

## Priorities for reducing the burden of injuries in sport: the example of Australian Football

Belinda J Gabbe, Caroline F Finch and Peter A Cameron

**TO THE EDITOR:** Safe sports participation has become a key national issue, especially in view of the potential for concerns about safety to inhibit sports participation,<sup>1</sup> in a nation where obesity rates are rising<sup>2</sup> and more exercise is recommended.

Australians participate in many sports, but the safety of the football codes is especially criticised by the media and the community because of the intense focus on injuries to players at the elite level. This is particularly the case for Australian Football (AF) and its elite game, the Australian Football League (AFL).

National reports released in 2006 have identified AF as the sport most associated with injury admissions to hospital<sup>3</sup> and with private health insurance claims.<sup>4</sup> These have sparked media commentary about the safety of AF. Response to these injury reports prompted an unprecedented media release<sup>5</sup> from the country's peak sports medicine body, Sports Medicine Australia, detailing issues with the report figures, urging caution in their interpretation and supporting the efforts of the football codes in improving participant safety.

The modified version of the game (Aus-kick), which is played by children, has been shown to be safer,<sup>6</sup> but there is a progression to adult rules by the under-15 age group, and the umbrella of safety provided by modified rules is eventually gone, raising the question of how safe the non-modified version is. Recently released AFL figures suggest that injury rates at the elite level are at a historical low,<sup>7</sup> but the report provided insufficient information to assess whether this represents a significant decline since 1997, and the data are already one season behind. Equivalent information for the more than 450 000 adult, non-elite participants is not available.

Published literature related to injury prevention highlights a dearth of knowledge relating to the causes of injuries in non-elite participants and a very small evidence base for ways to prevent injuries in AF. With AF played almost exclusively in Australia, the onus to provide evidence for improving the safety of participation clearly falls on the stakeholders of the sport here. Gains in reducing both the public health impact of football injuries and the fear of injury asso-

ciated with participation will only come from substantial investment in large-scale trials at the non-elite level, and a multidisciplinary approach to safety and injury issues across all levels of play. This will require active and committed collaboration of key stakeholders such as clinicians, allied health practitioners, researchers, clubs, sports administrators, coaches and the participants themselves.

**Acknowledgements:** Belinda Gabbe was supported by a Public Health Research Fellowship (237024) and Caroline Finch by a Principal Research Fellowship from the National Health and Medical Research Council of Australia.

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## Folate and vitamin B<sub>12</sub> in older Australians

Victoria Flood and Paul Mitchell

**TO THE EDITOR:** The recent viewpoint by Kamien<sup>1</sup> and letter by Gunasekera<sup>2</sup> rightly highlight the benefits of folate fortification and the unlikely occurrence of masking pernicious anaemia. Food Standards Australia New Zealand recently submitted a proposal supporting the mandatory fortification of bread-making flour to increase folate intakes in women of child-bearing age, with the aim of reducing the risk of children being born with neural tube defects.<sup>3</sup> This proposal has had extensive public comment and will be considered by the Australia and New Zealand Food Regulation Ministerial Council. Several public groups and individuals continue to raise concerns that higher dietary folate levels could increase B<sub>12</sub> deficiency. Our data, collected from a population-based sample of 2596 older people in the Blue Mountains region, from 1997 to 2000, do not suggest that this is a likely outcome.

We recently reported the prevalence of low serum vitamin B<sub>12</sub> levels in the Blue Mountains Eye Study cohort of people aged 50

### Mean serum vitamin B<sub>12</sub> levels in a population of older Australians, for various folate intakes (from diet and supplements) (n = 2596)

Folate intake	Mean serum B <sub>12</sub> (95% CI) adjusted for age and sex	Mean serum B <sub>12</sub> (95% CI) adjusted for age, sex and B <sub>12</sub> intake (diet and supplements)
<b>Folate (µg DFE)</b>		
Quintile 1-4 (< 571.8) (n = 2077)	273 (263-289)	278 (267-289)
Quintile 5 (> 571.8) (n = 519)	316 (295-337)	297 (275-319)
P	< 0.001	0.132
<b>Folate cut-points</b>		
< 500 µg DFE (n = 1828)	273 (261-284)	278 (267-290)
500-1000 µg DFE (n = 645)	294 (276-314)	289 (270-308)
> 1000 µg DFE (n = 123)	346 (303-389)	300 (253-348)
P for trend	< 0.001	0.239

DFE = dietary folate equivalents. ♦