HOW TO NAVIGATE THE INJURY REPORT

By Dr. W. David Hovis, M.D. and Dr. Jene Bramel, M.D.
with Joe Bryant

"Stay healthy." If you listen to opposing players talk after a game, that's the parting phrase you'll hear repeated. And for good reason – avoiding serious injury is a key to success.

But in a game like football, few players dodge the injury bullet for long. There will come a time when your player is injured. To succeed in fantasy football, you'll need to understand the basics of the different injuries, and more importantly, what kind of timeframe the injured player is looking at before returning to action.

To find answers to these questions, we consulted experts. Dr. David Hovis is an orthopedic surgeon specializing in Sports Medicine. He's a Team Physician for the United States Alpine Ski Team and he served as the Assistant Team Physician for the Denver Broncos. He's published numerous articles and has made many national presentations covering Sports Medicine with a particular focus on knee and shoulder injuries. He was gracious enough to give us the inside scoop on navigating the injury report. Dr. Jene Bramel is a member of our Footballguys staff, but his real job is at an Urgent Care Unit where he often diagnoses and treats the types of injuries discussed here.

SPRAINS VS. STRAINS

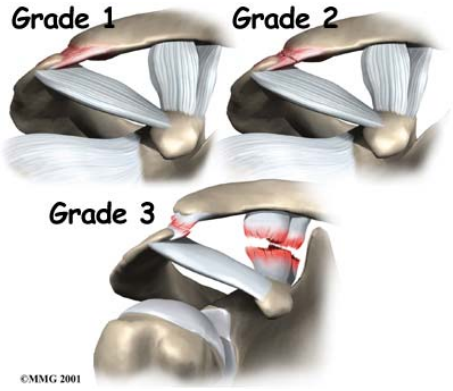
A **sprain** refers to a stretching injury to a *ligament*. Regardless, of the anatomic location, sprains are generally graded 1, 2, or 3, depending on severity. A Grade 1 sprain is simply a stretch injury to the ligament without significant tearing of fibers and no instability. Grade 1 sprains heal without surgery. A Grade 2 sprain denotes a partial tear to the ligament and while mild instability is possible, these injuries generally heal without surgery. Grade 3 sprains are complete tears of the ligament. Instability exists and treatment depends upon anatomic location. Surgery is often required, depending on where the injury occurs.

A **strain** is a stretching injury to a *muscle* or *tendon*. Hamstring or groin pulls are strain injuries. Strains can be graded as well, just like sprains. A Grade 1 muscle strain will be fairly minor, a Grade 2 strain would be a partial tear of the muscle and a Grade 3 strain would be a complete tear of the muscle belly. As we all know from following players with hamstring injuries, these problems can be nagging and extremely troublesome. The pressure of returning too quickly from injury can often entrap the player in a cycle of rehab followed by re-injury.

Let's take a look at some injuries and how they're treated.

SHOULDER INJURIES

Acromioclavicular joint (AC) shoulder separation. This is also known as a separated shoulder. This injury occurs as a result of a hit or blow to the top part of the shoulder, depressing the scapula (shoulder blade) and tearing the ligaments between the scapula and clavicle (collar bone). The classic case where you see this injury is when a QB is sacked and driven to the turf shoulder first. These don't usually require surgery and length of rehab depends upon severity and player position. For example, a quarterback with an AC separation on his throwing shoulder will obviously be a more serious injury than a similar injury to a wide receiver.

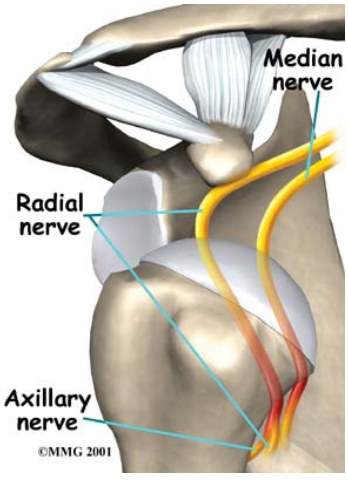


Treatment and Return to play: For less severe Grade 1 injuries, return to play may be immediate, especially with a pain killing injection. More severe injuries with Grade 2 or Grade 3 damage may take six weeks or even more.

Dislocated shoulder with anterior instability. The most common shoulder dislocation in football is out the front, or anterior. Dislocations occurring traumatically in this direction often tear the labrum in the front part of the shoulder, leaving the shoulder at risk for recurring dislocations.

Treatment and Return to play: For return to play, surgery is usually required to repair the torn labrum. The subsequent rehab is about four months, which means these are often season ending injuries.

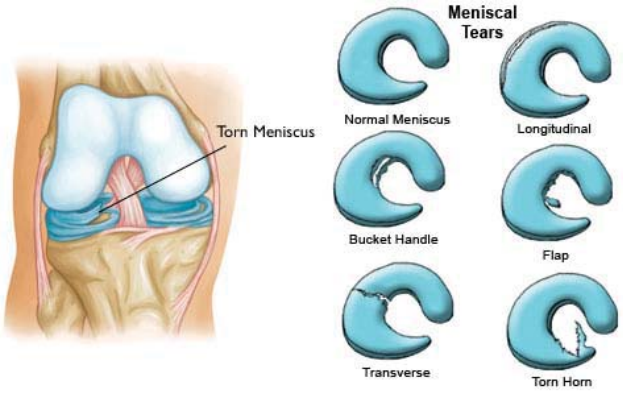
Note the big difference between a shoulder separation and a shoulder dislocation.



KNEE INJURIES

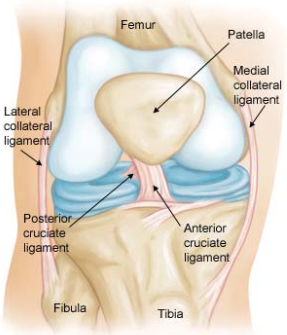
There are two types of cartilage in the knee, meniscal cartilage and articular cartilage. The great majority of knee cartilage injuries involve the meniscal cartilage. There are four major ligaments and several smaller ligaments around the knee. The major ligaments, in descending order of frequency of injury, are: medial collateral ligament (MCL), anterior cruciate ligament (ACL), posterior cruciate ligament (PCL), and lateral collateral ligament (LCL). MCL and ACL injuries comprise the majority of knee ligament injuries.

Meniscal tear. Think of the meniscal cartilage as a "shock absorber" between the femur (thigh bone) and the tibia (shin bone). Isolated meniscal tears are the most common knee injury in football. They are easily and commonly treated with arthroscopic resection (surgery). Making two or three tiny incisions on the front part of the knee, a camera and instruments can be inserted to clean out, or resect, the torn cartilage. The procedure is quick and players begin rehab immediately.

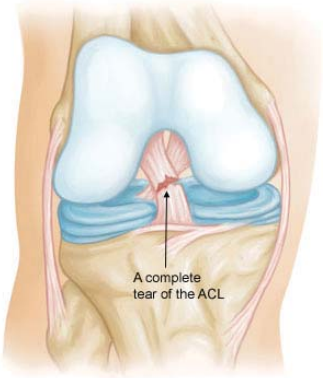


Treatment and Return to play: Recovery times for meniscal tears vary widely. Return to play usually depends on return of muscle strength and also depends heavily on the individual. Quick healers with minor tears may return to action quickly, but most players take longer to return. Often, arthroscopic surgery is necessary to repair torn meniscal cartilage. Most players take four weeks to return after surgery, as Reggie Bush did in 2008.

Anterior cruciate ligament (ACL) tear. If you were going to design a sport to create ACL tears, you would be hard-pressed to do better than football. The ACL controls stability to the knee by limiting anterior translation or shifting of the knee and coupling rotational motion of the knee. When the player plants his foot to cut and change direction, the ACL is placed under stress as it controls and couples the motion. If the stress is too much, the ligament can tear in a non-contact injury. Add to this scenario a blow from the side as in a linebacker tackling a running back, and the prevalence of ACL injuries goes way up. A healthy anterior cruciate ligament is a requirement to effectively cut side-to-side on the field.

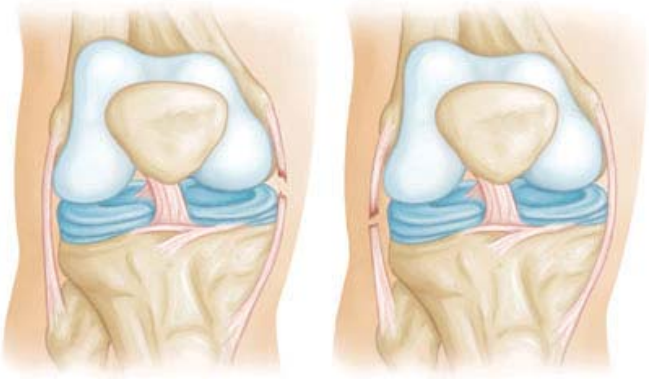


While there are some players who have navigated the football field for a whole career with an ACL deficient knee (John Elway had torn ACLs in both knees his whole career), today, a torn anterior cruciate ligament almost always means reconstruction. ACL reconstruction is performed by taking a tendon graft either from the player's own knee or from donated tissue in a tissue bank and routing it through drill holes in the bone to the exact location of the once-healthy ACL. The graft is generally fixed with screws on either side.



Treatment and Return to play: It's interesting that for ACL injuries, a great majority of them are Grade 3 or complete tears. In other words, when you hear "ACL Injury," there's a very good chance we're talking about a serious injury. Six months or longer is often required for a player to return from reconstructive ACL surgery. There are anecdotal stories of athletes returning to play in the same season but often with negative consequences. Jerry Rice reinjured his knee after returning in the same season with a very accelerated rehab program. If a player has an ACL reconstruction, this should be considered a season-ending injury. In fact, there is rampant speculation that a player may take up to 18 months to fully return to his pre-injury form.

Medial collateral ligament (MCL) tear. The MCL is subject to injury from a blow to the side of the knee. Offensive linemen are particularly prone to MCL injuries and most are prophylactically (not a word I get to write every day) braced to help prevent injury. In general, the braces are too restricting to be tolerated by most agility and speed players, but for lineman and less mobile QBs, it's a common protective precaution. (Peyton Manning has worn a protective knee brace on his left knee for several years.)

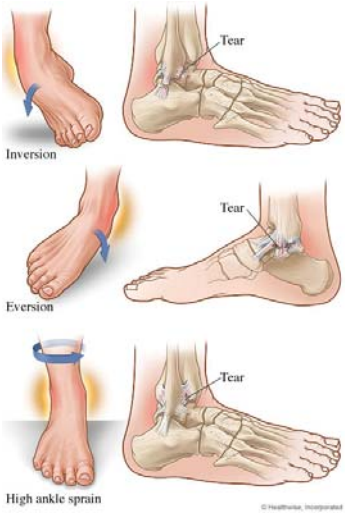


Treatment and Return to play: An injured medial collateral ligament often heals without surgery and responds well to bracing and rehab. Return to play depends on the grade of injury and player position. Most quarterbacks, receivers and running backs will return within two weeks with a Grade 1 sprain, as Indianapolis TE Dallas Clark did early in 2008. For a Grade 3 or complete tear, it can take up to six weeks to return. Houston QB Matt Schaub's month long recovery from a torn MCL in 2008 is the norm.

FOOT AND ANKLE INJURIES

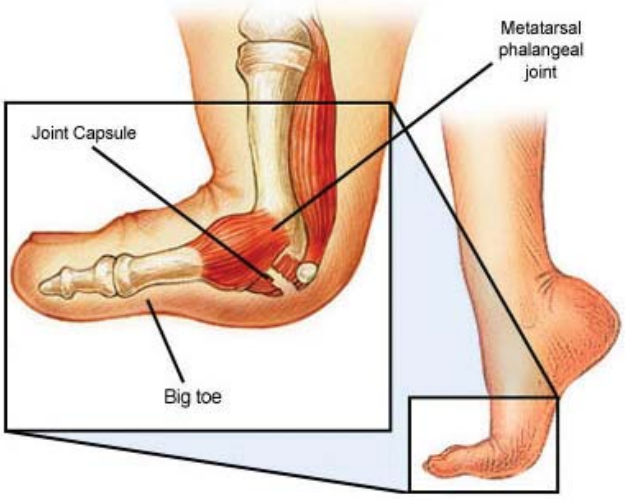
High ankle sprain. High ankle sprains are different from traditional sprained ankles in that the damaged ligaments are between the tibia and fibula, the lower leg bones that run from the knee to the ankle. The stout ligaments, called the "syndesmosis" or "syndesmotic ligaments" hold these bones together and can be stretched with a twisting mechanism of injury about the ankle. If severe enough, the ligaments can completely tear (Grade 3 sprain) and the fibula can even break. The most recent high profile instance of such a severe injury was that of Terrell Owens in 2004.

Syndesmotic injuries tend to heal more slowly than more common lateral ankle sprains. Treatment is determined by the stability of the ankle. If the ankle is stable, then the high ankle sprain can be treated in a cast or immobilizing boot. If the ankle is unstable, then "syndesmotic screws" can be placed between the tibia and fibula to hold the bones in proper alignment while the syndesmotic ligaments heal. Obviously, this would indicate a more serious injury with a longer recovery time.



Treatment and Return to play: For a Grade 1 or 2 high ankle sprain, a player can likely return in two to four weeks. If surgery is required, he can be out up to 12 weeks. Again, the fitness and motivation of the athlete can determine in large part how quickly he returns. For some athletes with little to play for, surgery following a high ankle sprain can end their season.

Turf toe. Turf toe is a hyperflexion injury of the big (great) toe. That means the big toe bends too far. Usually it's too far backward. This can produce a sprain of the capsule on the plantar (bottom) surface of the foot. Turf toe injuries are named due to the increased frequency with which these injuries are seen on artificial turf. Studies have shown that up to 87 percent of the turf toe injuries occur on artificial turf. The disparity is expected to decrease with the introduction of more player-friendly Field Turf, but turf toe injuries are expected to continue to be a common problem.



Treatment and Return to play: A Grade 1 sprain of the capsule is treated symptomatically and a rigid shoe insert often allows an immediate return to the field. "Treated symptomatically" means treating the symptoms of the injury, pain or swelling and so on. Grade 2 and 3 injuries are associated with increasing pain and usually require one to two weeks of rest, anti-inflammatories and icing. The rigid orthotics in the shoe usually allows return to play at that time. Also note that turf toe is similar to hamstring injuries in that it's one of those nagging types of injuries. Players often try to return too quickly and wind up injuring themselves even more. Darren McFadden's frustrating rookie season is a prime example of how difficult a turf toe injury can be to treat and return effectively in the same year.

STAPHYLOCOCCAL INFECTION

Infection has always been a known risk after a surgical procedure. In recent seasons, however, staph infections have approached epidemic proportions in NFL locker rooms. The problem first made headlines after multiple members of the Cleveland Browns were infected over a short period of time. In 2008, both Tom Brady and Peyton Manning had post-surgical complications blamed on a staph infection. The severity of these infections can be highly variable. Some minor infections may go unreported. More severe infections after major operations could set recovery times back by months. Invasive staph infections continue to steadily increase in frequency among the general public. Despite the best efforts of team training and medical staffs, these infections are likely to continue to be a problem in the NFL in coming seasons.

MRIS AND GAME-TIME DECISIONS

With the advancement in MRI diagnostics today, team physicians have a tremendous ability to diagnose injuries. MRIs show damage to the muscles, ligaments and tendons which an X-ray does not show well. When a player is injured, an MRI can be administered immediately and the results will be known right away. The team will often withhold that information until a course of action is determined, but they know what they're dealing with very soon after the injury occurs.

Often times, an athlete's playing status won't be determined until just before kickoff. This is the dreaded "game-time decision." In a great many cases, this decision has been made well before game time, but the team doesn't want to show its hand. In these cases, the best bet is to watch a player's participation in practice (or lack of it) through the week. Every team is different and one of the primary in-season tasks we perform at Footballguys is deciphering the signals regarding who will play and how effectively. Knowing that Jeff Fisher's "Questionable" is different from Andy Reid's "Questionable" or knowing which coaches enforce a fairly strict "practice to play" rule can make all the difference. That knowledge and experience with the coaches, plus the injury information here, should help shed some light as you navigate the sometimes tricky path of the injury report. Best of luck and here's hoping all your guys "stay healthy."