest possible concussion include:

- Lying motionless on the playing surface
- Disorientation or confusion, or an inability to respond appropriately to questions
- Balance, gait difficulties, motor incoordination, stumbling, slow laboured movements
- Slow to get up after a direct or indirect hit to the head
- Blank or vacant look
- Facial injury after head trauma

© Concussion in Sport Group 2017

STEP 3: SYMPTOMS

- | | | | |
|----------------------|-------------------------|----------------------|----------------------------|
| • Headache | • Blurred vision | • More emotional | • Difficulty concentrating |
| • "Pressure in head" | • Sensitivity to light | • More irritable | • Difficulty remembering |
| • Balance problems | • Sensitivity to noise | • Sadness | • Feeling slowed down |
| • Nausea or vomiting | • Fatigue or low energy | • Nervous or anxious | • Feeling like "in a fog" |
| • Drowsiness | • "Don't feel right" | • Neck Pain | |
| • Dizziness | | | |

STEP 4: MEMORY ASSESSMENT

(IN ATHLETES OLDER THAN 12 YEARS)

- Failure to answer any of these questions (modified appropriately for each sport) correctly may suggest a concussion:
- "What venue are we at today?"
 - "Which half is it now?"
 - "Did your team win the last game?"
 - "Who scored last in this game?"

Athletes with suspected concussion should:

- Not be left alone initially (at least for the first 1-2 hours).
- Not drink alcohol.
- Not use recreational/ prescription drugs.
- Not be sent home by themselves. They need to be with a responsible adult.
- Not drive a motor vehicle until cleared to do so by a healthcare professional.

The CRTS may be freely copied in its current form for distribution to individuals, teams, groups and organisations. Any revision and any reproduction in a digital form requires approval by the Concussion in Sport Group. It should not be altered in any way, rebranded or sold for commercial gain.

ANY ATHLETE WITH A SUSPECTED CONCUSSION SHOULD BE IMMEDIATELY REMOVED FROM PRACTICE OR PLAY AND SHOULD NOT RETURN TO ACTIVITY UNTIL ASSESSED MEDICALLY, EVEN IF THE SYMPTOMS RESOLVE

© Concussion in Sport Group 2017

Concussion Management – current guidelines

Table 1. Guideline for minimum return to play following concussion

Step Components	Rest	Recovery Symptom-limited activity	Graded loading – individual program Light aerobic exercise	Graded loading - full team training Non-contact training	Recovery	Limited contact training	Recovery	Full contact	Recovery	Return to play
Goal		Daily activities that do not provoke symptoms	Light aerobic exercise (e.g. walking/jog/cycling at slow to medium pace) No resistance training	Moderate aerobic exercise (i.e. Increased heart rate) No resistance training Increased intensity and duration of activity Add sports specific drills (e.g. goal kick, stationary handball, etc) Commence light resistance training	Return to full team training sessions – <u>non-contact only</u>	Can participate in other components of the training program (e.g. weights)	Full team training – but able to participate in drills with incidental contact (including tackling)	Can participate in other components of the training program (e.g. weights)	Full team training	Can participate in other components of the training program (e.g. weights) as well as a light skills session (known as a "captain's run")
Duration	24-48 hours	Minimum 24 hours	Minimum 24 hours	Minimum 24 hours	At least 1 day between sessions to monitor for recurrence of symptoms		At least 1 day between sessions to monitor for recurrence of symptoms		At least 1 day between sessions to monitor for recurrence of symptoms	
Requirements to move to next stage		24 hours completely free of any concussion related symptoms and medical clearance to enter graded loading program	Remain completely free of any concussion-related symptoms	Remain completely free of any concussion-related symptoms and medical clearance to commence full team training		Remain completely free of any concussion-related symptoms – and player confident to participate in training		Remain completely free of any concussion-related symptoms – and player confident	Remain completely free of any concussion-related symptoms – player confident to participate in training – and medical clearance for unrestricted return to play	

Soft Tissue Injuries

Signs and symptoms

Types of soft tissue injuries include:

Acute injury

Injuries that occur from a known or sometimes unknown incident. Signs and symptoms develop rapidly.

Bruise (contusion, cork)

Bruises are caused by a direct force applied to the body such as being kicked or making contact with a player and result in compression and bleeding into the soft tissue (hematoma).

Signs and symptoms: Swelling and/or discolouration.

Sprain

Sprains are caused when the joint is forced beyond its normal range of motion resulting in overstretching and tearing of the ligament that supports the joint.

Signs and symptoms: Swelling, loss of power or ability to bear weight, possible discolouration and bruising and/or sudden onset of pain.

Strain

Strains are caused by muscles over-stretching or contracting too quickly, resulting in a partial or complete tear of the muscle and/or tendon fibres.

Signs and symptoms: Swelling, possible discolouration and bruising and/or pain on movement.

Overuse Injury

Overuse injuries occur as a result of repetitive friction, pulling, twisting, or compression that develops over time.

Signs and symptoms: Will develop slowly, inflammation, pain.

Immediate management

The immediate treatment of any soft tissue injury consists of the RICER protocol – rest, ice, compression, elevation and referral. RICE protocol should be followed for 48–72 hours. The aim is to reduce the bleeding and damage within the joint.

The No HARM protocol should also be applied – no heat, no alcohol, no running or activity, and no massage. This will ensure decreased bleeding and swelling in the injured area.

This regime should be used for all ligament sprains, muscle sprains and muscle bruises. Referral for bumps and bruises which occur in sport or physical activity, other than those which are minor is recommended.

CORCKED THIGH

Signs and symptoms

At the time of this type of trauma a player may experience varying levels of pain and reduced range of motion. The extent of pain and loss of movement will be dependent on the amount of force and the impact of the force at the time of trauma. The traumatised area will become swollen and painful to touch.

Contusions are classified according to their severity:

Grade	Description
1 (Mild)	A player experiencing a mild contusion will usually be able to continue playing however may feel some soreness after cooling down or the following day. The affected area may be tender to touch, the ability to stretch the muscle may be diminished slightly, and the strength of the muscle may also be adversely affected. Return to play – 2 to 3 weeks*.
2 (Moderate)	A moderate contusion may prevent a player from continuing; however minimum stiffening/swelling may be experienced with rest. The player may experience some pain and the affected area will be tender to touch. A player with a moderate contusion of the quadriceps will often walk with a limp and range of motion will be diminished by up to 50%. Return to play – 4 to 6 weeks minimum*.
3 (Severe)	A severe contusion will be characterised by rapid onset of swelling and obvious bleeding. Both swelling and bleeding may not be able to be controlled. Movement loss will be severe and difficulty bearing full weight on the affected leg will be apparent. The affected area will be very tender and muscle strength will be diminished. Return to play – 8 weeks minimum*.

*The return to sport period from all grades of contusion injury may be significantly reduced with good early injury management practices and assessment by a sports medicine professional.

Immediate management

The immediate treatment of any soft tissue injury consists of the RICER protocol – rest, ice, compression, elevation and referral. RICE protocol should be followed for 48–72 hours. The aim is to reduce the bleeding and damage in the muscle. The thigh should be rested in an elevated position with an ice pack applied for 20 minutes every two hours (never apply ice directly to the skin). A compression bandage should be applied to limit swelling and bleeding in the injured area.

The No HARM protocol should also be applied – no heat, no alcohol, no running or activity, and no massage. This will ensure decreased swelling and bleeding in the injured area.

Gentle, gradual, pain free stretching of the muscle will assist in restoring full range of motion in mild muscle contusion injuries. Moderate to severe contusions may require the use of crutches to ensure complete rest, particularly if full weight bearing on the affected leg is painful.

Light stretching should be utilised immediately post injury. This will help reduce muscle spasms and make stretching more beneficial in the days to come. Utilise standard quadricep stretching techniques with the hip flexed and extended. These should be performed with a 10 second hold of the stretch, repeated three to five times daily.

Another early rehabilitation technique used is Quad Sets. These are isometric contractions of the muscle. The athlete tries to make the muscle flex and holds for 10 seconds, repeating 30–60 times, three to five times daily.

Strengthening of the injured muscle should begin two to seven days post-injury, depending upon the severity. These exercises include:

- Four plane straight leg raises.
- Seated hip flexion.
- Seated knee extension.
- Partial squats.
- Side step-ups.

Rehabilitation and return to play

HAMSTRING STRAIN

Signs and symptoms

Hamstring strains are classified as Grade 1–3 strains depending on severity. A hamstring strain may occur in one or more of the three muscles in the group.

Grade	Description
1 (Mild)	<ul style="list-style-type: none">Overstretching without tearing of muscle or tendon fibres.Symptoms may not present until activity is over.Usually no loss of muscular strength or flexibility.Increased tightness in the muscle during stretch or through a full range of motion.A feeling of pain may be reported with sitting or while walking uphill or ascending stairs.Depending on the severity, weight bearing activities may or may not be possible, walking properly may be possible and there will be minimal swelling.
2 (Moderate)	<ul style="list-style-type: none">Partial tear in the muscle.Muscular strength and flexibility is reduced.Pain is more immediate and more severe than the pain of a Grade 1 strain.Pain on stretch and contraction of the muscle, and is usually sore to touch.Limping is likely during walking and occasional sudden twinges of pain during activity may occur.Bending the knee against resistance will cause pain and there may be some difficulty in fully straightening the knee.
3 (Severe)	<ul style="list-style-type: none">Severe or complete rupture of the muscle. May be a large lump (of muscle tissue) above a depression where the tear is.Sudden, sharp pain in the back of the thigh.Walking is not possible without pain.After a few days with Grade 2 and 3 injuries, a large bruise may appear below the injury site caused by bleeding within the tissues.May require surgical repair.

Immediate management

The immediate treatment of any soft tissue injury consists of the RICER protocol – rest, ice, compression, elevation and referral. RICE protocol should be followed for 48–72 hours. The aim is to reduce the bleeding and damage in the muscle. The muscle should be rested in an elevated position with an ice pack applied for 20 minutes every two hours (never apply ice directly to the skin). A correctly sized compression bandage should be applied to limit bleeding and swelling in the injured area.

The No HARM protocol should also be applied – no heat, no alcohol, no running or activity, and no massage. This will ensure decreased bleeding and swelling in the injured area.

Rehabilitation and return to play

Timeframes for rehabilitation and return to sport vary depending on the nature and severity of the strain. As a general rule, Grade 1 hamstring strains should be rested from sporting activity for about three weeks and Grade 2 injuries for a minimum of four to eight weeks. In the case of a complete rupture (Grade 3 strain), the muscle may have to be repaired surgically and the rehabilitation to follow will take about three months.

Premature return to sport and inadequate rehabilitation will increase the risk of re-injury. Full stretch and strength should be achieved in addition to the ability to perform full speed training. Assessment of sport-related activities, such as twisting, jumping and changing direction suddenly should also be evaluated.

CALF STRAIN

Signs and symptoms

- A sudden pain at the back of the leg, particularly at the muscular tendinous junction.
- Difficulty in contracting the muscle or standing on tiptoe.
- Pain and swelling or bruising in the calf muscle.
- Pain on resisted plantar flexion or contracting the muscles against resistance.
- If the Soleus muscle is damaged pain might be incurred lower in the leg and when contracting the muscle against resistance with the knee bent.

Gastrocnemius strains are graded in three categories according to their severity.

Grade	Description
1 (Mild)	Sharp pain (during or after activity), may be unable to continue activity. Return to play – 10 to 12 days.
2 (Moderate)	Unable to continue activity. Return to play – 16 to 21 days.
3 (Severe)	Severe pain at junction between Achilles tendon and belly of the muscle. Return to play – approximately 6 months if surgery is required.

Immediate management

The immediate treatment of any soft tissue injury consists of the RICER protocol – rest, ice, compression, elevation and referral to a sports medicine professional. RICE protocol should be followed for 48–72 hours. The aim is to reduce the bleeding and damage in the muscle. The leg should be rested in an elevated position with an ice pack applied for 20 minutes every two hours (never apply ice directly to the skin). A correctly sized compression bandage should be applied to limit bleeding and swelling in the injured area.

The No HARM protocol should also be applied – no heat, no alcohol, no running or activity, and no massage. This will ensure decreased bleeding and swelling in the injured area.

As pain decreases, gentle exercise and stretching can usually begin in addition to treatment recommended by a sports medicine professional. Rehabilitation should be conducted with caution and under the supervision of a sport medicine professional due to the risk of injury recurrence. Recovery can often be quite a slow process.

Rehabilitation and return to play



ANKLE INJURY

Signs and symptoms

Sprains are graded on a scale of 1 to 3 (mild, moderate, and severe), depending on the degree of tearing to the ligaments. In most cases, x-rays are performed to rule out a fracture or dislocation.

Grade	Description
1 (Mild)	<ul style="list-style-type: none">Minor tear.Minimal pain.Little or no joint instability.Mild pain with weight bearing activities.Slight loss of balance.
2 (Moderate)	<ul style="list-style-type: none">Some tearing of the ligament fibres.Moderate to severe pain.Moderate instability of the joint.Swelling and stiffness.Pain with weight bearing activities.Poor balance.
3 (Severe)	<ul style="list-style-type: none">Complete tear of the ligament.Severe pain followed by minimal pain.Gross instability of the joint.Severe swelling.Possible pain with weight bearing.Poor balance.

Immediate management

The immediate treatment of any soft tissue injury consists of the RICER protocol – rest, ice, compression, elevation and referral. RICE protocol should be followed for 48–72 hours. The aim is to reduce the bleeding and damage within the joint. The ankle should be rested in an elevated position with an ice pack applied for 20 minutes every two hours (never apply ice directly to the skin). A correctly sized compression bandage should be applied to limit bleeding and swelling in the joint.

The No HARM protocol should also be applied – no heat, no alcohol, no running or activity, and no massage. This will ensure decreased bleeding and swelling in the injured area.

A sports medicine professional should be seen as soon as possible after the injury to determine the extent of injury and to advise on treatment and rehabilitation. In evaluating the injury the sports medicine professional may order an x-ray or other testing to determine the extent of the injury.

Most ankle sprains heal within 2 to 6 weeks, however severe sprains may take as long as 12 weeks.

A comprehensive rehabilitation program minimises the chance of the injury recurring and includes flexibility, balance, stretching, strengthening and sport specific exercises.

During this time taping or bracing the ankle may be prescribed to provide support until full function is regained. If, while performing a rehabilitation exercise, ankle joint pain or discomfort is experienced, stop immediately and reconsult a sports medicine professional.

Players with significant ligament injuries (Grade 2 or 3) are advised to use bracing or protective taping when playing sport for a minimum of 6 to 12 months post injury.

Rehabilitation and return to play

EYE INJURIES

Signs and symptoms

- Tenderness.
- Swelling.
- Bleeding.
- Bruising.
- Double/blurred vision.

There are different types of eye injuries that present with specific symptoms. These include:

Cuts or scrapes to the eyelids

Caused by fingernails and fingers and usually result in redness and pain, which should clear within a few days without serious long-term effects.

Blunt traumas

Caused by blows from fast moving projectiles (i.e. balls, racquets, sticks or fists/fingers). They can cause bleeding externally (i.e. black eye) or within the eye itself. Blunt traumas can also cause broken bones around the eye.

Penetrating injuries

In these types of injuries, a foreign body penetrates into the eyeball. This is most likely to occur when sports participants are wearing ordinary spectacle lenses as these can shatter on impact, possibly driving fragments into the eye.

Immediate management

- Do not examine or touch the eye.
- Do not forcibly remove any foreign object from the eye. Gentle flushing with general saline to remove dirt/grit is reasonable. Do not administer any creams/drops before medical assessment.
- Pad the eye and gently tape or firmly bandage a sterile dressing to the injured eye. (N.B. if the player will allow, it is preferable to cover both eyes).
- Pressure to the injured site should be kept to a minimum.
- Keep the player comfortable.
- Consult a medical practitioner or eye specialist or attend the emergency department at your nearest major hospital.

Athletes with a serious eye injury should be examined by an ophthalmologist and return to play only if the doctor says it is safe. The injured eye should feel comfortable and have adequate vision. The athlete should wear eye protection.

Rehabilitation and return to play

For a less serious injury, the team sports medicine professional can usually decide if the athlete can return to play based on the type of injury and how the athlete feels. Athletes should never use topical anaesthetics (pain medicines) so they can keep playing.

ACL (Anterior Cruciate Ligament) - KNEE

Signs and symptoms

Most athletes who experience a full tear of the ACL describe a loud sound such as a 'pop' or 'crack'. This is often followed by a few minutes of extreme pain.

A torn ACL is often accompanied by hemarthrosis (bleeding into the joint space) which may be visible as a large tense swelling of the knee. Examination of the knee is more easily done within the first hour following the injury before the development of hemarthrosis. Presenting for medical assessment as soon as possible after injury is recommended even if significant swelling has occurred.

Athletes with a torn ACL often have severe restriction of movement, particularly extension.

Other knee injuries such as damage to the meniscus (knee cartilage), and the medial or lateral collateral ligaments may also accompany a torn ACL.

Immediate management

The immediate treatment of any soft tissue injury consists of the RICER protocol – rest, ice, compression, elevation and referral. RICE protocol should be followed for 48–72 hours. The aim is to reduce the bleeding and damage within the joint. The knee should be rested in an elevated position with an ice pack applied for 20 minutes every two hours (never apply ice directly to the skin). A correctly sized compression bandage should be applied to limit swelling and bleeding in the joint.

The No HARM protocol should also be applied – no heat, no alcohol, no running or activity, and no massage. This will ensure decreased swelling and bleeding in the injured area.

A sports medicine professional should be seen as soon as possible to determine the extent of the injury and to provide advice on treatment required. A sports medicine professional may perform a physical examination and take x-rays of the knee. An MRI test may be recommended to confirm the diagnosis.

Rehabilitation and return to play

Surgical reconstruction is a very common method used to repair a completely torn ACL. This usually involves replacing the torn ACL. Various factors are considered when deciding on whether to surgically reconstruct a torn ACL.

These include:

- The degree of knee instability.
- Associated injuries of the knee.
- Social factors such as cost of treatment and time away from work.
- The type of sports played by the injured athlete.
- The age of the athlete.
- The expected demands to be placed on the knee.

Rehabilitation for a reconstructed ACL will be conducted under the direction of an orthopaedic surgeon and the supervision of a physiotherapist. A number of rehabilitation program schedules exist however more recent programs commence with a schedule of protected mobilisation, followed by strengthening activities and ultimately progress to functional exercises. This rehabilitation usually takes between six and nine months.

It is recommended that athletes with reconstructed ACL injuries return to sport with the approval of their orthopaedic surgeon. This is usually when strength, range of motion and co-ordination are nearly at full capacity.



AC JOINT – SHOULDER

Signs and symptoms

- Pain at the end of the collar bone.
- Pain may feel widespread throughout the shoulder until the initial pain resolves; following this it is more likely to be a very specific site of pain over the joint itself.
- Swelling often occurs.
- Depending on the extent of the injury a step-deformity may be visible. This is an obvious lump where the joint has been disrupted and is visible on more severe injuries.
- Pain on moving the shoulder, especially when trying to raise the arms above shoulder height.

There are various grading scales for AC Joint Injuries. Most grading scales range from 1–3 as shown in the table below:

Grade	Description
1 (Mild)	An athlete with a Grade 1 injury of the AC Joint will experience tenderness and discomfort during palpation or movement of the joint. Grade 1 sprains involve only partial damage to the joint capsule and the AC ligament. Return to play – up to 3 weeks.
2 (Moderate)	A Grade 2 injury will involve complete rupture of the acromioclavicular ligament and partial tear of the coracoclavicular ligament. This tearing allows the clavicle to move upward, and as a result the bump on the shoulder is more pronounced. Pain is more severe and movement of the shoulder is restricted. Return to play – minimum 4 to 6 weeks.
3 (Severe)	A Grade 3 injury involves the complete rupture of the acromioclavicular and coracoclavicular ligaments. The bump visible in a Grade 2 tear is even more pronounced in a Grade 3 injury due to complete dislocation of the acromioclavicular joint. Return to play – dependent on management e.g. surgery.

Immediate management

The immediate treatment of any soft tissue injury consists of the RICER protocol – rest, ice, compression, elevation and referral. RICE protocol should be followed for 48–72 hours. The aim is to reduce the bleeding and damage within the joint. The shoulder should be rested in an elevated position with an ice pack applied for 20 minutes every two hours (never apply ice directly to the skin). The arm should also be immobilised in a sling. This may be for as little as two days in a mild injury or up to six weeks in a more severe case.

The No HARM protocol should also be applied – no heat, no alcohol, no running or activity, and no massage. This will ensure decreased swelling and bleeding in the injured area.

A sports medicine professional should be seen as soon as possible to determine the extent of the injury and to provide advice on treatment required. A sports medicine professional may perform a physical examination and take x-rays of the shoulder.

Rehabilitation and return to play

Most AC Joint Injuries are treated conservatively using various combinations of strengthening exercises following the immobilisation phase once pain permits. Surgery is usually reserved for cases where there is a complete dislocation of the AC Joint (Grade 3) or in cases where a less severe injury fails to respond adequately to conservative treatment.

The below information is taken directly from aflcommunityclub.com.au

Soft Tissue Injuries

Soft tissue injury is a term used in relation to body structure damage. This includes muscle, tendon, ligament and surface tissue—including skin, fat and bursae. These tissues can be injured by either extrinsic or intrinsic trauma.

Extrinsic trauma

Extrinsic trauma refers to contact made with a sharp or blunt object that causes damage either open or closed to the tissue. This could be by contact with an opponent, or other sporting equipment involved in the game such as a stick, racquet, ball or goal post etc.

Intrinsic trauma

Intrinsic trauma is damage caused to the tissue from within by over-stretching, over-contracting or uncontrolled internal stress. Repetitive overuse is also a cause of intrinsic tissue damage.

Common extrinsic trauma injuries to muscle are usually known as corkies, which usually occur in the thigh in football, but this can also happen in the biceps and the calf. The external force causes macro and micro break down in the tissue with a leaking of fluids into the surrounding areas.

Common intrinsic trauma injuries are muscle strains and the most common in football is hamstring tear. Calf and thigh strains are also common. The breakdown of the tissue causes leakage of fluids into surrounding tissues as well as the localized breakdown of muscle fibres.

Ligament damage

Ligament damage can be extrinsic (being struck) or intrinsic (twisting injury), causing similar local damage along with fluid leakage into the area.

Repetitive strain

Repetitive strain causes local inflammation and fluid accumulation in tendons—the most common site being the Achilles tendon.

RICER still stands as the gold standard for management of soft tissue injuries:

Rest—not complete rest, but active rest. This can be achieved by keeping the muscle switched on with mini contractions or tightening which prevents it from shutting down, resulting in the ability to contract the muscle.

Ice—(or cold pack) around the injured part to close down the vessels that have dilated or been damaged in the trauma. This should be repeated for 15-20 minutes every two to three hours for the first 24-36 hours.

Compression—compress the area above and below and over the injured tissue to constrict flow of fluids out of vessels that are damaged. This needs to be firm, but not enough to become a ligature that cuts off blood supply to the rest of the limb.

Elevation—of the injured part at a level that is comfortable, but reduces the effect of gravity draining fluids to more distal tissues.

Referral—arrange to see a qualified health professional (doctor or physiotherapist) immediately. This will determine the extent of your injury and provide advice on the treatment and rehabilitation required.

Managing Basic Injuries

Treating injuries: heat v ice

Ice is used in the first 72 hours for any new injury from muscle strains to direct contact - "corks". Ice works in tandem with other components of the RICER regime. Initially the application is every two hours for 20 minutes and then eased off to two to three times a day.

Heat is best used to pre-warm muscles prior to exercises using a heat pack or heat rubs. It can be used during activity to ease stiffness and tightness but be aware not to apply heat to new injuries.

When to return to sport after a muscle injury

A simple assessment protocol to predict how many weeks will be missed with a muscle injury is:

1. Ran from the playing field with some restriction and pain **Grade I** muscle injury - miss 1-2 weeks
2. Limped from the playing field but could not run **Grade II** muscle injury - miss 2-4 weeks
3. Assisted from the field, needed support
Grade III muscle injury -miss 4-6 weeks

This is only a guideline and return to sport should be assessed with specific functional and muscle testing.

The benefits of core stability

In recent years research has shown that specific exercises to strengthen the pelvic, lower back and lower abdominal muscles together to gain a coupling effect is very beneficial for preventing injuries and improving an athlete's performance. Sit ups, Roman Chair - trunk extension, and swimming were historical exercises that were prescribed to strengthen the abdominals and lower back.

However with a new understanding on the need to have the "internal corset" effect, the approach to exercise prescription has changed markedly. Specific mat, fit-ball and Pilates-type exercises used in isolation or with other exercises to improve core strength are now mandatory in athlete preparation.

Does muscle turn into fat?

This is one of those old wives tales which has proved to be incorrect. Someone who is healthy and fit, with good muscle mass, who then stops training, will find in time that the muscle size is reduced.

This is a separate process to fat accumulation. What often happens is that people maintain the same eating habits but reduce their activity levels. This is the main reason that muscle mass decreases in size, and the extra kilograms of fat around the waist, the legs and the butt then become more pronounced. **Shin splints**

Shin splints are a condition where an individual complains of pain along the inside border of the larger lower leg bone - the tibia. The main cause is the tractioning effect of the muscles that attach to the bone. This can be due to a sudden increase in training loads, poor supporting shoes or pronated (flat) feet.

You can often feel a very tender and painful lump in the area which makes running very difficult. Advice and assistance in settling down your symptoms and safely returning you to playing can be obtained from your club or local physiotherapist.

Soft Tissue Rehabilitation

Rehabilitation following soft tissue injury involves the management of the athlete from the time of injury to return to sport. Soft tissue injuries vary in type (e.g. tendon, muscle, ligament, muscle contusion etc) and severity; however, a generalised program of staged rehabilitation is relevant for all injuries. The length of the program will vary depending on the severity of injury but all stages will still need to be addressed.

The stages of rehabilitation from injury to return to sport are:

1. Unloading Phase (Tissue Recovery/Regeneration)
2. Restoration of Normal Physiology (Early)
3. Restoration of Normal Physiology (Late)
4. Functional Training (Sport Specific Demands)

If we briefly consider each of these stages and the rehabilitation aspects it helps us to more effectively guide our management.

1. Unloading Phase (Tissue Recovery/Regeneration)

This commences immediately following trauma and involves protecting the injured structure from excessive loads likely to impact on normal tissue healing. Total rest is not necessary, rather protection at an appropriate level is required.

The length of time for protection is dependent on the severity of trauma involved.Utilisation of RICER principle (Rest, Compression, Elevation and Referral) is vital in the early stages with emphasis on compression. Compression at all times immediately following

injury is arguably the most important of the RICER principles. Thus keep compression on even when undertaking other aspect of RICER management.

2. Restoration of Normal Physiology (Early)

This involves the introduction of increasing loads/demands on the tissue after suitable time for tissue recovery has been allowed. Loads need to be kept at an appropriate level for timeframe of tissue healing. This involves both stretching and strengthening aimed at tissue involved without causing excessive pain or any post exercise swelling/prolonged soreness.

Additional techniques (home and clinic based) may be incorporated to assist in tissue healing or movement restoration (e.g. massage, mobilisation, electrotherapy etc.). The intensity of massage needs to be kept at a suitable level for the tissue healing time (i.e. not too strong as may cause further tissue damage/bleeding!).

3. Restoration of Normal Physiology (Late)

Continuation of loading of tissues to full strength/stretching loads. Loading through this phase will begin to mimic normal daily and sporting loads. Loading is progressed through from slower to faster rates of application and from short to longer duration.

Should have normal tissue strength at the end of this stage in preparation for the final stage.

4. Functional Training (Sport Specific Demands)

Final stage of rehabilitation to be completed before full return to sporting activity. This stage is vital to ensure athlete has suitable 'dynamic joint stability' via appropriate activation of muscle to prevent recurrence or new injuries. Utilisation of dynamic balance/loading activities is important during this stage. Techniques such as plyometrics and agility training are very useful in mimicking sport specific demands. Frequently final stage rehabilitation is poorly directed, leaving the athlete vulnerable to injury on return to competitive environment.

For successful return to sport all stages of rehabilitation need to be addressed! Recurrence of injuries do occur, even if we follow all stages. However, failure to adequately rehabilitate players, especially the final sport specific stage, significantly increases re-injury rates!