Entitled
By Robert S. Waskowitz, MD

We've come a long way. Forty years ago, we were forty years younger. Many were in the fledgling years of a career; some of us were attempting to figure out exactly what the word “career” meant. Challenges didn’t seem as significant, concerns appeared easier to tackle, and nothing seemed to stand in the way of one’s aspirations...

...unless you were a woman who wanted to pursue athletics.

This year marks the fortieth anniversary of Title IX, a decision that established the groundwork for gender equity in sports. It is worth looking back at history to move forward, as future foundations will be built upon past experience.

The reasoning behind the establishment of Title IX is important to understand. Prior to Title IX’s enactment, there existed an undercurrent of thought that women and girls could not, or even should not, compete on the playing field. That mindset even extended to arguments that females were not physically capable of performing in sports. This opinion was not based on any science or study, but was rooted in the idea that there existed gender differences that needed to be upheld. This baseless stereotype of male exclusivity over female in sport was a product of the time predating the 1950s, 60s and 70s. As opinions and facts evolved, this mindset changed. A groundswell of gender equality and recognition attained prominence and led Congress to enact Title IX in 1972. Initially, the statute was designed to prohibit gender discrimination in programs that received federal financial support, providing an equal opportunity for participation in tax-supported programs. The Title IX bill was introduced to Congress by Senator Birch Bayh of Indiana. The bill passed through the House Subcommittee on Higher Education, the Senate, and the full House of Representatives. It was signed into law by President Richard Nixon on June 23, 1972. The statute itself underwent revision from its original form to include intercollegiate sports, and eventually was applied to high schools, colleges and universities that received government support.

Sports Hygiene: Soap, Water and Common Sense
By Thomas G. Ward, MD

Cleanliness is important, particularly for wrestlers. Sports hygiene is also a significant factor for athletes participating in rugby, football, hockey, and boxing. Mixed martial arts (MMA), a new player on the field, can be affected as well.

Herpes Simplex Virus Type 1 (HSV-1)

In recent years, Herpes gladiatorum (HG), caused by HSV-1 (also known as Herpes labialis), has received a great deal of attention. HSV is of particular concern, given its ability to spread quickly (within 6.8 days of contact). Current data suggests that 29.8% of college wrestlers had reported previous HSV infection. There have even been recommendations to place all wrestling camp participants on prophylactic antiviral medication to prevent outbreaks. HSV infection can have long-term, or even career-ending, consequences for the infected athlete.

HSV-1 is the agent of vesicle-like lesions, commonly called cold sores. HSV-1 can cause disease in other anatomic locations. Inoculation at mucosal surface or skin sites permits entry of HSV-1 into the epidermis, the dermis and on into the sensory and nerve endings. The primary onset after this entry is sudden, with multiple vesicular lesions on top of an inflamed erythematous base. Fever and fatigue may accompany the infection; lesions can last 10-14 days. Most primary HSV-1 infections are asymptomatic. The virus as we know lives in a latent state in nerve bodies.
Dear SportsMed Reader:

This issue of SportsMed coincides with the 40th anniversary of the passage of Title IX. The act has drawn as many praises as it has criticisms. However, as Dr. Waskowitz points out, the act accomplishes its goal of improving and equalizing opportunities for women in sport. Looking simply at the increased number of females participating in sports today – at all levels – confirms the success of this goal of the act. In this issue’s other article by Dr. Thomas Ward highlights the issues surrounding infectious skin diseases. This is an ongoing issue in all sports, but especially so in sports requiring repeated or continuous body contact. Unfortunately, as Dr. Ward notes, many contagious skin infections exist and are often cared for less than they should be. Some of this is due to a lack of recognition of the diseases, as well as many of these conditions not being brought to the attention of appropriate caregivers. I encourage all providers involved in caring for athletes such as these to read his article in hopes of improving the health of the athletes while also lessening the loss of participation time for affected athletes.

I also want to update readers on the progress being made on establishing an injury surveillance system (ISS) in Connecticut. In March of this year, SB 966 was introduced to the State Legislature proposing the establishment of an ISS. The swelling of support for the program is encouraging. With the help of several Connecticut organizations, as well as the opportunity to coordinate and utilize a national injury surveillance program (RIO), the ISS will start up with the fall sports season this year. The system will allow us to gain information upon which to make informed decisions to protect the health and safety for student-athletes participating on Connecticut fields, rinks, and courts. We welcome all who might be interested in being involved to contact a member of the Sports Medicine Committee on the Medical Aspects of Sport. The project is a large one, but its benefit for athletes will be significant. Thank you in advance for your assistance.

Sincerely,

Carl W. Nissen, MD
Chairman, Committee on the Medical Aspects of Sports

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Connecticut SportsMed
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Entitled
continued from page 1

The statute evolved in content to its final regulation in 1975 to say:

No person shall, on the basis of sex, be excluded from participation in, be denied the benefits of, be treated differently from another person or otherwise be discriminated against in any interscholastic, intercollegiate, club or intramural athletics offered by a recipient...etc.

The importance of inclusion over exclusion in sport is far-reaching. The lifetime benefits of sports participation have been discussed in many forums. It is understood that a healthy active lifestyle promotes both physical and psychological well-being. The experiences gained on and off the field expose a participant to the concepts of teamwork and leadership. Time management enables a competitor to strengthen self-discipline and enhance the ability to become involved. It is thought that these benefits may lead to improved academic performance, higher self-esteem and positive social behavior.

The essential tenet of Title IX is to provide equal opportunity for both sexes. It does not require preferential treatment to the female athlete, as this in itself would imply gender bias. It also does not require an institution to have the same teams for men and women, nor to have gender assimilated teams. A point that has stimulated discussion, however, is that where a school has a separate men’s and women’s athletic program, Title IX does require equivalent opportunities for both sexes. This “equality” in opportunity has been left up to interpretation for each institution in determining whether there are comparable programs available for men and women. The statute does not mandate that the same teams need to exist for both sexes, but an initial interpretation of the law was that certain men’s teams would necessarily need to be “dropped” from a program in order to accommodate for the opportunity for women. This concern, however, did not lead to across-the-board cuts in men’s programs and did lead to positive changes in the number of athletic teams offered for women by many institutions.

Compliance with Title IX is based on defined institutional benchmarks. Equal treatment is evaluated by the U.S. Department of Education on a number of factors, including:

1. Whether sport selection and competition reflects the interests and abilities of both sexes
2. Provision of equipment and supplies
3. Scheduling of games and practice slots
4. Allowance for daily and travel expenses
5. Opportunity to receive academic tutoring
6. Coach and Tutor assignment and compensation
7. Locker room, practice and competition facilities
8. Medical/Training facilities and services
9. Housing/Dining facilities and services
10. Publicity

The Department of Health Education and Welfare delineated three ways that compliance could be achieved, known as the “Three Part Test.” An institute can demonstrate compliance by meeting any one of the following three parameters:

1. Provide participation opportunities that are substantially proportionate to student enrollment;
2. Demonstrate continued expansion of opportunities for the underrepresented sex; or
3. Accommodate the interest and ability of the underrepresented sex.

The Connecticut experience demonstrates a representative example of the dramatic increase of female involvement in sports. Available quantified records at the high school level date back to 2001-02. There are differences in the current requirements for entering eligibility lists, compared to what was standardized then. With that in mind, the total number of girls registered on lists in 2001-02 was 37,748; in 2006-07 the number increased to 44,865; and in 2011-12 the number escalated to 50,498. The number continues to grow, as this tabulation does not include the spring athletic season (Hoey and Fischer, CIAC 2013). This translates to an 18.8% increase from 2001 to 2006, and a trending increase of 12.5% from 2006 to 2012. Over the ten-year span, the increase trends to approximately 33.7%.

Title IX has changed the basis of sports competition by enabling participation based on equality and not performance. To this end, both male and female athletes have succeeded in establishing exemplary role models for future generations. Specific to

(cont. on p. 4)
female athletes, gender equality has brought to the forefront recognition of the concept of a “star athlete,” not just a “female star.” A list of the all-time top female athletes is impossible to compile, but several names reoccur on most rosters of the “greatest” competitors. Of these, ten important female athletes were instrumental in establishing the “Female Athlete” as a force to be reckoned with, including: Jackie Joyner-Kersee (Track and Field) age 10 when Title IX passed; Babe Didrickson Zaharias (multi-sport, 1911-1956); Billie Jean King (Tennis) age 29 when Title IX passed; Sonja Henie (Figure Skating, 1912-1969); Martina Navratilova and Chris Evert (Tennis) ages 16 and 18 when Title IX passed; Bonnie Blair (Speed Skating) age 32 when Title IX passed; Nadia Comaneci (Gymnastics) age 11 when Title IX passed. These few gave a name and face to female athletics that signified a progressive evolution of gender equity in sports. At the local level, top female athletes in Connecticut have compiled stellar careers and paved the way for the next generation of regional female stars. Among many names, this list includes: Jen Rizzotti, Diana Taurasi, Rebecca Lobo, Sue Bird, Maya Moore, and Kristine Lilly. All were born after Title IX was enacted, except for Lilly who at the time was the ripe old age of one year.

At this milestone mark in its establishment, Title IX celebrates its fortieth anniversary with a bright future. Title IX needs to continue its evolution as one door closes and another opens. As a sports medicine community, we gain insight from where we have been in order to plan for the future. What might be the next topic to stimulate discussion: paying the student-athletes for their performances? That will be another topic at another time.

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LEGAL REFERENCES
Athletics Scholarship regulation: 34 CFR 106.37(c) July 1975.

Connecticut State Medical Society and Connecticut Medicine present:

2013 Healthcare Leaders & Innovators Awards

As the healthcare landscape continues to change, Connecticut physicians are looking for new ways to face those challenges. In recognition of the many ways our members have developed creative and innovative approaches to the modern practice of medicine, Connecticut State Medical Society (CSMS) and Connecticut Medicine are pleased to present the 2013 Healthcare Leaders and Innovators Awards.

This award will recognize physicians at all stages of practice who have demonstrated exceptional commitment to leadership and innovation. Nominations from fellow physicians are being accepted through July 1, 2013. To download a nomination form, please visit www.csms.org.

The Awards will be presented at the CSMS House of Delegates meeting in September 2013. Winners will be featured in a special section of the October 2013 issue of Connecticut Medicine.

Nominees must hold active CSMS membership. They must have demonstrated proven leadership accomplishments in their medical fields and/or innovative achievements in the medical profession.

Categories for nomination include:
• Active practice (private practice or group) • Senior/retired • Medical student • Resident/Fellow

For questions, please contact Connecticut Medicine Managing Editor Patrick Prince at pprince@csms.com, or call 203-865-0587 x113.

The deadline for nominations is July 1, 2013.
Unlike primary HSV-1, recurrent HSV-1 is rarely associated with systemic signs or symptoms. Most patients are aware of its reactivation with such sensation as pain, burning, tingling or pruritis. Triggers are predictable for the individual and tend to recur at the same site. Subclinical shedding is common. Factors that induce HSV-1 recurrence include trauma to the area of primary infection, sunlight, fever, menstruation, and emotional stress. Of note, primary ocular HSV infection can occur in less than 5% of patients.\(^3\) On diagnosis of these lesions, antiviral medications such as acyclovir, valacyclovir and famciclovir are treatments of choice.

### Prevention: The Name of the Game

Athletes are affected by other infectious skin offenders, such as MRSA, tinea (ringworm) and molluscum contagiosum that can spread quickly through a sports team. In all cases, prevention is the name of the game. Both the NCAA and the National Federation of State High School Associations (NFHS) are active in this pursuit. The NFHS website offers a Preventing Skin Infections webinar in conjunction with the NWCA (National Wrestling Coaches Association) and NATA (National Athletic Trainers Association).\(^4\) The webinar is available to coaches, trainers, team doctors, athletes, and parents.

Preventing Skin Infections is broken into several sections, including a description of the describes the pathology of infection, explains the differences between bacteria, fungi and viruses, and he webinar addresses the infection matrix (contacts contact made between athletes, their equipment and their environment) and provides strategies to break this infection matrix with the wash cycle. The webinar reinforces the need for athletes, team managers, trainers, coaches, athlete families and physicians to work together to prevent infection.

### The 3 Es of the Wash Cycle: Epidermis, Equipment and Environment

Epidermis is the athlete's envelope against infectious intruders. All athletes, especially those in sports with close skin-to-skin contact, should wash their bodies from head to toe before and after participation. (Whether athletic directors and coaches would allow this is another issue.)

Equipment must be kept clean. This includes elbow pads, knee pads, braces, mouth guards, head gear, helmets, uniforms and towels. Gear used next to the skin should be cleaned after every use. Mouth guards need to be cleaned. Dirty, smelly towels need to be placed in the laundry bins and sent to the washer.

Environment includes mats, weight training devices, exercise equipment, weight benches, equipment bags, lockers, locker rooms and showers. Anything that comes into contact with the skin needs to be wiped down after the proper cleanse. Showers and locker rooms need to be kept clean of all skin debris. These areas should be cleaned on a regular basis.

This all seems so simple and common-sense, but too often these measures are overlooked. For the athlete, proper sports hygiene could mean the difference between a championship season and one spent sitting the bench watching teammates compete.

THOMAS G. WARD, MD, is a pediatrician at Bristol Pediatric Center of ProHealth Physicians in Bristol, CT and a member of the CSMS Committee on Sports Medicine.

### REFERENCES

MEDICAL RELEASE FOR WRESTLER TO PARTICIPATE WITH SKIN LESION

Name: ____________________________________________ Date of Exam: ___ / ____ / ___

Diagnosis ____________________________________________

Location AND Number of Lesion(s) _______________________

Medication(s) used to treat lesion(s): _______________________

Date Treatment Started: ___ / ____ / ___

Form Expiration Date: ___ / ____ / ___

Earliest Date may return to participation: ___ / ____ / ___

Provider Signature ____________________________ Office Phone #: ______________________

Provider Name (Must be legible) __________________________

Office Address _______________________________________

Note to Appropriate Health-Care Professionals: Non-contagious lesions do not require treatment prior to return to participation (e.g. eczema, psoriasis, etc.). Please familiarize yourself with NFHS Rules 4-2-3, 4-2-4 and 4-2-5 which states:

“ART. 3 . . . If a participant is suspected by the referee or coach of having a communicable skin disease or any other condition that makes participation appear inadvisable, the coach shall provide current written documentation as defined by the NFHS or the state associations, from an appropriate health-care professional stating that the suspected disease or condition is not communicable and that the athlete’s participation would not be harmful to any opponent. This document shall be furnished at the weigh-in for the dual meet or tournament. The only exception would be if a designated, on-site meet appropriate health-care professional is present and is able to examine the wrestler either immediately prior to or immediately after the weigh-in. Covering a communicable condition shall not be considered acceptable and does not make the wrestler eligible to participate.”

“ART. 4 . . . If a designated on-site meet appropriate health-care professional is present, he/she may overrule the diagnosis of the appropriate health-care professional signing the medical release form for a wrestler to participate or not participate with a particular skin condition.”

“ART. 5 . . . A contestant may have documentation from an appropriate health-care professional only indicating a specific condition such as a birthmark or other non-communicable skin conditions such as psoriasis and eczema, and that documentation is valid for the duration of the season. It is valid with the understanding that a chronic condition could become secondarily infected and may require re-evaluation.”

Once a lesion is not considered contagious, it may be covered to allow participation.

Below are some treatment guidelines that suggest MINIMUM TREATMENT before return to wrestling:

Bacterial Diseases (impetigo, boils): To be considered “non-contagious,” all lesions must be scabbed over with no oozing or discharge and no new lesions should have occurred in the preceding 48 hours. Oral antibiotic for three days is considered a minimum to achieve that status. If new lesions continue to develop or drain after 72 hours, MRSA (Methicillin Resistant Staphylococcus Aureus) should be considered and minimum oral antibiotics should be extended to 10 days before returning the athlete to competition or until all lesions are scabbed over, whichever occurs last.

Herpetic Lesions (Simplex, fever blisters/cold sores, Zoster, Gladiatorum): To be considered “non-contagious,” all lesions must be scabbed over with no oozing or discharge and no new lesions should have occurred in the preceding 48 hours. For primary (first episode of Herpes Gladiatorum), wrestlers should be treated and not allowed to compete for a minimum of 10 days. If general body signs and symptoms like fever and swollen lymph nodes are present, that minimum period of treatment should be extended to 14 days. Recurrent outbreaks require a minimum of 120 hours or five full days of oral anti-viral treatment, again so long as no new lesions have developed and all lesions are scabbed over.

Tinea Lesions (ringworm scalp, skin): Oral or topical treatment for 72 hours on skin and 14 days on scalp.

Scabies, Head Lice: 24 hours after appropriate topical management.

Conjunctivitis (Pink Eye): 24 hours of topical or oral medication and no discharge.