SUBSPECIALIST CONSULT

Treasuring Sports Overuse Injuries

O
erve injuries are very com-
mmon in children and teenagers, especially among kids who play sports throughout the year.

A high volume of sports puts your pa-
tients at higher risk for an overuse injury. Ask which sports they play, how often they play them, and how many teams they play for when taking the patient his-
tory. It is more and more common now that kids play on multiple teams at the same time or that sports seasons overlap. Here in the South, for example, baseball – a winter sport – is still go-
ing on.

Year-round participation in multiple sports has an advantage as well – it be-
comes a form of built-in cross-training. Your patients will be using different muscles but developing them in different ways.

Encourage your athletic patients to play different sports and discourage “ear-
ly specialization.” You can counsel pa-
tients regarding future diversification – during well-child visits and school or sports physical examinations. Patients who play football or soccer in the fall; basketball or wrestling in the spring; and softball or lacrosse in the spring generally are at a lower risk for overuse injuries.

In contrast, specialization in the same sport throughout the year increases the risk for overuse injuries as well as “burnout.” For example, a child who plays hockey for 7 or 8 years and plays the same sport for years might find participation becomes less fun by age 13 or 14. In some cases, parents get enthusiastic, pay for pri-
ate training to extend the “season” to 12 months, and the kids just never have a time to rest.

For some families, it seems like success of the team or success on the playing field becomes more important than the health of the child. You can face a dilemma if you recom-
 mend rest for a child about to play a big game or tournament. The best way I found around that is to spend sufficient time to explain why you are making your recommendations. If you just say, “His knee hurts, and he shouldn’t play,” the patient and parents are less likely to be compliant.

We give advice. We rarely forbid a kid from playing. But you can explain what could happen if they don’t follow rec-
ommendations. You might say some-
thing like, “Here is what I think you have, here is what I think you should do, and here’s why. If you don’t, the risk of mak-
 ing this a stress fracture is higher.” You can also explain that a non-
surgical elbow injury could become surgical if you con-
 tinue to throw, play, or turn;

Pediatricians can manage most overuse injuries. Watch for signs that can warrant re-
ferral, however, such as a swollen joint, limitation of joint movement, or symp-
toms of trauma/acute injury. Consider consulting with a subspecialist when the child can-
not completely bend or extend the el-
bow; for example, these findings suggest something worse than just overuse.

In general, the best way to treat an overuse injury is to understand the affer-
ced area. Apply the PRICEMM techniques (protection, rest, ice, compression, eleva-
tion, medication, and [physical thera-
py] modalities) for 2 or 3 days. If there is no improvement, expand your differen-
tial diagnosis. Overuse injuries should improve quickly if patients start under-
ning the affected area in addition to modifying their workouts and using ice and anti-inflammatory medications.

Recommend the patient back off after you identify the likely source of pain. If a baseball player presents with elbow-pain, for example, he might improve by pitching less or switching from shortstop to first base. Rarely do children need to stop playing altogether. Modification of the workout a little bit might be all it takes to give the body a chance to adapt.

You could recommend a child play only part of the soccer game or avoid partic-
ular conditioning drills during practice, for example.

An overuse injury is defined as repet-
tive, submaximal stress applied to a tis-
sue that occurs when the adaptive capa-
bility of the tissue is exceeded and injury results. A blaster is a perfect example. If you put on a new shoe that starts rub-
ing your foot too much, eventually the skin breaks down. But if you wear the new shoes for a little bit, then switch to sandals, then boots, and finally put your new shoes back on, you slowly introduce those stresses. This way, the body has a chance to adapt, the skin will become calloused, and you won’t develop a blaster.

Acute trauma is another reason to consider referring the child to a sports medicine specialist. If a child comes to you with instant pain from a jump off the monkey bars or a slide into home, she should be referred to rule out some-
thing more serious, such as a fracture or a dislocation or a ligament tear.

Another time to refer is anytime you feel uncomfortable. If you sense some-
thing isn’t right, you will never be fault-
less for referring the patient to a specialist. So, when in doubt, go ahead and refer.

Typically, a good history and physical examination will be sufficient, with or without x-rays, for a pediatrician to de-
terminate the best recommendations for the patient.

Although x-rays are a necessity for evaluation of most orthopedic or sports injuries, it is preferable to refer the child and have the subspecialist order imaging tests. This avoids duplication of radiation exposure for the child and the unneces-
tary time and expense of repeated x-rays. In addition, laboratory assays typically do not help in the evaluation of a suspect-
ed overuse injury, unless you suspect a comorbid condition such as arthritis or joint infection.

Dr. MArshall is medical director of the Sports medicine program at Children’s Health Care in private practice at Children’s Orthopaedics of Atlanta, and is a clinical assistant professor of pediatrics at Emory University, Atlanta. Dr. Marshall said he had no relevant financial disclosures.

The TeenScreen National Center for Mental Health Checkups at Colum-
bia University is establishing a registry for primary care providers who offer mental health screening during routine adolescent care. The Columbia Univer-
sity TeenScreen Registry is a resource for information sharing among those providers. Registrants will receive free evidence-based screening questions, patient education materials, and access to a private online community to share infor-
mation about mental health screening in primary care. They also will receive a certificate from Columbia University.

Their profile information will be made public on the page of the registry Website.

Launching in June, the registry will be open to pediatric primary care providers who use evidence-based questionnaires to identify teens with depression, anxiety, and other mental disorders. Such ques-
tionnaires need not be the ones provid-
ed by TeenScreen.

The TeenScreen National Center for Mental Health Checkups at Columbia University is a nonprofit health initiative, and national policy and resource center. The TeenScreen National Center is affili-
ated with the Columbia University Di-
vision of child and adolescent psychiatry in New York.

To learn more, visit www.teen-
screen.org.

Providers may enroll in the registry now or request more information about adolescent mental health screening in primary care at healthcare.university. A new website will be launched, accessible at www.healthcare.university. 

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