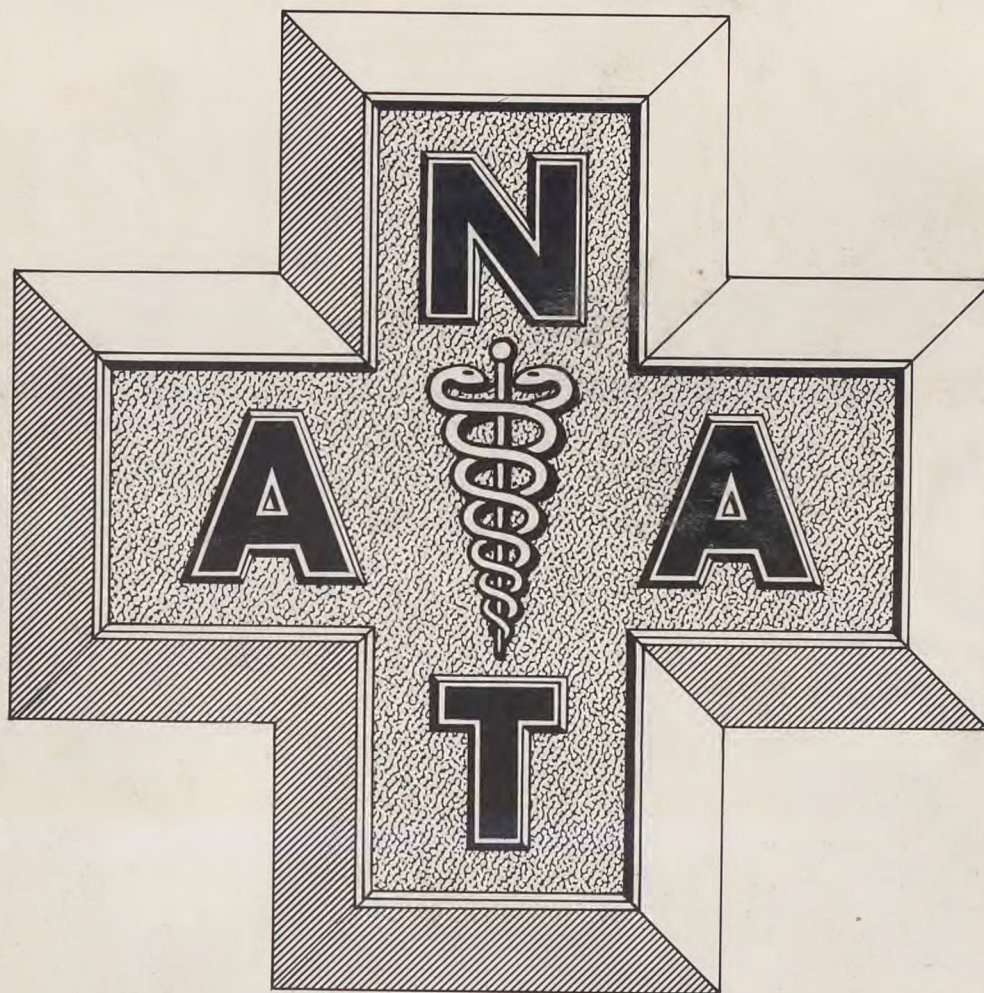


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THE **J**OURNAL  
*of the National Athletic Trainers Association*

WINTER 1965-66







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## CONTENTS

Establishing an Airway in Athletic Emergencies . . . . .	3
California Trainer Praised in Neck Injury Case . . . . .	10
Research Gives Support to Liquid Pregame Diet . . . . .	12
<i>Marvin Roberson</i>	
Athletes Warned About Anabolic Steroids . . . . .	14
<i>Wesley K. Ruff</i>	

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The *NATA Journal* editors welcome the submission of articles which may be of interest to persons engaged in or concerned with the progress of the athletic training profession. The following suggestions are offered to those submitting articles for consideration:

1. All manuscripts should be typewritten, double-spaced, on ordinary typing paper.
2. When references are made to other

published works, include superscript numerals and appropriate footnotes giving author, title of book or article, periodical or volume number, pages, and date of publication.

3. Photographs must be black-and-white prints, preferably on glossy paper. Graphs, charts, or figures should be clearly drawn on white paper, in a form which will be readable when reduced for publication.

4. It is the understanding of the *Journal* editors that any manuscripts submitted will not have been published previously.

Unused manuscripts will be returned when accompanied by a stamped, self-addressed envelope. Please address contributions to the Editor.

## EDITORIAL

**I**N OUR DAY-TO-DAY WORK most members of the National Athletic Trainers Association become so involved that there seems to be little time for extra activities in which we, because of our particular professional knowledge, might make a significant contribution. Yet it behooves us to be prepared for the future.

The nation always faces the prospect of massive disaster, possibly a military attack but also such events as the Texas City explosion and the Alaska earthquake. Usually such tragedies overload the capacity of local organizations to cope with first aid requirements; by the time outside help is brought to the scene there have been fatalities which could have been prevented with immediate attention.

In such situations, does it not make sense that trainers should be counted as a part of the ready reserve of human resources to combat death and agony?

How many trainers have made it known to our local fire and police departments that we would be available in such emergencies? How many of us have registered with local Civil Defense agencies? How many are aware of the nature and quantity of medical supplies available to Civil Defense authorities, and under what circumstances they might be used? How many have offered our skills as a back-up for the American Red Cross?

Trainers are not doctors, nor are we expected to be. Yet we *are* paramedical personnel, trained to work rapidly and effectively in time of personal injury. We also are qualified to instruct groups of laymen in medical self-help, not only in emergency situations but also as a part of community preparedness.

If each NATA member were thus "on call" in time of crisis, if he were also contributing to his community apart from his regular job, the potential of his town or city for coping with disaster would be significantly enlarged. It is to be hoped that America's trainers, each year a larger, better-trained, more professional corps of men concerned with human welfare, will make that distinguishing extra effort.



# ESTABLISHING AN AIRWAY IN ATHLETIC EMERGENCIES

*Purdue University physician outlines three emergency actions within the province of every trainer which each should be prepared to use as life-saving measures on the field.*

**T**HREE EMERGENCY ACTIONS within the competence of every trainer — establishing a proper airway, artificial respiration, and external heart massage—were emphasized by Dr. Loyal W. Combs, director of student health and team physician at Purdue University, in his address, "Establishing the Proper Airway in Athletic Emergencies," at the July national convention of the National Athletic Trainers Association.

Dr. Combs drew upon a tragic experience at Purdue during spring football practice last year, in which a player suffered a cervical vertebra injury which resulted in his death 12 hours later, to bring home to trainers the importance of their having immediately available the simple, inexpensive devices which can save a life on the field. In the Purdue case the athlete died despite having been brought back from both cardiac and respiratory arrest, so that everything which might have been done was done; yet, Dr. Combs pointed out, in another situation it may be emergency measures taken on the field which will save a life.

Early in his talk Dr. Combs made it clear that cardiac or respiratory arrest, or both, can occur in many sports. A blow to the chest from a baseball or bat, for instance, can stop the heart or cause a bronchial spasm which might well result in anoxia. In any case in which the trainer evaluates an injured athlete and finds him without a pulse or not breathing, he should take these steps immediately:

**1. Establish a proper airway.** Dr. Combs suggested at the outset that the oral screw used by some trainers to pry their way into an athlete's mouth ought to be thrown away. "If you have to screw your way into someone's mouth, just to get

inside, you are not going back to the rear where the obstruction actually is," he said. "His jaws may be clenched, or maybe because of motor irritation he is in convulsive seizure. . . . (but) as soon as he gets anoxic enough his muscles are going to relax and thus you are going to be able to get into the mouth adequately without trying to screw your way in with this oral screw."

He showed some airways which he considered suitable—plastic, metal, rubber, and rubber-tipped metal. He pointed out that a curved airway in particular was easy to use, simply by putting it on the back of the tongue and thrusting it gently down. Care should be taken to prevent injury to the rear of the mouth.

In the case of a rubber airway, Dr. Combs had this to say: "When we took our injured boy to the hospital we had our own airway in him. The nurse in the emergency room wanted to give us our airway back, so she took it out and put in a rubber one. When he was about halfway conscious he just chewed it off, so we had to put the metal one back in."

**2. Provide artificial respiration.** Better than mouth-to-mouth resuscitation, which he still considers "excellent," is one of a variety of bellows now available, Dr. Combs believes. They provide a means for "breathing" artificially, with intermittent, positive pressure, and they can be operated by anyone—another player, a coach—simply by pumping at the normal rate of breathing. This is particularly valuable when the trainer must also apply cardiac massage when the injured person is in both cardiac and respiratory arrest.

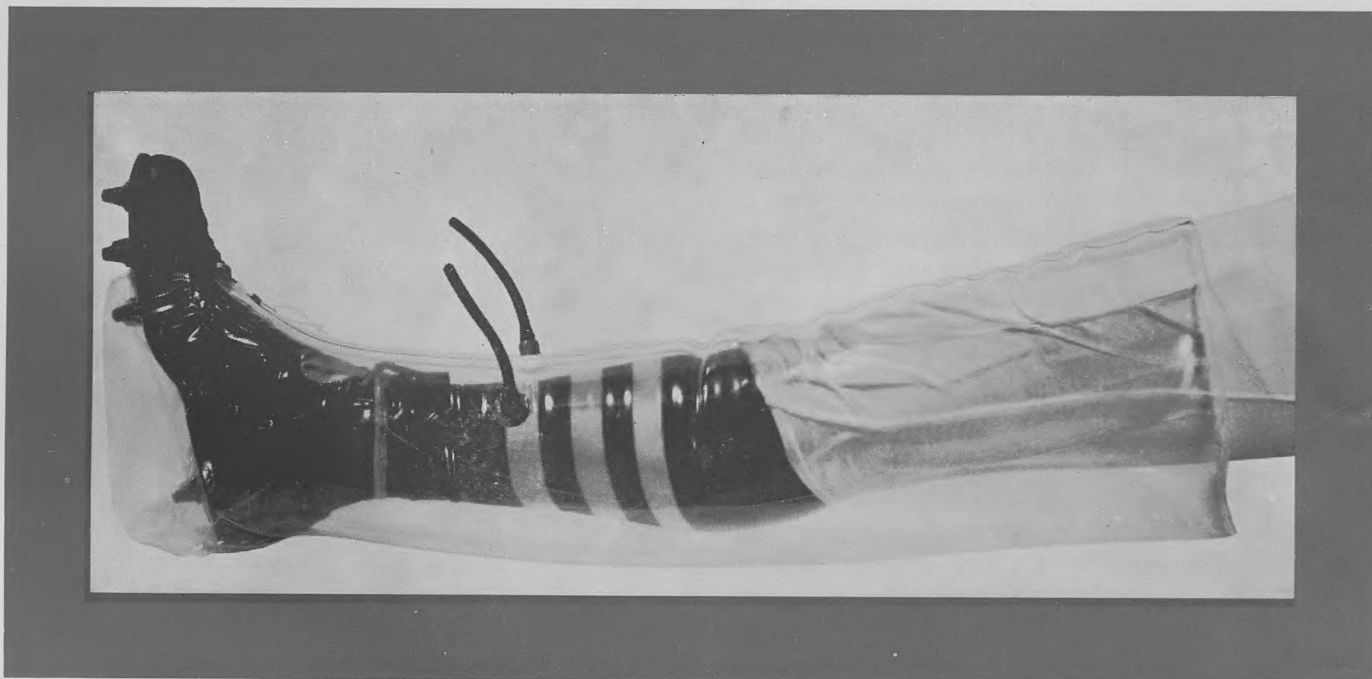
**3. Provide cardiac massage.** "There isn't

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DAVID C. BLANCHARD, assistant trainer at Stanford University, demonstrates to a group of students some basic equipment and techniques in emergency aid: (from top left) Use of the common plastic mouth-to-mouth airway, use of the bellows-type hand resuscitator, and external heart massage.

any reason that you as a trainer cannot start an external cardiac massage," said Dr. Combs. "This means no more than that you get on top of him, put the palm of your hand on the lower part of the breastbone, and start pumping at the rate of the normal heartbeat—50 to 70 times a minute. Don't be afraid to compress them. These are big, muscular, strong people."

Dr. Combs said that in the case of the fatally injured Purdue player "we only pumped him four or five times and he started to get some heart action."

WHILE THESE were the major points Dr. Combs made, he touched upon many others in passing. For example, he warned against jerking off a football player's helmet, for fear of aggravating possible cervical injury. It may be necessary to remove it partly, or cut it off, to establish an airway, but nothing more than that





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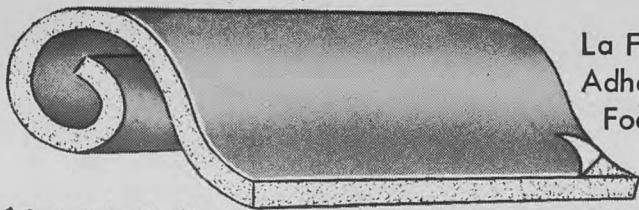
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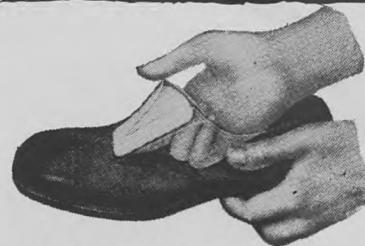
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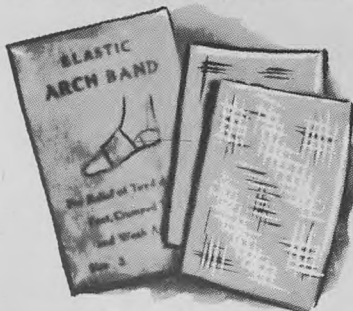
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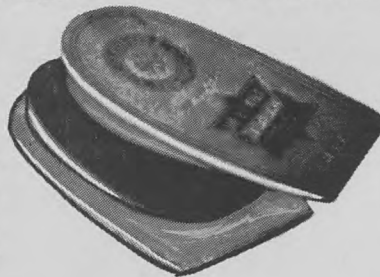
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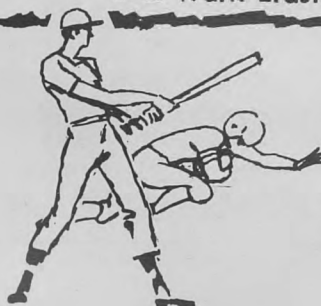
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need be done. Getting air to the patient's lungs and assuring a heartbeat are the critical problem—to delay by seconds or minutes will result in brain damage from anoxia.

In order to apply external cardiac massage it usually is necessary to remove the shoulder pads. Again, they should be cut free, gently, to protect against further injury.

"People don't swallow their tongues. The tongue merely relaxes and obstructs the rear of the mouth. It is no problem to insert an airway."

Respiratory obstruction, he pointed out, is something different from respiratory arrest. Dental plates he did not consider to be a serious problem, but he cautioned against permitting athletes to chew gum or any substance on which they conceivably could choke.

In cases in which the injury is obviously serious, waste no time in having an ambulance called, he said. While the trainer is doing everything he can to solve the problem, the ambulance ought to be getting there to take the injured man to a facility that can give him maximum care.

In recommending the airway and bellows, Dr. Combs said, "Of course, this equipment is not going to do any good sitting in the training room. This should be out on the playing field."

A number of questions were posed to Dr. Combs when he had finished his discussion. These were some:

**Q.** In handling such serious injury, in what position should the head be?

**A.** I am glad you brought that up . . . this is of real importance. The chin should be extended and the head should be back. In this way you are not kinking the trachea. . . . The patient may be vomiting, which he could be doing in the case of a head injury. After you get in your airway, you may have to turn the individual on his side or on his face. . . . The position also is important in relation to the insertion of the airway. . . . When the head is properly back there is no problem to slipping in an airway.

**Q.** Would you still do this if you had a cervical injury and the patient wasn't breathing?

**A.** Yes, I would still gently tilt the head. I am not going to know on the field whether there was a fracture to the cervical spine. The important thing I know at this point is that the patient is not breathing and that I do have to establish an airway so that I can help him breathe, or he is going to die. Therefore, you don't have to throw the head back,

but you can gently put the head back enough to insert the airway.

**Q.** Is there any indication or reason for a trainer to do a tracheotomy?

**A.** Well, my answer would be that if I were a trainer I don't think I would attempt a tracheotomy. . . . If you establish an airway . . . then you are going to correct most of the problem. The only indication for doing a tracheotomy is if there is some respiratory obstruction, something in the throat so that you cannot get an airway through. Even in the fracture with compression you can still get an airway through. . . . People die if they aspirate a chunk of meat or something like this. I think you can eliminate those problems before they happen. In other words, don't let people chew two or three pieces of gum or tobacco.

**Q.** In the case of hemorrhage, where the person has been hit in the throat with a baseball, have you any suggestions?

**A.** If a man had a hemorrhage, of course he would be aspirating blood . . . here, once again, position is important. You still endeavor to get an airway. The air will come through the airway and the blood will be around the airway, and then your position is important.

Of course, every man here has to realize his limitations. . . . However, the thing I am trying to impress upon you is that there are certain things you can do, within your individual limitations. We don't expect you to do tracheotomies and to stop massive hemorrhage, but you can use common sense in establishing an airway.

**Q.** When you get into the back part of the neck, how about the patient's fear?

**A.** Fear is important in connection with any sickness or injury. The art of training, gentlemen, is the same as the art of medicine—the things that you have done prior to the injury are the important things in controlling fear in athletes. An athlete already knows you, he wants you, he has an affection for you, he has confidence in you. . . .

**Q.** I brought this up in relation to the trainer talking to the patient in order to calm him down.

**A.** When you have a respiratory arrest there are probably going to be convulsions and that patient will not be talking to you. Now, if he has had a blow on the neck and is conscious, certainly he is going to be afraid. Therefore, it is the rapport you have with these patients that will be of real importance.







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Rae Anders, Sacramento State College (Calif.) gymnast who suffered a dislocated neck in a trampoline accident, is shown during traction in Mercy Hospital, Sacramento. Chatting with him is LVN Mrs. E. J. Hughes. At left is Lew Crowl, SSC trainer, whose careful handling of Anders immediately after the accident has been credited by the attending physician with saving the youth from permanent paralysis.

—Photos by Erhardt Krause, courtesy of The Sacramento Bee.



## California Trainer Praised in Neck Injury Case

**L**EW CROWL, trainer at Sacramento State College in California, is being given a good deal credit for the prompt and intelligently applied emergency care that apparently has saved one of the College athletes from a life as a quadriplegic.

On December 20 Rae Anders, 19-year-old sophomore gymnast, over-spun while doing a trampoline practice routine and landed on his head. He went limp in the middle of the trampoline but was conscious when Crowl arrived from the training room.

"I eased carefully onto the trampoline and placed a hand under his neck, steadying his head, because there was a bow in that area from the curvature of the mat and it could have caused some pressure on the neck," said Lew. "I pinched his arms and legs and plucked a few hairs. Except for the upper part of his arms, he had no feeling. He was paralyzed from the nipple line down."

An orthopedic surgeon arrived 20 minutes after the accident to supervise movement of the athlete to the hospital. Once there, X-rays showed a dislocation of the fifth on the sixth cervical vertebra, and traction was immediately applied. The surgeon, Dr. Harold B. Strauch, said, "We started with an 8-pound weight. We weren't having much success with that so we used a 28-pound weight for an hour. After that he was able to move his toes, and in a couple of days he was on his way to recovery."

Today Anders is back on his feet and attending classes, wearing a back brace and undergoing therapy. Surgery is a possibility later, but he is well on his way to complete recovery.

About Crowl's part in the treatment Dr. Strauch said, "Lew did the right thing in keeping the boy's head still. It had to be a terrifying experience for Rae, and Lew gave him comfort."

"I imagine many athletes take their coaches and trainers for granted. Rae is lucky Crowl was around. . . . If Lew had allowed the boy to be moved, that dislocated vertebra would have damaged the spinal cord and paralysis would have been permanent."

Anders spent a good many days in traction, with the 8-pound weight pulling on skeletal tongs attached to 1/8th-inch holes drilled in his skull. According to Dr. Strauch the youth showed "a tremendous amount of courage."

Lew Crowl has been head trainer at Sacramento State since 1961. He came from Ohio State University, where he spent three years as assistant to Ernie Biggs (and for three years before that a student assistant while he was earning his bachelor's degree in physical therapy). He received his M.A. from Ohio State in 1964. In a note to *The Journal* Lew wrote, "I would like to express my thanks and appreciation to Ernie Biggs. . . . Care and treatment of these injuries become routine for most trainers, but only because we have been well-trained by others."



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# RESEARCH GIVES SUPPORT TO LIQUID PREGAME DIET

*Experiments by University of Nebraska Health Service  
staff bring success in control of digestive upset.  
Others have found liquid nutriments helpful in  
controlling weight and maintaining strength.*

By MARVIN ROBERSON

*Trainer, Foothill College  
Los Altos, California*

THERE ISN'T MUCH NEW about the theory that violent exercise immediately after a heavy meal is quite likely to result in digestive upset. It is probable that our caveman ancestors realized they weren't much good at chasing sabre-toothed tigers right after they had gorged themselves on mammoth steak.

Yet even in our advanced society, and in extremely well organized competitive systems such as intercollegiate athletics, the experience of centuries and the lessons of research are ignored often enough to produce an unconscionable amount of such digestive upset.

Investigations into proper nutrition for athletes have been going on for many years. Notably since World War II there has been much discovered about the nature, amount, and timing of meals for athletes. Significantly, the most recent of this research, on liquid pregame diets, creates some very strong doubts about the validity of the generally accepted "strong boy" diet of steak and potatoes.

The athletic trainer has always faced a problem in keeping his charges on a proper diet, properly timed. Now comes a new problem: convincing the athlete that he doesn't *really* need a steak for breakfast in order to play well in the afternoon, and in fact that he might play *better* if he avoids the steak until after the game.

The basis for this contention comes largely

from a review of research findings by Dr. Kenneth D. Rose and his associates at the University of Nebraska. They have worked continuously on the problems of nutrition for athletes for the past six years. They have reported their findings on various occasions, one of the earliest being at the 1960 convention of the National Athletic Trainers Association in Kansas City. Their primary purpose has been to circumvent pregame nausea and vomiting, an effort in which they have had marked success; a secondary gain from their experiments has been an improved sense of well-being on the part of the athlete during competition.

The starting point was the concern expressed by the Nebraska athletic director about pregame vomiting among football players. The team was being given the generally accepted diet: steak (8 oz.), potatoes, vegetables, etc. at 9 to 9:30 a.m. It had been established that the normal young male will digest a meal almost entirely in four hours, and that it will have left his stomach entirely in two hours—under normal circumstances.<sup>1</sup> What Dr. Rose's group discovered was that the circumstances were not normal. Emotional tension before a contest seemed to interfere seriously with gastrointestinal motility. These normal young males were falling as much as four hours behind schedule in their digestive cycles, which meant that on the playing field their muscles were competing with their digestive systems for the available blood supply. Further, X-rays also showed that 2½ hours after eating, when the meal should have been completely out of the stomach, as much as 90 per cent of it was still there.



It had also been established<sup>1</sup> that the consistency of food in the stomach seemed to have much to do with its motility. It has to be reduced to a fluid or semi-fluid state in order to pass the pyloric valve, which reacts to solids by closing. Fluids and semi-fluids commence to leave the stomach almost immediately after being swallowed.

These data led to experiments with liquid meals, so timed that the stomach and small bowel would be empty at the beginning of the game. In their report of results<sup>2</sup> Dr. Rose, Trainer Paul J. Schneider, and Assistant Trainer George F. Sullivan noted that pregame vomiting was completely eliminated, as were abdominal, generalized, or localized muscular cramps. Strength and endurance were improved. The players had an improved sense of physical well-being.

That report and a follow-up report<sup>3</sup> are recommended reading for all trainers. The follow-up report dwells to some extent on the value of a carbohydrate-heavy rather than a protein-heavy diet, and on the fetish of avoiding water during competition. Dr. Rose also comments in this follow-up that liquid pregame meals are not going to provide some mysterious new source of energy; rather, they permit the athlete to perform closer to his full potential by eliminating bothersome upsets and cramps. "It is not and has never been intended as a gimmick to supplant good coaching and motivation," he said.

Nor is such a diet an absolute for every athlete. Not all athletes like it, not all require it. Some play just as well on an empty stomach, some insist on playing with a full stomach. But after three years 29 of 36 Nebraska varsity football players still used the liquid meal voluntarily. It is particularly suited to athletes whose digestion is upset by pregame emotional tension, but it also seems to be useful for all.

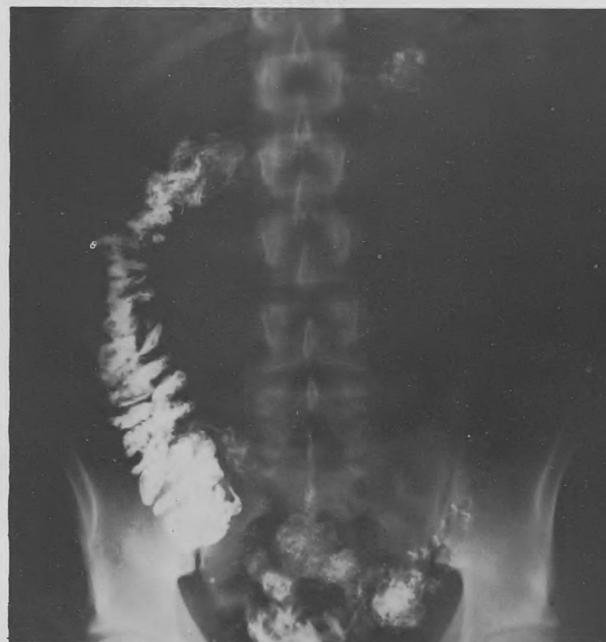
The experiments at Nebraska were prompted by a problem in football, and were carried out with football players, but by no means is the usefulness of liquid pregame meals restricted to that sport. Laurence "Porky" Morgan, trainer at Kansas State University, uses the program in basketball as well as in football. Nebraska track men have found it helpful, and one of the Cornhusker wrestlers, undefeated at 137 lbs. in two years, claimed it was "the best invention since the wheel." At Foothill College we have had fine re-

*(Continued on page 15)*



That pregame tension can slow markedly the digestive process is the point made by this X-ray. It shows that almost all of a meal consumed by a football player 2½ hours earlier was still in the subject's stomach. He had eaten the conventional pregame meal of steak, potatoes, vegetables, etc. (plus a small glass of barium sulfate) four hours before game time. (University of Nebraska Health Service.)

In a liquid pregame meal experiment with football players it was the consistent observation that the stomach was empty at 2 hours. This X-ray, taken 6 hours after eating and immediately after a game, shows a liquid meal almost completely through the digestive process and into the colon. (University of Nebraska Health Service.)



# ATHLETES WARNED ABOUT ANABOLIC STEROIDS

*Indiscriminate use of steroid drugs in an effort to increase growth rates can be quite dangerous. Adverse side effects are known to occur; the drugs should be used only on a physician's prescription.*

By WESLEY K. RUFF

*Associate Professor of Education  
and Physical Education  
Stanford University*

RECENTLY the American Medical Association's Committee on the Medical Aspects of Sports issued a statement condemning the indiscriminate use of steroids and DMSO (Dimethylsulfoxide) by athletes.<sup>1</sup> Even more recently all DMSO has been recalled by the Pure Food and Drug Administration, and all use by humans, even experimental, has been forbidden. Some explanation of the background for these announcements would seem to be in order.

First, some definitions: An *anabolic* aid may be broadly defined as a food or chemical preparation taken orally or by injection in an effort to increase the rate of growth. The term *steroid* is used to define a large group of substances chemically related to fats. An *androgen* is a substance that produces male characteristics, such as testosterone.

For years food supplements and vitamin preparations have been sold as anabolic aids. While knowledgeable persons have reason to doubt the value of unwarranted use of these products, there has been no evidence that such preparations are harmful and therefore no objection to their use as dietary supplements has been heard. On the other hand, uncontrolled use of androgenic steroids for the purpose of stimulating the growth of normal young men is quite another matter.

Androgenic steroids have been produced synthetically for many years. Studies are continuing

in an effort to select the results desired by chemical manipulation of these compounds. Most research has been an effort to find aids in the treatment of glandular disorders, such as failure of the testes to develop normally. Symptoms of testicular deficiency may be retarded growth, feminine body characteristics, or absence of such male characteristics as deepening of the voice, growth of the genitals, and facial hair. The clinical use of these steroids with such patients has been encouraging, and is not the issue of the AMA's announcement. The AMA is concerned because of the adverse side effects the drugs produce, and because recent research indicates that no growth in stature, girth, strength, or performance ability can be expected when these drugs are administered to normal young men.<sup>2,3</sup> Perhaps it would be expedient simply to list some of the adverse side effects commonly encountered when these steroids are administered.<sup>1,4,5,6</sup>

1. When given to prepubertal boys they may actually stunt the potential height by maturing the bones prematurely.

2. They may suppress the production of testosterone by the developing testes in the pubertal male.

3. In postpubertal males they tend to decrease testicular size, and they produce changes in liver function.

4. They may cause water retention, often manifested as edema in the lower limbs.

5. They inevitably cause growth of the prostate gland.

As for DMSO, the AMA's announcement last September<sup>1</sup> focused attention upon its misuse



and pointed to the fact that the drug was then available for registered experimental use only, not for clinical purposes. Possibly dangers were enumerated, among them removal of symptomatic pain without treatment of cause and the indication that the drug might serve as a carrier of other agents into the body (*i.e.*, insecticides, weed killers, lawn fertilizers). It was further suspected that impure DMSO was being purchased for use on athletes. And recent research findings have suggested eye damage as an additional possibility. As a result the Pure Food and Drug Administration stepped in and called a halt to any use by or on humans.

It is also of interest to note that the *British Medical Journal* published in January 1964 a statement similar to that of the AMA. The closing remark was, "It must be stressed that anabolic steroids are still in the experimental state and that their efficacy in many clinical situations remains to be proven."<sup>5</sup>

Androgen steroids are available by prescription only. An individual's physician will recommend their use when indicated. They spell

potential trouble for the athlete who thinks he can be his own doctor and seeks the drugs *sub rosa*.

<sup>1</sup> *The A.M.A. News*, September 13, 1965. Page 3.

<sup>2</sup> William M. Fowler, Jr., Gerald W. Gardner, and Glen H. Egstrom. "Effect of an Anabolic Steroid on Physical Performance of Young Men." *Journal of Applied Physiology*. Vol. 20, No. 5, pp. 1038-1040. September 1965.

<sup>3</sup> Leo T. Samuels, Austin F. Denschel, and Ancel Keys. "Influence of Methyltestosterone on Muscular Work and Creatine Metabolism in Normal Young Men." *Journal of Clinical Endocrinology and Metabolism*. Vol. 2, 649-654, 1942.

<sup>4</sup> Aaron Arnold, Gordon O. Potts, and Arthur L. Beyler. "Relative Oral Anabolic and Androgenic Activity Ratios..." *ACTA Endocrinology*. Vol. 44, pp. 490-98, December 1963.

<sup>5</sup> "Today's Drugs... Androgenic and Anabolic Steroids." *British Medical Journal*. Vol. 1, pp. 105-7, January 11, 1964.

<sup>6</sup> R. L. Pullen, J. A. Wilson, E. C. Hamblen, and Kenneth Cuyler. "Clinical Reviews in Andrologic Endocrinology: II, Treatment of Androgenic Failure." *Journal of Clinical Endocrinology*. Vol. 2, pp. 655-663, November 1942.

(Continued from page 13)

sults in controlling the weight of some of our wrestlers without their having to resort to detrimental diets or weakening dehydration. In track and field we have found it especially helpful in keeping up the strength of emotional athletes who, under normal diet conditions, have a tendency toward nausea.

Trainers are familiar with the struggle to establish proper eating habits among athletes. We all know how complicated this becomes in a situation such as a tournament, when game schedules throw everything out of whack and a careless trainer can let a team eat itself right out of a championship. Connie Jarvis at Stanford has noticed that basketball teams particularly have a habit of sneaking snacks just to be doing something before a game.

This education of athletes must be done, however, and it must be a continuous thing as a new crop of athletes arrives each year. For this education to be effective there must also be complete

understanding and uniformity of purpose among the coach, the team physician, and the trainer. This, too, may require an educational program. Sometimes coaches don't fully realize the importance of diet control.

The recent findings on liquid meals offer the trainer and coach a new tool in fielding teams with maximum physical fitness and a sense of well-being. This new tool is no magic key to victory—but research and trial have shown it to be both simple to use and of real benefit.

<sup>1</sup> Best, D. H., and Taylor, N. B., *The Physiological Basis of Medical Practice*, 6th Ed. (1955), The Williams and Wilkins Co., Baltimore, Md.

<sup>2</sup> Rose, K. D.; Schneider, P. J.; and Sullivan, G. F., "A Liquid Pregame Meal for Athletes," *Journal of the American Medical Association*, Vol. 178, pp. 30-33 (October 1961).

<sup>3</sup> Rose, K. D.; Schneider, P. J.; Sullivan, G. F.; and Fuenning, S. I., "The Liquid Pregame Meal, Three Years Later," *The Journal of the National Athletic Trainers Association*, November 1964, pp. 2-4.

## Trainer Markson Honored In "Outstanding Young Men"

Richard F. "Dick" Markson, since 1957 a member of the NATA and currently studying for his master's degree in hospital administration at the University of California, has been honored by inclusion in the 1965 edition of "Outstanding Young Men of America," published annually by the United States Junior Chamber of Commerce.

Markson was chosen on the basis of his work in Alaska, where from 1962 to 1964 he was administrator for the Alaska State Elks Association Cerebral Palsy Program. During this period he established a home-care program for physically handicapped children and adults in Western



Alaska Eskimo villages. Among his many extracurricular activities was the arranging of medical and training room facilities for the National Alpine Championships and Olympic Trials held at Mt. Alyeska in 1963.

He returned to California in 1964 to spend a year as an administrative intern in Franklin Hospital, San Francisco, and then won a U. S. Public Health Service scholarship for more advanced training. Dick received his Certificate in Physical Therapy from Stanford University in 1957, was trainer for the Ottawa Roughriders for a year, then got started in hospital work. To keep his trainer's touch he has worked at high school and college levels, and the last two seasons has been trainer for a California semi-pro football team. (They liked him well enough to elect him president of the six-team Pacific Football League.)

Dick and wife Jeanne have two sons, 16 and 10, and a girl, 6.

## Canadian Trainers Organize; Mert Prophet First President

Mert Prophet, trainer of the Toronto Argonauts Football Club, is first president of the new Canadian Athletic Trainers Association. Elected with him last year for two-year terms were Bob Haggert, Toronto Maple Leaf Hockey Club, vice-president; Stew Langdon, Queens University (Kingston, Ontario), secretary-treasurer; Sandy Archer, Regina Rough Riders Football Club, western director; and Guy Girardeau, Montreal Alouettes Football Club, eastern director. All officers are also members of the NATA.

Goals of the new Association are to forge a stronger, more knowledgeable group of professionals, to form closer ties between full- and part-time trainers, and to encourage and help student trainers.

## Ellis Murphy Named Advertising Representative

Ellis Murphy, marketing, advertising, and public relations firm, 600 South Michigan Avenue, Chicago, Illinois 60605, has been appointed advertising representative for *The Journal*. Any questions regarding advertising in *The Journal* should be asked of Mr. Murphy at the above address.

**PLAN AHEAD**—the 17th annual NATA Convention will be held June 13-16 at the Muehlebach Hotel, Kansas City, Mo.



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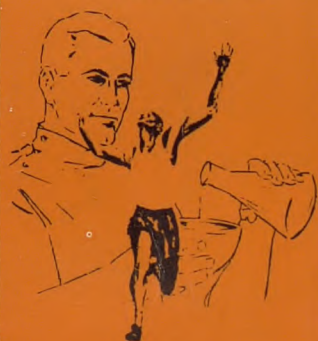
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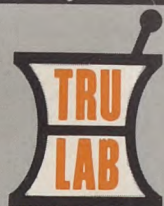




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