Forgive me if I return to a favorite topic of mine for this editorial message—evidence-based medicine. As another semester of teaching “Evidence-Based Sports Medicine” to this year’s group of graduate students comes to a close, the topic is fresh in my mind. In addition, J. Timothy Sensor’s eloquent guest editorial1 in the July/August 2012 issue of Athletic Training & Sports Health Care continues to stress the importance of athletic trainers staying in touch with the latest evidence in support of their clinical practice.

Perhaps that message has become more clear following the release of an article in the August 2012 issue of the Journal of Athletic Training, titled “What is the Evidence for Rest, Ice, Compression, and Elevation Therapy in the Treatment of Ankle Sprains in Adults?”2 Perhaps as American as “Apple Pie” has the acronym RICE (Rest, Ice, Compression, Elevation) become, not only in athletic health care but in most acute injury situations. I can still remember being told by my mother, when I would get a bump or bruise as a child, to just “RICE” it!

The excellent exposition by van der Beekom et al2 set out to answer a simple question: What is the evidence to support the effectiveness of applying RICE therapy within 72 hours after trauma for patients in the initial period after ankle sprain? I thought—as I’m sure many others who read that article also did—hasn’t this question already been answered? RICE therapy has been such a foundational aspect of sports health care in the United States over the past 60+ years that most clinicians probably thought its effectiveness was a given. So much for believing all that you hear and are taught! Amazingly, the systematic review by van der Beekom et al2 was able to include only 11 randomized controlled studies to make their case that RICE is not very effective in treating acute ankle sprains. Eleven studies in 60+ years on an injury intervention protocol that is so popular among sports health care professionals is unbelievable! So much for progress!

Here is the bottom-line message from those authors: “Insufficient evidence is available from the randomized controlled trials to determine the relative effectiveness of RICE therapy for acute ankle sprains in adults.”2 Say what? Will this cause clinicians to stand up and take notice? Clinicians must begin to realize that even some of our most prevalent and commonplace treatment interventions have not been properly scrutinized by randomized controlled trials to en-
sure their effectiveness. Clinicians need to be vigilant in utilizing only treatment schemes that have proven effectiveness, even if it means getting rid of those they believe are effective.

We health care professionals must wake up to the evidence around us and continually question “why” we provide treatment interventions in an effort to return athletes back to competition swiftly and effectively. I urge clinicians and researchers to develop partnerships to find ways to better study and understand many of the treatment routines we have so robustly accepted and instituted through the years, despite any real evidence to support their effectiveness. We cannot wait; our client base is depending on us to choose the most effective treatment.

Season’s greetings from all of us here at Athletic Training & Sports Health Care! This 6th issue closes the 4th volume of the journal. Many thanks to our editorial board and staff for their hard work and dedication and for their contributions to the success we have enjoyed these past 4 years. Best wishes as we move forward in 2013 with Volume 5.

REFERENCES


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