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A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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Sports Injuries... New Birth Control Data

Dr. Robert Mendelsohn

As more Americans are devoting more and more time to exercise--running, jogging, walking, swimming, playing tennis, etc.--more and more of them are injuring themselves in the process. A whole new specialty, sports medicine, has come onto the scene, and its practitioners minister to many patients--from the humblest neighborhood jogger to the loftiest Olympic athlete.

But treatment for sports injuries sometimes boils down to just plain common sense. My favorite story concerns the man who sprained his ankle while playing tennis and called his doctor to ask whether he should apply hot compresses or cold compresses. "Hot," the doctor answered. The man applied hot compresses for three days, but the ankle was getting no better. On the fourth day, his housekeeper suggested he put on cold compresses. Lo and behold, on the fifth day, the man was cured! He called his doctor to tell him how well the cold compresses had worked. "Funny thing," responded the doctor, "My housekeeper says hot compresses!"

Q I have spurs in my left heel. Just what are spurs, and what is the treatment, if any? Will they have to be removed, or do they hurt for a while and then disappear? Is this a form of arthritis? Does diet affect spurs?

I've never had spurs before, and this condition is very painful. Can you give me any advice?--O.C.

A *Heel spurs*

Doctors have taken a perfectly respectable word--spur--which ordinarily refers to a pointed device secured to the outside of a horseback rider's heel used to urge on the horse, and have applied it to a deformity that occurs inside the body.

Your particular spur is an outgrowth in the heel which develops from a structure (plantar fascia) originating from the heelbone. An x-ray may or may not help in the diagnosis, since in early stages of pain, no evidence of calcification or other changes due to overgrowth is seen on the x-rays. The diagnosis can be made by careful palpation (probing with the fingers) of the heel pad to identify the deep area involved. Intense pressures may be necessary to locate a heel spur because the heel pad is so thick. Spurs may cause localized swelling and, even though usually hard, they may be difficult to evaluate because of a soft sac which forms over them.

Usually, spurs result from chronic trauma, e.g., ill-fitting shoes, but be sure your doctor searches for a variety of arthritic conditions

(ankylosing spondylitis, Reiter's syndrome, psoriatic arthritis, enteric arthropathy) that may underlie the presence of spurs locally. Relief can be provided by wearing proper shoes or by reducing mechanical stresses (e.g., jogging), weight reduction in overweight people, foam rubber inserted under the heel of the foot, elevation of the foot, hot compresses, and by the passage of time. Surgical treatment and injections are available, but they should hardly ever be necessary if the above recommendations are carried out.

My 12-year-old son has Osgood-Schlatter Disease. The doctor told him to rest his knees as much as possible and to avoid bike riding, running, etc.

However, after four months of rest, the knees do not appear to be improving, and the doctor has put him in a knee brace. If that doesn't help, the doctor says he may have to give my son hormone pills. I don't like this for one so young. What is your opinion?--Mrs. S.B.

Osgood-Schlatter disease

This common condition in athletically active adolescents is significant for two reasons: It has memorialized two otherwise obscure physicians (Osgood and Schlatter) forever, and it vies with a few other conditions for top position as the most overtreated problem in medicine.

Your doctor's original advice was excellent. The appropriate treatment is rest and, sometimes, elastic bandages. Insofar as anything in human life can be stated with 100 per cent assurance, it can be stated that all cases of Osgood-Schlatter's will disappear if one waits long enough.

However, when confronted with forced inactivity, tenderness, pain and some swelling just below the knee (the only area in the body affected by this condition), your 12-year-old son may pressure the doctor for a quick cure. As a result, the doctor may decide to try measures such as hormone pills, hydrocortisone injections and immobilization in a plaster cast that can add risk to the situation. You don't like such measures, and neither do I.

About two months ago, I experienced pains in my left shoulder and arm which were diagnosed as tendinitis. The doctor gave me a shot of cortisone, and he advised me that two shots would be required before the pain subsided. In the meantime, he said I should rest the shoulder and arm as much as possible and told me to keep my hand in my trouser pocket while I was up and around.

Because I have heard about side effects from cortisone injections, I decided to visit another doctor. The second doctor also diagnosed tendinitis, but he said that although the usual treatment in the past had been cortisone shots, he was against this treatment because of possible complications. He told me it was imperative for me to keep the shoulder and arm in motion as much as possible because otherwise they could become immobile. He prescribed physical therapy as well as a daily oral dose of 7.5 mg of Prednisone to be taken for one month.

Although I have shown some improvement, and the pain has lessened somewhat, I now am concerned about side effects from this drug. For several days, I have had hoarseness in my throat, and I wonder whether this could be caused by Prednisone.

Please give me your opinion about the treatment I've gotten as well as any advice you can give me about further treatment of this extremely painful condition. I am 70 years old.--W.S.

A

Cortisone shots for tendinitis

The two doctors you saw were far more anxious to rush to extreme measures of treatment than is William Southmayd, M.D., a doctor specializing in sports medicine who regularly treats tendinitis. Dr. Southmayd explains ("Sports Health: The Complete Book of Athletic Injuries," by William Southmayd, M.D., and Marshall Hoffman, Quick Fox, $14.95), that he treats the kind of shoulder ailment the doctor says you have (which he considers a "thrower's ailment") with ice and rest. He recommends pendulum exercises as soon as the pain decreases. If the tendinitis condition is severe, Dr. Southmayd recommends an anti-inflammatory medication and two weeks of rest. He recommends cortisone injections around the tendon only if the above course does not alleviate pain. Dr. Southmayd is plenty wise to hold back on cortisone (and Prednisone is a close cousin), since this hormone is one of the most powerful and dangerous drugs in modern medicine.

Oh, by the way, did your doctor ask you the series of questions necessary to determine why you have tendinitis (rather than arthritis or bursitis) in your left shoulder and arm? Have you recently begun a new kind of athletic activity? Did you, following retirement, begin a new job involving some strenuous movement? Have you started a new hobby which involves muscular exercise? In other words, why you? why in that spot? and why now?

Q

My left knee has been bothering me for more than six years. About six months ago, a respected bone doctor took x-rays and said I have three bone spurs under the kneecap and probably some cartilage damage.

I am 51 years old and have always been very active. I've played handball for more than 20 years and tennis for the past 15 years; I'd like to continue tournament play in doubles tennis.

Can you tell me what sort of success ratio a good doctor has with the removal of spurs from under the kneecap? My knee now obstructs my play, and it really hurts on the day after a match.--V.V.

A

Bone spurs

Since the success rate of knee operations depends not only on the physician but also on the type of operation, you must ask your physician precisely what type of surgery he plans to do. Is he contemplating open surgery to smooth out the spurs on your kneecap, an operation which would keep you off the tennis court for months? Or is he planning to use arthroscopy (a tube introduced into the knee through which the surgeon uses a kneecap shaving device to remove bony irregularities and loose fragments)? If this latter procedure (which markedly reduces convalescence time) is the one your doctor is contemplating, you should know that the long-term effect of shaving is not yet known. The procedure is only several years old.

Q

I have had tennis elbow pain in my right elbow for several years. I've had several injections of cortisone (administered when the injury first occurred), and I'm still taking physiotherapy. Recently, I've had to take a painkiller because the pain worsened quite a bit after I used my arm.

How long does it take for tennis elbow to heal, and how can healing be brought about?--Mrs. C.V.

Tennis elbow

A Cortisone injections and pain-killers are treatments of last resort for tennis elbow, yet you do not mention having received other treatments. Did your physician fail to tell you that the best treatment for tennis elbow is rest? Did he fail to tell you to avoid opening car doors, and not to carry a briefcase or lift milk cartons with the affected arm? Did he fail to tell you about the use of ice and heat treatments? If you play tennis (and tennis elbow may occur in plumbers, mechanics, surgeons, bowlers, pitchers, factory workers, or anyone who uses his wrist in a powerful way), have you tried seeing a tennis coach to change your stroke, or wearing an elbow brace or support, procedures which have proved almost universally effective?

The longer you rest your arm, the better are the chances that it will heal completely. However, the older you are, the slower will be the healing process. One study has shown that tennis players older than 40 have a significantly higher incidence of elbow pain than do younger players. This coincides with my own experience--although I have been playing tennis since my early teens, I didn't develop tennis elbow until age 45.

Q I was quite interested in your comments on "tennis elbow" because I was afflicted with that condition in my right elbow a few years ago. My doctor treated me with a cortisone shot and then with a shot of a pain killer. The pain came back after two weeks, at which time the doctor repeated both shots.

After the second office visit, the pain in my elbow became almost unbearable. This pain lasted for more than three months. Since I didn't want any more shots, I tried both heat and cold, but that didn't work either. The one thing that did help was daily, almost constant, massage. The pain has been gone for a year, and I've often wondered whether massage did the trick or whether it merely eased the pain while nature did the rest.--Mrs. A.M.

Massage and tennis elbow

A I appreciate your letter, particularly since it raises the issus of massage, a form of therapy that goes almost unrecognized by modern medicine in its headlong rush toward better living through chemistry. But after all, why should physicians be expected to know the techniques of massage, manipulation, specialized exercises, hydrotherapy, etc., when most of them learned nothing about physical medicine and rehabilitation during their medical school years? Plenty of doctors have trouble distinguishing between a psychiatrist and a physiatrist (specialist in physical medicine).

If the physician finds out that a patient like you recovered after massage, he is likely to claim it would have happened anyway. When a patient tells a physician, "I got better after I went to the chiropractor," the physician's kneejerk response is, "spontaneous remission." Patients report this so frequently that I half-seriously recommend that anyone with chronic disease--arthritis, cancer, stroke, etc.--go to a chiropractor if they want a "spontaneous remission."

New birth control data—

One of the best sources of information about the major complications of various methods of birth control can be found in, of all places, "Making Choices," a 1983 publication of the Alan Guttmacher Institute, the research arm of Planned Parenthood.

The Pill

Instead of merely sending you to this 72-page booklet (which tries to tell you how much more dangerous a pregnancy is than birth control, as well as how wonderful The Pill is because it presumably can save women from ovarian cancer and lots of other illnesses), let me tell you about the 10 pages which deal with complications. Each year, 9,400 current Pill users are hospitalized because of diseases brought about by Pill use. Heart attack and stroke account for the overwhelming majority of the estimated 500 fatalities associated annually with Pill use. Blood clots (thrombosis) in the superficial veins affect 11,800 Pill users annually. Liver tumors (hepatocellular adenomas), a serious complication with a 10 per cent fatality rate, account for 300 yearly hospitalizations of Pill users. In addition, 860 women annually are hospitalized with gall bladder problems associated with Pill use. Common complaints which do not require hospitalization include nausea, breast enlargement, weight gain, dizziness, and chloasma (light brown patches, also known as liver spots on the skin of the face and elsewhere). These latter so-called "minor symptoms" are disturbing enough to cause many women to discontinue Pill use, both because of the symptoms themselves and because of fear of more major complications which they believe such symptoms foreshadow.

Prescription of birth control pills is "absolutely contraindicated" for women who have a history of phlebitis, stroke, coronary artery disease, benign liver tumor, and cancer of the breast or reproductive system. It also is contraindicated for women with impaired liver function and with unexplained abnormal vaginal bleeding. The birth control pills are "usually contraindicated" for women with high blood pressure, acute or chronic liver disease, gall bladder disease, and those who are wearing long-leg casts or who have a major injury to their lower extremities. The Pill is "relatively contraindicated" for women with diabetes or pre-diabetes, and women should stop The Pill if they plan to have surgery within four weeks. A "general contraindication" exists for women who do not yet have an established menstrual pattern.

I hope every woman on The Pill is taking the correct dose, since the Guttmacher people inform us that at least 10 per cent of Pill users (and 25 per cent of those ages 40 and over) take the more dangerous high-dose Pill which increases the risk of cardiovascular and other diseases. While there is "virtually no reason" for a woman to take an oral contraceptive containing more than 50 micrograms of estrogen, more than one million U.S. women (about 12 per cent of all Pill users) take the high dosage Pill. Older Pill users--those at highest risk--are more than five times more likely to be taking a high-dose Pill than are women in the youngest age group.

IUD statistics

As a result of IUD (the intrauterine device inserted by the doctor into the mouth of the womb for birth control) use, 9,600 women are hospitalized yearly. Most of these hospitalizations are for pelvic inflammatory disease (PID), a major cause of infertility because of resulting scarring and blockage of the fallopian tubes. Infection occurs because of bacteria ascending the IUD's strings. One of the most dangerous complications associated with IUD use is second trimester septic (infected) abortion which may occur after a woman inadvertently becomes pregnant with the IUD in place. If the IUD is left in the uterus after conception, the woman is 25 times more likely to develop this complication and 50 times more likely to die than is a woman who becomes pregnant without an IUD in place. An estimated 185 IUD users are hospitalized for this problem each year, and about one per cent of these women die from it.

An estimated 875 IUD users are hospitalized annually because the device has perforated the uterus. Breastfeeding mothers know the damaging effects of The Pill on both the quantity and quality of their milk and are often told by their doctors to use an IUD instead. They should know that women who are breastfeeding at the time an IUD is inserted are 10 times more likely to experience a perforation than are women who recently have had a child but who are not lactating.

The IUD is not as effective in preventing ectopic pregnancies as are some other contraceptive methods, and about five per cent of women who do get pregnant with an IUD in place have an ectopic (tubal) pregnancy.

Tubal ligation

Perhaps these IUD and Pill statistics will point you toward tubal sterilization. If so, you should know that 32,000 women are hospitalized annually for major surgical complications which result from tubal sterilization. These complications include (1) major surgery to control bleeding because of technical difficulties in continuing the surgical procedure, due to pelvic or abdominal adhesions or other problems; (2) rehospitalization because of pelvic infection, vaginal bleeding, or pregnancy, and (3) high and continued fever because of urinary tract infections or other problems.

It is notable that none of the above is the major cause of death among women who have had tubal sterilization. Instead, the largest number of tubal sterilization deaths are due to complications resulting from the use of general anesthesia. Anesthetic deaths account for four out of every 10 fatalities associated with tubal sterilization. The other two major causes of mortality from this kind of sterilization are infection and hemorrhage. The most serious long-term risk is ectopic (tubal) pregnancy.

Hysterectomy

If you think that hysterectomy provides a safer alternative, the Guttmacher report reveals that the risk of major complications of such surgery is 41 per cent, and the mortality rate is 25 per 100,000. These risks are about 24 and seven times greater, respectively, than the risks of tubal sterilization.

Abortion

If your birth control method fails and you decide to go for an abortion, you should know that 5,000 women annually suffer major complications as a result of abortion. The most frequent complications are hemorrhage, requiring blood transfusion; fever for three days or more, and "major unanticipated surgery." The rate of complications is lowest for abortions performed by vacuum aspiration, rises for abortions performed by D & E (dilatation and evacuation), and increases still more for abortions induced by saline, prostaglandins, or urea. The rate is many times higher for abortion performed by hysterectomy or hysterotomy (cutting into the uterus). The largest proportion of abortion-related fatalities result from infections, thromboembolisms (both stable and traveling clots), amniotic fluid embolisms, hemorrhage, anesthesia and analgesia. Surprisingly, there is no difference in the rate of major complications and mortality resulting from abortions which are performed in a hospital and those performed in a non-hospital clinic.

Future forms of birth control

What about future forms of birth control? In its publication, "Making Choices," the Guttmacher Institute discusses the new technology which is on the horizon. Depo-Provera, a long-acting progestational agent, injected every three months, now is being used in some 80 countries, but is still prohibited in the U.S. because animal studies have suggested that the drug can cause cancer of the breast and uterus. Other progestational methods (including one named Norplant) also are controversial. A vaginal ring, similar to but somewhat smaller than the rim of a diaphragm, does not seem to be as effective as The Pill, and a new progestin-releasing IUD (Progestasert) has to be replaced annually. Reports about the cervical cap show that about half the women who want to use it cannot be fitted with this device, and many others discontinue its use because of odor problems, difficulty in insertion or removal, and dislodgement of the cap during intercourse. Eight per cent of the women who continued using this method became pregnant during the first year. A new method of tubal sterilization which consists of filling the fallopian tubes with a plug of liquid silicone rubber (the Guttmacher people refer to this technique as "most highly advanced") requires considerable skill in using a delicate fiberoptic device to insert the material through the cervix into the uterus and into the fallopian tubes. In one study, nearly one-fifth of the attempts to close both tubes failed. Furthermore, reversibility of this method of sterilization thus far has not been demonstrated.

Other methods "still on the drawing board" include something called a "menses-assurer" (steroids, prostaglandins, or medicinal plant agents taken at the time of the expected menstrual period); gossypol, the Chinese derivative of cottonseed oil; certain brain hormones; a disposable spermicide-releasing diaphragm, and an antipregnancy vaccine. All of these exhibit more of the character of wishful thinking than of realistic expectation.

But these Planned Parenthood people do reach conclusions that I can heartily agree with. They believe that many U.S. women want a low-cost contraceptive that gives long-lasting protection against pregnancy and at the same time has no hazardous complications, does not disturb the menstrual cycle, has no annoying side effects, does not interfere with sexual activity or pleasure, and has instant reversibility. But they conclude that in the near future, just as today, it is almost certain that "People will have to continue to make tradeoffs between safety and contraceptive effectiveness."

The process of making such tradeoff decisions will be more rational, says the Guttmacher Institute, if the information given the women about benefits and risks is accurate. Since none of us can disagree with that statement, I recommend "Making Choices" as a good starting point for accurate information on both the presumed benefits and alleged risks of one of the most bizarre experiments in all of human history--the entry of modern medicine into the field of birth control.

("Making Choices" is a publication of The Alan Guttmacher Institute, 360 Park Avenue South, New York, NY 10010.)

"MalePractice: How Doctors Manipulate Women," Dr. Mendelsohn's latest book, is now available in paperback from Contemporary Books ($6.95).

"Confessions of a Medical Heretic" is available from WarnerBooks ($3.25).

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Another View

by Marian Tompson
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When the Chicago Sports Medicine and Dance Injury Center opened its doors recently, I was delighted to learn that the Medical Director was David Birnbaum, M.D. Even when I first met David when he was a student of Dr. Mendelsohn's, he had a strong interest in the treatment of sports injuries. After a few years in private practice as a family physician, Dr. Birnbaum was awarded a fellowship in sports medicine at Harvard University, and this past summer he served as attending physician at the U.S. Olympic training camp. He was just the person to explain sports medicine to me, so one afternoon we got together to talk about this relatively new field.

"What is different about sports medicine?" was my first question. "The athlete has different demands," Dr. Birnbaum replied. "He doesn't want to stop playing because of an injury, so we have to figure out what is negotiable. Where doctors ordinarily cured problems like shin splints and sprains with pills and rest, we've found that active rehabilitation works better. You can actually move healing along with proper therapy. It's true that until recently there was an abuse of athletes to get them back into competition earlier. Today we know that if the injury is suitable, the athlete still can play. By using appropriate therapy, like ice, exercise or whirlpool afterwards, we can help him get better faster than if we had just used rest."

"Athletes are used to being active," Dr. Birnbaum continued. "So if a specific rehabilitation plan is not instituted, they become weakened and prone to re-injury and chronic aches and pains. If you injure your knee, for example, and stop using it, the muscles around your knee would weaken. The weakened muscles can't do the job, so it's up to the ligaments which become stretched and hurt. Because of the chronic pain and inflammation in the ligaments, you might stop exercising and weaken them further."

This is where a Sports Medicine Center with its latest "state of the art" equipment for diagnosis and treatment has an advantage. At the Chicago Center, this equipment includes the Cybex II, which precisely determines the point of pain in a muscle or joint; Video/Treadmill Analysis which is used to study and assess a person's walking and running gait, and the Electrodynogram system which makes a computer-assisted analysis of the working joints and muscles of the moving foot.

"The majority of injuries are preventable," Dr. Birnbaum explained. "Most are caused by inadequate warmup and cool down. People who have exercised all their lives without warming up first will suddenly start having aches and pains as the body finally gives up on this insult to it. When the body is tired is when many people get hurt, and we see muscle tears and ligament strain."

Sports medicine, I was surprised to learn, goes beyond athletic injuries. Rehabilitation of accident victims is similar to sports injuries in evaluation and complications. Dr. Birnbaum's interest is with helping people who have particular health problems yet who want to be more active. Those suffering from hypertension, learning disabilities, heart disease, or other constraints can receive guidance on how to perform to the best of their ability in a particular sport. With some diabetics, proper diet and exercise make insulin unnecessary.

There are only a handful of Sports Medicine Centers in operation at this time. The Chicago Center offers a Hotline Number (312/332-6570) to assure athletes and dancers of treatment within 24 hours of their phone call. The American College of Sports Medicine, One Virginia Avenue, Suite 340, Indianapolis, Indiana 46206 (317/637-9200) has a directory of physicians who specialize in this field.