

Presidents Message

By Dr. Mike Nicholls

It is with great honor and humility that I accept the role of 4th President of the Sport Medicine and Science Council of Saskatchewan. Previous presidents – Dr. Jack Alexander (1988 – 1992), Mr. Chuck Armstrong (1992 – 1994) and Dr. Marlys Misfeldt (1994 – 2002) - have served the Council generously and with great vision and it is my primary goal to uphold the high standards that they have set before me. Because of the work of these individuals, as well as the work of the many other volunteers and staff, we have an organization that is second to none in Canada in providing sport medicine and science programs and services.

The Council is entering a very exciting time in its history. We have seen our programs and services expand to levels that we could have never imagined four or five years ago. The number of individual athletes and coaches, teams, schools, recreation boards, and provincial sport governing bodies to which we provide services continues to grow each year.

The announcement last year that the 2005 Canada Summer Games would be hosted in Saskatchewan has provided the sport community the opportunity to enhance high performance programming. The resulting increase in programming demand will result in an expanded role for the Council. We will work with each provincial sport governing body in the development of their high performance programs and provision of sport science and medicine services. We will also continue to provide the many high performance services on a daily basis to any athlete, team or coach that requests our assistance. Also, we will continue to provide direct sport medicine and science services for all Canada Games and Western Canada Games teams as they prepare for competition. Currently we are working with many of the athletes and teams that will be attending the Canada Winter Games in February 2003 and the Western Canada Summer Games in July 2003.

Our so-called "grassroots" educational programs and services continue to service a huge need across the province. The Canadian Sport Safety Program, the Medical Coverage Program, and our Sport First Aid Supplies Sales Program are just a few of the many programs that are available to the sport and recreation community in Saskatchewan. The "Team Sport" Speakers Bureau Program has been a unanimous success training and pairing athlete speakers with interest groups and has expanded to the point that we have almost received and accommodated the same number of requests in the first three months this year as we received during the entire nine months the program was operational in 2001.

In closing, I wish to extend an invitation to you all to contact any of us here at the Sport Medicine and Science Council of Saskatchewan with your comments as we are always open to suggestions to improve the way our programs and services are offered. We can only get the job done by giving you what you need. We wish you all success in 2002-2003.

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LONG TIME EXECUTIVE MEMBERS RECOGNIZED FOR YEARS OF SERVICE

At the SMSCS's Annual General Meeting held on March 21, three long time volunteers were recognized for their many years of service as Executive Members on the Board of Directors – Dr. Marlys Misfeldt, Mr. Don Fry, and Mr. Chuck Armstrong. Noted below are only some of their many contributions to the Council. Note: Also recognized previous to the AGM was Dr. Jack Alexander, who was the Council's first President and one of the founding members.

Dr. Marlys Misfeldt

Board Member, 1992 -1993
President-Elect, 1993 -1994
President, 1994 - 2002
Chairperson, Provincial Drug Education Advisory Committee

- Instrumental in the amalgamation of the Sport Medicine Council of Saskatchewan and the Sport Science Program
- Overseen the development of our award winning **Body Image Video**
- Served on numerous Committees and provided numerous sport medicine educational workshops to athletes and coaches in the province
- Directed/Assisted the Council on the development of key policy issues

*** Marlys will now serve as Past President**

Mr. Don Fry

SMCS Board Member, 1996 -1997
SMSCS Executive Member, 2000 - 2002
Chairman, Sport Science Program Committee, 2000 - 2002

- Instrumental in the amalgamation of the Sport Medicine Council of Saskatchewan and the Sport Science Program
- Chairman and driving force behind the creation of the Sport Science Project in 1989 which developed into the Sport Science Program created in 1991. The Program was the original provider of sport science services for Saskatchewan athletes
- Don served as the Chairman of the Sport Science Program from 1991 until the amalgamation of the Program with the Sport Medicine Council in March of 2000.

Mr. Chuck Armstrong

Chuck was our longest serving Executive Board member and was one of the founding members of the SMCS.

SMCS Vice President 1988 -1992
SMCS President 1992 -1994
SMCS/SMSCS Past President 1994 - 2002

- Instrumental in the amalgamation of the Sport Medicine Council of Saskatchewan and the Sport Science Program
- Directed/Assisted the Council on the development of key policy issues
- Sport First Aid Workshop Instructor
- Sport Taping Workshop Instructor
- Drug Education and Doping Control Workshop Conductor
- Served on numerous Committees and provided numerous sport medicine educational workshops to athletes and coaches in the province



L-R (Mr. Chuck Armstrong, Dr. Marlys Misfeldt, Mr. Don Fry)

DOCTORS ENCOURAGED TO GET ACTIVE ABOUT PHYSICAL INACTIVITY

Mississauga, Jan 15, 2002 - Doctors across Canada are being urged to write physical activity prescriptions for their patients as a more effective way of tackling the problem of obesity among Canadians, in addition to a myriad of other inactivity-related chronic diseases.

According to a series of articles being released today in the January issue of *Canadian Family Physician*, researchers have found that the effectiveness of physical activity counseling interventions for overweight patients can be improved if family physicians add written materials, especially if provided in the form of a "prescription". The likelihood that patients will increase their physical activity levels may be further enhanced through the use of simple evaluations to assess fitness capacity and guide physical activity prescriptions.

Currently, 16 per cent of family physicians provide patients with a written physical activity prescription according to The College of Family Physicians of Canada (CFPC) 2001 National Family Physician Workforce Survey.

"Canadians are becoming dangerously inactive and obesity has reached epidemic levels," says Dr. Andrew Pipe, Chair of The College of Family Physicians of Canada's (CFPC) Physical Activity and Health Strategy Coordinating Committee. "Evidence shows that family physicians can facilitate improved physical activity levels among their patients."

In 1999, approximately 21,000 Canadians died prematurely as a result of medical problems related to physical inactivity and added \$2.1 billion in direct costs to Canada's already burdened health care system.

Statistics linked to the physical activity levels of Canada's youth are most concerning:

- Between 1981 and 1996, obesity nearly tripled among boys, and more than doubled among girls.

- Canadian children now expend 400 per cent less energy than their counterparts did 40 years ago.
- Two-thirds of Canadian children and youth are not active enough for optimal growth and development.

"Not only is it imperative for family physicians to focus more on physical activity counselling - in particular for youth - but we are asking them to use an approach similar to that used to identify and influence smokers when dealing with their patients sedentary lifestyles: "ask, advise and assist", Pipe said.

The CFPC has been urging its members to become more active in addressing physical inactivity by encouraging the use of Canada's Physical Activity Guide (which recommends the accumulation of at least 30 minutes of moderate physical activity on most days of the week), the Go For Green Prescription and counseling tools such as Pace-Canada (Provider-based Assessment and Counseling for Exercise) and the STEP program (Step Test Exercise Prescription).

Canadian Family Physician is published 12-times a year by the CFPC. The January issue is dedicated to physical inactivity in order to raise physician awareness of the importance of physical activity counselling.

Green Prescription Pads are available from the CFPC upon request.

For further information, please contact:

Patricia Marturano, Physical Activity Project Coordinator
The College of Family Physicians of Canada
905-629-0900 x203
pmarturano@cfpc.ca <<mailto:pmarturano@cfpc.ca>>



The SMSCS would like to acknowledge the financial support of the Saskatchewan Dairy Foundation for their continued support of the High School Athletics Nutrition Workshops that the SMSCS provides throughout the province. As requests continue to grow it is evident the workshops provide invaluable information to high school teams in Saskatchewan.

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UNDERSTANDING BURNOUT IN SPORT

by Ryan Flett, M.S.E.S.S, SMSCS Mental Training Consultant



Burnout is a state of physical, mental and emotional exhaustion. Burnout negatively affects vitality, purpose, self-concept, and attitudes towards life and sport (Shaufeli, Maslach, Marek, 1993). Due to the nature of sport—as well as the nature of burnout itself—athletes and coaches are prone to burnout because they are often achievement-oriented, highly dedicated, and very stressed (Feigley, 1984). Unfortunately burnout is, therefore, a significant barrier for individuals who work hard and contribute to society. For this reason, burnout is an important issue for everyone. Understanding the psychology of burnout enables us to cope with it, and even prevent it, more effectively.

Demands and Causes

The causes of burnout can be divided into two categories: situational/environmental demands; and individual/personal factors (Smith 1986). **Environmental causes** include: *physical* factors (e.g., over-training & injury); *logistical* factors (e.g., time constraints & organizational problems); and *social-interpersonal* factors (problems with others). Examples of environmental factors include: an unrewarding environment (both intrinsic, as well as extrinsic motivation); excessive stress; monotonous training that lacks variety (staleness); and less practice, but playing more competitively than average (Gould, Udry, Tuffey, & Loehr, 1996; Henschen, 1998). **Personal factors** include: high expectations; a lack of enjoyment; lack of assertiveness skills; perfectionism; poor relationship skills; poor coping strategies for stress; and a lack of personal control in training—which is partly situational (Gould et al.; Henschen; Shank, 1983; Smith). Everyone involved in a team—including players, coaches, and managers—should consider these factors when developing an ideal team atmosphere.

Cognitive Appraisal

As Smith (1986) rightly acknowledged, these “environmental” and “personal” causes do not automatically create burnout (see also, Silva, 1990). **Cognitive appraisal** is the next stage in the burnout process. Cognitive appraisal is the interaction between personal perceptions and opinions, and environmental factors. An athlete’s perceived ability to meet the demands of the situation essentially moderates the impact of both the personal and the environmental factors. When athletes do not believe that they can meet the physical, emotional, social, competitive, and mental demands ahead of them, the situation will appear to be overwhelming. What complicates the issue

is that if a person does not feel that a situation is challenging enough, the result will be boredom and staleness. As such, it is critical that athletes perceive there to be a “skill-challenge balance” in their training (Jackson & Csikszentmihalyi, 1999). So how does the issue of “cognitive appraisal” affect our understanding of the burnout process? People must acknowledge that what they say may not be exactly what others hear. Perception is sometimes more important than reality, and the best way for people to understand what someone perceives is to establish open and trusting communication. In addition to understanding how an athlete perceives a situation, it can be helpful to assess their motives for participating (Raedeke et al., 2000). It is also important to remember that—because personalities are complicated, and situations offer copious demands—an athlete may have multiple cognitive appraisals of a situation. An athlete will often have several opinions. As such, a behavioural response is often a product of some type of cost-benefit analysis, rather than simple, linear thinking.

Physiological Symptoms & Behavioural Responses

“Behavioural Responses” represent the final stage of the cognitive-affective model (Smith, 1986). Behavioural responses are a product of cognitive appraisals and physiological responses, such as anxiety and fatigue. Behavioural responses to the antecedents of burnout include: changing moods, apathy, depersonalization, anxiety, emotional isolation, exhaustion, decreased motivation, low self-esteem, performance decrements, and even substance abuse (Henschen, 1998). For the most part, behavioural responses (or “symptoms”) are negative in that they have a detrimental effect on the well being, as well as the performance, of athletes. Although these symptoms of burnout are essentially natural coping strategies, it does not mean that they cannot, and should not, be changed.

Tips for Prevention of Burnout (Dale & Weinberg, 1989; Gould et al., 1996; Henschen, 1998)

- ❖ Schedule breaks! During practices, and between competitions, give your athletes an opportunity to regroup, relax a little, and perhaps even smell the roses. Applying this idea to an entire season: it is important to provide athletes with a transition period where they can escape the sport environment.
- ❖ Allow your athletes a degree of decision-making autonomy. Anything that you can do to improve an individual’s perception of personal control, will improve that person’s confidence, productivity, and enjoyment.
- ❖ Teach athletes fundamental communication, stress management, and coping skills.
- ❖ Be weary of “going through the motions”...Variety—and

even a degree of unpredictability in practice—can prevent staleness while making practice more challenging and thereby more productive. Challenge your athletes, but be realistic.

- ❖ Try to control outcomes whenever possible. This has a lot to do with the importance of perceiving control. Athletes who do not have a sense of control feel helpless, and perhaps even manipulated and hopeless. You could, for example, improve the probability of success in a particular drill.
- ❖ Minimize post-competitive tension. Teach athletes to deal with the results of competition (both good and bad) maturely.
- ❖ Lastly, be aware of burnout and staleness. Do what you can to create an environment that does not generate negative (i.e., counter-productive) attitudes. If you know someone that is in a bit of a slump, be aware of the fact that it could be burnout. In helping such individuals, be sensitive and compassionate; it is not entirely their fault that they are burning out!

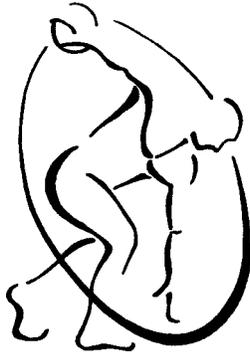
Assessing Burnout

- The following instruments have been recommended by Gould et al. (1996) and/or Henschen (1998).
- Eades Athletic Burnout Inventory (Eades, 1991). This is a 36-item inventory using a 7-point Likert scale. Before recently*, this was one of the only sport specific burnout inventories.
- COPE (Carver, Scheiere & Weintraub, 1989). This inventory uses a 4-point Likert scale across 52 items and is used to assess coping skills.
- Sport Anxiety Scale (Smith, Smoll, & Schutz, 1990). This is a 21-item inventory that uses a 4-point Likert scale.
- The Sport Motivation Scale (Pelletier, Tuson, Fortier, Vallerend, Brier, & Blais, 1995). This also uses a 7-point Likert scale.
- Multidimensional Perfectionism Scale (Frost, Marten, Lahart, & Rosenblate, 1990). This is a 35-item inventory using a 5-point Likert scale.
- Athletic Identity Measurement Scale (Brewer, Van Raalte, & Linder, 1993). This is a 10-item questionnaire with a 7-point Likert scale.
- Profile of Mood States (McNair, Lorr, & Droppleman, 1971). This assesses six different affect states, including: tension, depression, anger, confusion, fatigue and vigour.
- Raedeke and Smith (2001) have recently devised a new assessment tool specifically for burn out in sport.

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300 - 2197 promenade Riverside Drive
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March 15, 2002

MEDIA RELEASE

Most tests ever conducted by the CCES in one year

(Ottawa, ON) The Canadian Centre for Ethics in Sport's (CCES) is pleased to report that 3,400 doping control tests were conducted in the year 2001. This number represents the highest number of tests conducted by the CCES in any given year. Of the total tests conducted by the CCES, 2,299 of these tests were conducted on Canadian athletes.

Rosemary Foerster, the CCES's Drug-free Sport Program Manager, noted that "our increased testing level in 2001, both of Canadian athletes and international athletes training and competing in Canada, sends a strong message to all athletes that they may be tested anytime, anywhere".

The CCES reports statistics in the following categories:

Domestic Program: A total of 1,931 tests were conducted as part of the domestic testing program. Of these tests, 1,920 were conducted on Canadian athletes with 1,288 (67%) on an unannounced basis and 632 (33%) on an announced basis. Thirteen infractions were recorded in ten different sports including Athletics, Biathlon, Bobsleigh, Canadian Interuniversity Sport (CIS) (Basketball, Field Hockey, Football & Ice Hockey), Junior Football, Taekwondo and Weightlifting.

Major/International Games: A total of 921 tests were conducted at international events held in Canada last year resulting in 150 Canadian athletes and 771 foreign athletes being tested. A total of 36 international events were held in Canada where doping controls were conducted by the

CCES.

World Anti-Doping Agency (WADA) tests: A total of 430 tests were conducted at the request of the World Anti-Doping Agency. One hundred and fifty-six (156) tests were carried-out on Canadian athletes and 274 on foreign athletes. All of these tests were conducted on an unannounced basis.

International Federation (IF) tests: At the request of various International Federations, the CCES conducted 45 tests on foreign athletes last year. All of these tests were conducted on an unannounced basis.

Contract Service tests: As a result of requests received from sport organizations outside of the Canadian Policy on Doping in Sport, a total of 73 tests were conducted. One (1) infraction was recorded in the sport of Bodybuilding.

The CCES is responsible for all aspects of drug-free sport, including athlete testing. Recently certified under ISO 9002 for the management of its domestic doping control program, the CCES provides quarterly and annual reports of all doping control tests carried out in Canada.

For more information, please contact Paul Melia, Chief Operating Officer (ext. 3221) or Joseph de Pencier, Policy Advisor (ext. 3220) at the Canadian Centre for Ethics in



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ABS Gymball	55cm	STE01	\$29.20	\$1.75	\$2.04	\$33	x	\$
	65cm	STE02	\$31.86	\$1.91	\$2.23	\$36	x	\$
ABS PRO Gymballs	55cm	STE04	\$35.40	\$2.12	\$2.48	\$40	x	\$
	65cm	STE05	\$38.94	\$2.34	\$2.73	\$44	x	\$
	75cm	STE06	\$41.59	\$2.50	\$2.91	\$47	x	\$
Medicine Balls	1 kg	STE07	\$21.24	\$1.27	\$1.49	\$24	x	\$
	2 kg	STE08	\$30.09	\$1.81	\$2.11	\$34	x	\$
	3 kg	STE09	\$40.71	\$2.44	\$2.85	\$46	x	\$
	4 kg	STE10	\$49.56	\$2.97	\$3.47	\$56	x	\$
	5 kg	STE11	\$60.18	\$3.61	\$4.21	\$68	x	\$
SitFits	13"	STE12	\$39.82	\$2.39	\$2.79	\$45	x	\$
	15"	STE13	\$45.13	\$2.71	\$3.16	\$51	x	\$
Fit Tube	light	STE14	\$8.85	\$0.53	\$0.62	\$10	x	\$
	medium	STE15	\$9.74	\$0.58	\$0.68	\$11	x	\$
	strong	STE16	\$10.62	\$0.64	\$0.74	\$12	x	\$
Ankle Tube	light	STE17	\$11.50	\$0.69	\$0.81	\$13	x	\$
	medium	STE18	\$12.39	\$0.74	\$0.87	\$14	x	\$
Physio Toner	light	STE23	\$7.08	\$0.42	\$0.50	\$8	x	\$
	medium	STE24	\$7.97	\$0.48	\$0.56	\$9	x	\$
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 The Council has limited in stock supplies so most orders will be filled from 1-4 weeks.

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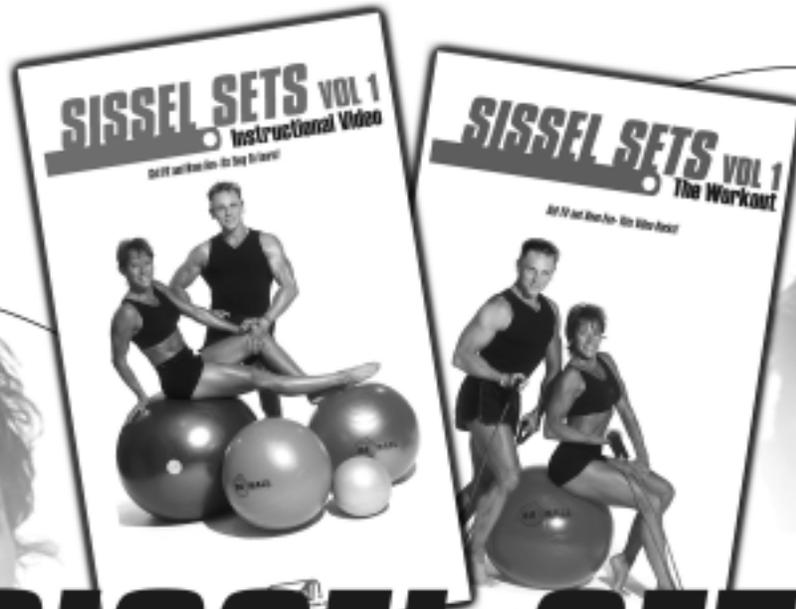
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NEW DOPING AGENT MADE OLYMPIC DEPUT

(taken from "The Physician and Sportsmedicine", April 2002 Edit.)



Three skiers, including two gold medallists, were disqualified from the Winter Olympic Games in Salt Lake City because they tested positive for darbepoietin, and analogue of erythropoietin (EPO). The drug, recently approved in the United States, offers less frequent dosing than EPO for the treatment of anemia associated with chronic renal disease.

Though darbepoietin is not specifically listed in the Olympic Movement Anti-Doping Code, the code states that substances related to EPO are prohibited. In a press release issued by the International Olympic Committee (IOC), Donald Catlin, MD, who headed the IOC-accredited drug testing lab during the Salt Lake City games, said that the urine test for EPO also detects darbepoietin, which can easily be differentiated from EPO because the new drug is an artificial substance.

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DRUG EDUCATION AND DOPING CONTROL WORKSHOPS

The 2003 Canada Winter Games is just around the corner. One of the requirements for all teams going to the Games is to attend a drug education and doping control workshop. As there will be testing at the Games we strongly encourage all coaches and managers to contact Scott Julé at the Sport Medicine and Science Council at 780-9446 and let him know when your camps will be held. Ideally we would like to be able to do as many sports as possible at each workshop. If two or more teams are training in the same city on the same weekend, we will make every attempt to accommodate everyone's schedule that weekend.



SPORT FIRST AID KITS AND SUPPLIES

The *Sport Medicine and Science Council of Saskatchewan* has available three different sizes of *sport first aid kits*. The kits are designed to be user friendly as each comes with a listing of the contents as well as a description of what each item is used for. In addition, all kits contain a sport injury prevention booklet that provides information in injury prevention, developing an emergency action plan, liability and risk management, and injury care.



The Council also sells individual supplies to re-stock current kits or to start a new kit. We can also develop sport 1st aid kits that are sport specific.

The kits and supplies are very reasonably priced. In some instances items are half the cost that you would find in retail outlets.

KIT PRICES: DELUXE \$285.00 STANDARD \$110.00 SMALL \$66.00
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SPORT BODY BASICS!

What You Need to Know About Osteoarthritis and Sport
Submitted by: Karen Craven B.Sc. (PT), Cert. Sport (PT)
Sport Body Basics Program Coordinator

Osteoarthritis (OA) is the eighth worldwide cause of disability with estimated costs of the disease at 15.5 billion dollars, largely from lost days from work¹⁰. OA is not a consequence of aging but rather a metabolic change in cartilage that results in degeneration of the cartilage. Individuals of all ages can be affected by osteoarthritis with 70 – 85% of the population over 55 years of age having radiographic evidence of these changes⁶.

Speculation exists about most of the risk factors for OA, but many researchers agree that injury can predispose a person to the development of OA^{2,3,4,6,7,10,12}. A mechanical injury to a joint results in a response of chondrocytes. Following an injury chondrocytes synthesize both collagen and proteoglycan at a markedly accelerated rate but the collagen fibers are thinner and much looser in their orientation. Enzymes (proteoglycanases and collagenases) are released from the chondrocytes. These enzymes degrade the proteoglycan and collagen of the cartilage. Inadequate repair mechanisms of cartilage make it more vulnerable to damage by extrinsic forces and cause more stress to the subchondral bone. These pathological changes compromise the joint's ability to withstand repetitive loads, cause joint space narrowing and eventually joint destruction. The types of injuries reported to have an influence on chondrocyte activity include: fractures, dislocations, meniscal tears, ligament injuries, contusions, and injuries which result in an irregular surface and angular deformity after healing^{1,5}.

Children of all ages are involved in various sports and with sport involvement there is a risk of injury. Young athletes have anatomical and developmental differences when compared to adults. The growth cartilage in children is less resistant to repeated microtrauma, and can result in overuse injuries. This leads to more injury at the epiphyseal plate, the joint surface, and the insertions of muscle-tendon units, usually due to the taut joint structures from body growth. The articular surfaces in children are more susceptible to joint shearing forces, and during rapid growth there are periods of decreased flexibility which can lead to tight muscle-tendon units; when these units are taut, there is increased risk of injury to muscle and surrounding structures which may lead to OA development⁸.



The cellular process of OA can begin during youth although clinical and radiological (x-rays) signs are not usually apparent until later in life. Due to lack of innervation (nerves) to the cartilage pain will not be felt until significant unreparable damage has occurred¹¹. Since children are susceptible to injury and injury leads to OA, we should be concerned with safe levels of sport participation and prevention and care of injury for children in order to prevent the pain and disability of OA in their futures.

The Arthritis Society – Saskatchewan Division has developed a health promotion program for youth entitled "Sport Body Basics". The Sport Body Basics program has been designed by Physical Therapists specialized in sports and rheumatology working together with members of The Arthritis Society. Sport Body Basics informs youth, ages 6-16 on prevention and care of sports injuries and about osteoarthritis (OA) and its relationship with sports. Sport Body Basics presents information on injury prevention and care. By actively involving youth in injury prevention early in their sport experience, Sport Body Basics hopes to establish lifelong practices that will prevent OA. The philosophy that Sport Body Basics encourages is injury prevention and care through the use of warm-up, stretches, conditioning and cool-down.

The Sport Body Basics program began in 1999 with the production of brochures on soccer and then hockey. These sports were selected based on their high incidence of injury. Hockey has a high incidence of joint injury because of the high speeds, frequent collisions, and potentially dangerous equipment¹. The high incidence of joint injury in soccer can be attributed to jumping, accelerating, turning, and torsional (twisting) movements¹.

In March 2002, we will go ONLINE! Sport Body Basics will have its own website- www.SportBodyBasics.ca. The website has been designed to attract youth: it will be interactive, animated and informative. It will include the prevention and conditioning exercises devised for soccer and hockey. In the near future figure skating will be added followed by other sports.

If you require further information please contact Karen Craven, Sport Body Basics Program Coordinator, at 306-244-9922 or email at kcraven@sk.arthritis.ca.

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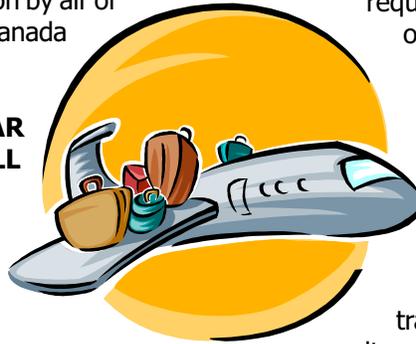
DANGEROUS GOODS CARRIED BY SPORTS TEAMS

(taken from Transport Canada's Website)

The Transportation of Dangerous Goods Regulations (TDGR), and by reference the International Civil Aviation Organization Technical Instruction for the Safe Transport of Dangerous Goods by Air (ICAO TIs), regulates the transportation by air of items classified as dangerous goods both in Canada and internationally.

THIS NOTICE IS FOR THE PARTICULAR ATTENTION OF SPORTS TEAMS AND ALL ATHLETES WHO TRAVEL BY AIR:

1. Each Passenger is responsible for any dangerous goods in his or her own checked or carry-on baggage.
2. Dangerous goods used in sports activities, such as battery-powered tools and equipment, propane torches, liquefied carbon dioxide for the treatment of sport-related injuries, first aid kits, compressed air cylinders, flammable adhesives, leather and fabric conditioner, aerosols, etc. are strictly prohibited for transfer on board an aircraft as passenger checked or carry-on baggage.



3. Transportation of Dangerous Goods Regulatory Training is required prior to offering these goods for transport as cargo. (The types of items listed above would require specific packaging and documentation in order to be transported by air as cargo).

4. Air operator acceptance staff and security screening personnel must be vigilant and adequately trained to identify dangerous goods carried by athletes.

5. Sports organizations should inform their members of the prohibitions surrounding the transport of dangerous goods by air and provide alternative methods of transporting such goods.

The TDGR, does permit some dangerous goods to be transported by passengers as checked or carry-on baggage on board an aircraft (certain conditions must be met). Please check their web-site at www.tc.gc.ca/en/menu.html

The Sport Medicine and Science Council of Saskatchewan would like to thank *Bauer/Nike* for their generous donation of new hockey equipment. This equipment is currently being used in the Council's Sport 1st Aid Course. It has proved to be an invaluable component of the course.



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HELP GOLFERS AVOID FOOT HAZARDS

(Taken from "The Physician and Sportsmedicine, Vol 29, No. 6)

Now that golf season is in full swing in most parts of the country, the American College of Foot and Ankle Surgeons (ACFAS) highlights foot problems that can occur in seasoned golfers.

Repeated movement and weight transfer during the golf swing is often the culprit. During the follow-through part of the swing, golfers can overextend the big toe joint of their back foot, leading to hallux limitus. "Those who have played the game avidly for several years can eventually wear out the cartilage or jam the big toe joint" says Daniel Hatch, DPM, a podiatric surgeon based in Denver, in a press release from the ACFAS. If left untreated, the condition can develop into arthritis, which makes it difficult to play golf. He notes that a history of big toe trauma or having a long first metatarsal puts the patient at risk for hallux limitus, Hatch notes that the orthoses can often provide relief, but that advanced cases may require surgery.



Weight transfer to the front of the foot during follow-through can lead to a neuroma at the bottom of the foot.

Poorly located spikes on a golf shoe are another cause of foot injury. Spikes directly beneath the ball of the foot can cause locally acute pain and swelling. Removing the offending spikes can relieve symptoms without sacrificing traction.

HAVE YOU EVER ASKED YOURSELF...

- as a parent or coach am I prepared to handle an emergency?
- am I even prepared to handle minor sport related injuries?
- do I have a base understanding of how to identify a sport injury?

If you answered "no" to even one of these questions then you will be interested in the Canadian Sport Safety Program (Sport First Aid Courses and Sport Taping Courses). Contact SMSCS office at 1-888-350-5558 for more details.

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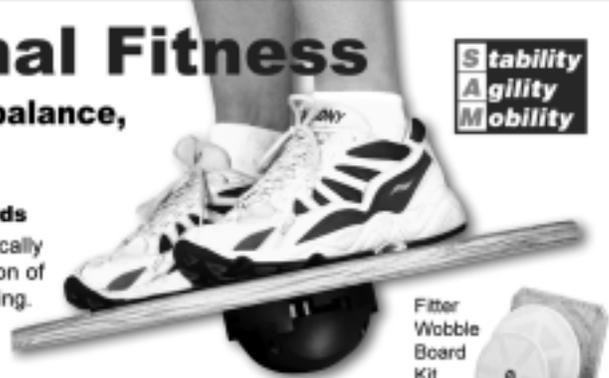
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Running Research News
by Walt Reynolds, Vol 14, #10



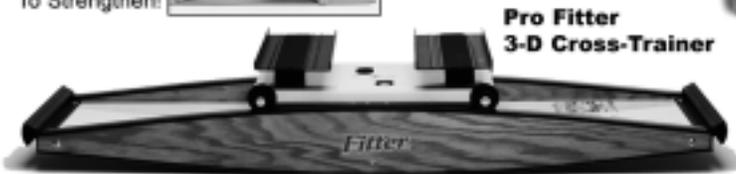
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