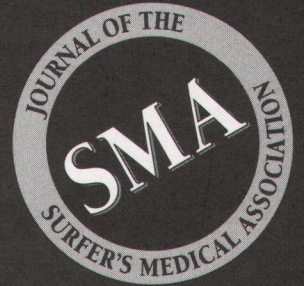


SURFING MEDICINE

Issue #20: Winter 2000/2001



High Society Black Tie **Surf Docs**

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Time flies, and here we are with issue #20. Over a dozen years gone by and the SMA paddles on. The original intentions of furthering surf medicine and contributing in some ways to the health and welfare of those we encounter are intact as well, as evidenced by the contents of this and past issues of this journal. And, almost as important as any contributions the SMA has made is the fact

that everything the SMA's members have done has been approached in a spirit of fun, cooperation, minimal "bureaucracy," and sometimes even humour, intentional or otherwise. Along the way, many new friends have been made. So check our new directory, don't be shy, and go out and make a few of your own. Let us know what happens and you just might end up in print....

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Surfing Medicine

Editor Kahuna: Mark Renneker
 Managing Editor Kahuna: Steve Heilig

Art Kahuna: David "Homeboy" Bender
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SURFING INJURIES: AN INTERNET-BASED SURVEY

Introduction

The use of the ocean's waves for board surfing or surfcraft riding has blossomed in popularity since the early 60's. A surfer is generally defined as any person who rides a wave on a board. Traditionally, only those who stand on boards would be included, but for the sake of this chapter it also includes those who ride boards seated (surf skiers and surf kayakers), on their knees (knee boarders), on their belly (foam-, belly-, body- or boogieboarders), with a sail (windsurfers), and those who just use flippers or nothing at all (bodysurfers). Surfing, a sport that was once only associated with Australia, California and Hawaii, now has been embraced by enthusiasts on every part of the globe. Its growth has been fueled by a billion dollar surfing-related clothing industry, which markets the cultural idiosyncrasies of surfing to the non-surfer with great success. With the advent of water theme parks and wave pools that simulate real surf, more landlocked populations will be able to learn to surf. Due to the combination of the speed obtained during wave riding and the fact that the board can become a weapon of injury, there exists a risk of potentially serious injury, especially for the novice.

Evolution of Surfing

For hundreds of years Hawaiian royalty rode heavy koa wood surfboards on waves, unseen by foreigners. After Captain Cook landed on the islands, reports describing the sport began to emerge from the islands. After Hawaiian surfer George Freeth surfed in southern California in 1907 to promote real estate, the sport spread throughout the mainland. Olympic swimming champion Duke Kahanamoko became surfing's

ambassador to the world. A central fin or skeg was added to the bottom of the board for greater stability in the early 1900's. Balsa wood blanks were enhanced with Fiberglas in the 1950's but the boards were still up to 12 feet long. Polyurethane foams were introduced in the 1960's and, when combined with Fiberglas, created light weight controllable boards. Multiple different board lengths, numbers of skegs or fins, and tail shapes have been combined to create the best functioning board. The advent of the leash essentially eliminated swimming after lost boards. Shorter boards became the rage in the early eighties and, with the addition of multiple fins in different arrays, untold numbers of new surfers were attracted to the sport. Extreme crowding has become a major problem and "localism" (territorial attitudes of surfers leading to malicious acts) has brought notoriety to the sport. Nonetheless, surfing remains popular due to the exhilarating experience wave riders enjoy. Surfers describe their sport as the only one where the ocean's energy is harnessed and then released without damage to the environment. Because of this, there is no sport comparable to surfing.

Wave Characteristics

To understand the mechanisms of surfing injuries, the characteristics of how waves are created should be understood. Waves may be created by the wind of storms, changes in the atmospheric pressure, passage of the moon, earthquakes, and landslides. Velocity, duration, and direction of the wind are important factors. When the initial influence of the inciting event dissipates, the energy is transformed into

smooth, long swells that can travel thousands of miles, losing little energy. The wave finally breaks when the swell meets the resistance of the rising ocean bottom. The contour of the ocean bottom determines the intensity of the break. The swells hit the Hawaiian islands with such intensity because, unlike the U.S. mainland, there is no continental shelf to dissipate the energy. The top of the swell is pushed upward and it becomes a steep wall of water, with a face and a crest. When the top of the swell falls down the face of it, the wave is breaking. The surfer takes off as the swell is being pushed up and attempts to ride the face of the wave, avoiding the area where the wave is breaking.

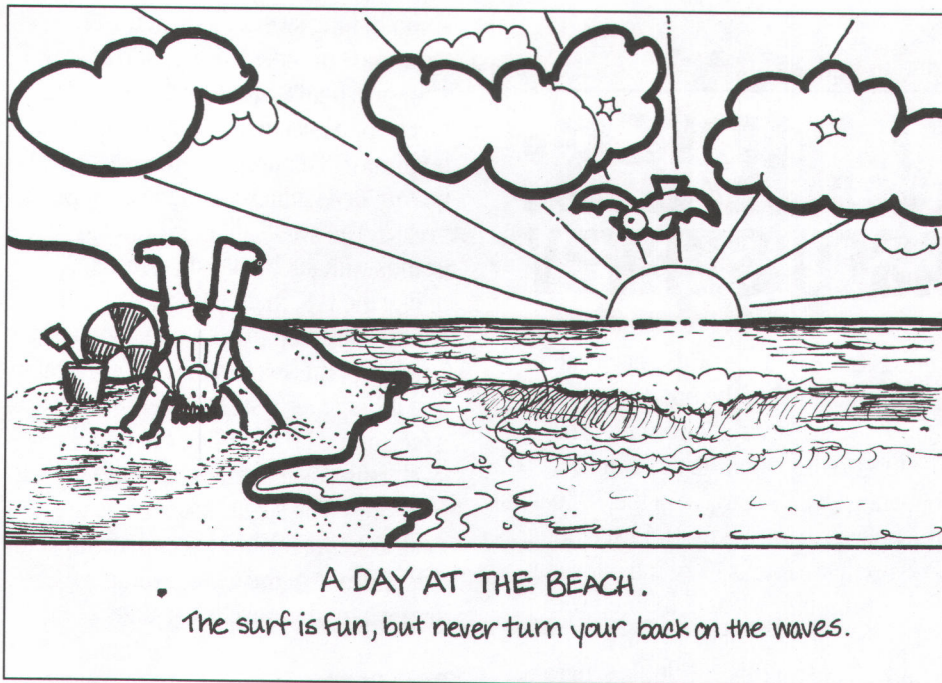
Body Surfing

Body surfing is one of the most challenging and stimulating individual sports currently enjoyed by many. The Hawaiian Islands (mainly Oahu), southern California, and Australia top the areas where this sport is popular. It may be thought of as a one on one competition: the surfer versus the wave, one's body lying on and within a curving wall of rapidly moving water.

The body surfer need only wear a swimsuit and use one necessary accessory, a pair of fins or flippers (occasionally a single fin). The body surfer must be a strong swimmer, as he or she may be carried out beyond the surfline. Foot fins help speed and endurance as well as one's ability to cover longer distances if necessary. The initial cost is low, but the cost of injury can be horrendous permanent paralysis secondary to spinal cord injury or death caused by drowning.

Body surfing beaches are numerous in Oahu and are named, numbering at least 17. Perhaps the most famous areas are Makapuu, Sandy Beach, Point Panic, Pounders, Waimea Bay, Pipeline, Makaha, and Bellows. Some might even be considered infamous.

In addition to "the wave" and subsequent waves, the body surfer must contend with the ocean bottom (packed sand, coral, and rocks); other surfers



A DAY AT THE BEACH.

The surf is fun, but never turn your back on the waves.

(both body and board surfers); and other objects in the water such as surfboards (with their points, tails, and fins), air mattresses, Boogie boards, canoes, kayaks, and catamarans. Some of these are directly dangerous on contact, while others can be distracting or physically upsetting, causing the body surfer to lose control, which could be dangerous.

Knowledgeable body surfers first study the surf from the beach. They then enter the water, put on their fins, tread water (or stand in water about chest deep), and face out to sea, watching each wave as it approaches. When a surfer believes he or she is in a correct position and capable of riding the oncoming wave (usually 2 to 6 feet high) and has analyzed the direction of the break of the wave (left to right, right to left, or straight ahead), he or she then decides whether to "take it" or not. If the surfer decides not to take the wave, he or she dives under and through the base of the wave and comes up on the other side in front of the next wave. It may be necessary to do this several times in a row, thus requiring stamina and good breath holding abilities. If the surfer decides to take the wave, he or she turns and faces the shore; and when the nearly breaking wave is several feet behind the surfer, he or she begins to swim rapidly with several short, strong strokes and kicks to gain momentum so that as the wave catches

the surfer, he or she can ride it. Once caught by the wave, the surfer should be in front of the wave with the upper body, with the remainder of the body encased in the mass of moving water. The surfer extends an arm straight in the direction of the angled body (right arm extended when going to the right on a left to right breaking wave) and rides the wave. It may crash in just a few feet (typical for Sandy Beach) or roll for several yards (10 to 30 would be ideal) and even tube such that the surfer exits far down the tube from where he or she entered, having been completely surrounded by a tunnel of moving water for several ecstatic moments.

Once the ride is almost over, the surfer must safely terminate it before the wave crashes. The proper and safest way is to "curl under" (cut out, kick out) and come out behind the wave, heading out to sea to face the next one. This end of the ride is the most dangerous part, and it is here that even the experienced body surfer can become injured. It is the timing of this critical move that has cost lives as a result of head injury with loss of consciousness, spinal cord injury with paralysis, and drowning. It is here that the now head/neck flexed surfer can be driven head first into the beach bottom, sustaining a neck injury. The surfer may escape with only a cervical vertebral body compression fracture or perhaps only a

spinous process fracture, or he or she may sustain a fracture dislocation with resultant, usually immediate, spinal cord injury. The experienced body surfer may also be injured by collision with other surfers (body or board) or objects, but the most serious remains a collision with the ocean bottom.

The inexperienced surfer (in Hawaii often the pale tourist or the newly arrived military person) may be injured by just entering unfamiliar waters. If the newcomer should choose to run and dive into the surf, he or she may hit the head, usually the vertex, on the sand or coral bottom, on a projecting hidden rock, or on the head of an oncoming body surfer. The surfer may walk into the water because he or she sees many others in the surf (often 100 or more at Sandy or Makapuu on a Saturday or Sunday), but standing only knee or waist deep, the surfer may be almost immediately pounded downward or thrown backward by a huge wall of water that crashes violently to the ocean bottom. Concussion; near drowning; fractured cervical, thoracic, or lumbar vertebrae; arm/shoulder dislocations; hip dislocations; lacerations; and severe sand abrasions can occur.

If surfing at a lifeguarded beach, there is a good chance of rescue, resuscitation, stabilization, and expeditious transfer to an acute care hospital, all too familiar with the receipt and care of such an injured surfer. Not all bodysurfing beaches have lifeguards.

Body surfing can now include riding on an air filled beach mattress, Boogie board (a soft, light, preformed Styrofoam board about 3 feet long), and short, thin, hard plywood boards. These add a new risk for the rider, because they are frequently ridden directly into shore and can cause an over the falls type of injury, with the rider being thrown forward by his or her own momentum as the wave stops abruptly and crashes down. The surfer may land with neck flexed into the water ahead of the wave (now only inches to perhaps 1 foot deep) or in a head neck extended position, each causing its own particular type of cervical spine injury.

Most body surfing is done at sand

bottomed beaches, with or without coral, but one challenging area (no beach) is Point Panic. Here, the waves eventually crash on boulders on a projection of land, but the requirement is to ride the wave and then curl out before the final crash! Championship contests are actually scheduled at Point Panic, and winners are determined by style, number of rides, and innovation. Several surfers have ridden a wave too long.

No swimmer or surfer should be in the water alone, and the beginner or novice body surfer must have respect for all waves. Prevention of injury is the only way to enjoy body surfing. One should surf only at a lifeguarded sand beach, be an accomplished swimmer, and choose waves that break slowly and smoothly and are not too high (1 to 2 feet as seen from the front). Beach areas that allow board surfing, boat launching and landing, and sail boarding should be avoided. There are beaches that are restricted in use for the appropriate water sport. When a red flag is posted at a guarded beach, the surf is considered dangerous even for the expert!

Sharks, needle fish, sea urchins, sting rays, blow fish, and Portuguese men of war have caused injuries to the body surfer, the latter being the most common. Coral cuts and deep sand abrasions also need medical attention. The most devastating of the injuries remains the spinal column injury, usually cervical, often resulting in permanent quadriplegia or paraplegia.

Epidemiology of Surfing Injuries

A variety of reports have led to estimations of surf injury incidence. Incidence of injury in surfing has been estimated to be 1 injury per 17,500 surfer days. A rate of 3.5 moderate to severe injuries per 1000 surfing days has been calculated. It has been estimated that the average surfer surfs 2.7 days/week, 4 hours/day. Lacerations occur in 41% of all surfing injuries, with the surfer's own board responsible for most. Sprains and strains have been seen in 35% and fractures in 15%. Eye and ear injuries are common. Fortunately, catastrophic head and spinal injuries, as well as

drowning events are uncommon. Alcohol and drug use has been variously associated with injuries during surfing. Less experienced surfers have increased risk of injury.

An ongoing epidemiologic study is currently underway via the Brown University School of Medicine. The study can be accessed at www.surfstudy.sitehosting.net and was active at the time this manuscript went to press. The study hopes to evaluate the types, causes, and frequencies of surfing-related injuries and deaths. The questionnaire is divided into four parts and contains 12 to 34 questions. It takes approximately five minutes to complete the survey. The site states that the results of this survey will be published on the web page or in a surfing magazine at some time in the future.

Specific Surfing Injuries

Minor Lacerations

Many different studies have shown that surfers are most susceptible to lacerations. The etiologic agents involved include surfboards (self-inflicted and other surfer's boards) and submerged rocks and coral. Surfers are at risk for stings from various sea organisms, most of which are benign. The skull, chin, foot, leg, and eyebrow most commonly require sutures. Excess sewage outfalls are near many surf breaks, so thorough irrigation of wounds prior to closure is required. Some advocate delayed closure if the wound incurred prolonged exposure to aquatic environs before definitive irrigation. Lacerations have a higher propensity to develop into infected or chronic ulcers since many surfers will attempt to "get back into the water" before adequate epithelialization can occur.

Soft Tissue Sprains and Dislocations

The most common muscle sprains reported involve the low back and cervical spine. The knee and ankle are frequently involved as well. Overuse and stress from vigorous surfing maneuvers are the leading causes of injury. The shoulder is frequently injured and it is

thought that rotator cuff impingement during the act of prone paddling (excessive hyperextension and internal rotation) leads to a "surfer's shoulder" syndrome. Acromioclavicular, glenohumeral and knee dislocations have been reported. "Surfer's elbow" has been described as a form of lateral epicondylitis. Rest, functional rehabilitation and anti-inflammatory medications usually adequately treat most of these injuries. Stretching and warm-up activities before surfing are emphasized to reduce the incidence of injury.

Bone Injuries

Fractures are relatively uncommon and affect the nose, arms, hands, tibiae, feet and teeth. An exacerbation of spondylolisthesis has been described as have wrist and humerus fractures in body surfers. A talar osteochondral lesion has been described due to the penetrating effects of the skeg. Basic splinting techniques are employed before the surfer obtains definitive fracture care.

Life-Threatening Injuries

Fortunately, life threatening injuries are rare in surfing. Severe trauma which would result in extended hospitalization has been estimated at 1 incident per 175,000 days surfed. Closed head injury, cervical spine injuries, thoracolumbar spine fractures, splenic rupture, drowning, and axillary artery injury have been described. Shark attacks have been reported but are highly infrequent. The incidence of catastrophic injury is increased in the most experienced surfers due to their choice of most difficult surf conditions. Knowledge of cervical spine precautions and cardiac life support is recommended of any health care provider who intends to cover surfing competitions.

Ear

Surfer's ear is the presence of exostoses in the external ear canal in response to the irritation of water and wind. Symptomatic surfer's ear can be treated with antibiotic drops with cortisone to reduce inflammation.

Use 3 to 4 drops per ear, 3 to 4 times per day for one week. Rupture of the tympanic membrane can occur if the ear suffers impact with waves. Antibiotic ear suspension and avoidance of the ocean is required. Occasionally surgical myringoplasty may be required to close a large perforation.

Eye

Pingueculae and pterygia are hyaline nodules of the conjunctiva, usually found on the nasal side of the cornea. They are also thought to be caused by irritation of sun, water and wind. While pingueculae can be treated symptomatically, pterygia can encroach on the pupillary area and interfere with vision. Those that do can be removed with a simple operative procedure. Ocular burn should be prevented with appropriate protection. Eye wear which eliminates UV light while on the beach and brims or visors while in the water afford excellent shading for the eyes. Unfortunately, most surfers will not wear the in water eye protection. Blunt trauma to the eye has decreased with the introduction of padded nose guards which eliminate the sharp point of surf boards.

Skin

Nipple and axilla rash are less common now with the advent of rash guard shirts. These nylon shirts protect the surfers' nipples from a tender rash which occurs a result of friction from the surfboard and wax, when surfing during the spring and summer. They are worn with seams on the outside so that irritation, which occurs from paddling in wetsuits about the axilla, is lessened. Protection from the damaging effects of the sun is afforded with sun screens and block. Older surfers should be screened for any malignant or pre-malignant lesions as many older surfers predate the awareness of skin cancer and its prevention. High-risk, seldom-examined areas such as the tops of the ears, the back, and the back of the leg should be evaluated. "New moles" and previously badly sunburned areas should be especially scrutinized with referral to a specialist if the area is in question.

Idiosyncratic Injuries

"Surfer's sinus" is a chronic rhinitis and sudden sinus release seen commonly in individuals who frequent the ocean. "Surfer's chest knots" are innocuous subcutaneous masses over the lower rib cage many veteran surfers have developed. "Surfer's rib" is an isolated first rib fracture secondary to performing a "layback" maneuver, in which the surfer is in a limbo-like position. "Surfer's neuropathy" is a peroneal nerve compression as a result of sitting on a surfboard. "Surfer's knots or knobblies" are overgrowths of connective tissue at the tibial tubercle and dorsal foot seen in surfers who paddle long boards in the kneeling position.

Prevention of Surfing Injuries

Precautions for surfers that can increase safety in the ocean include: **a)** properly fitted wet suits to prevent hypothermia, **b)** surfboards without sharp points and edges, **c)** use of a leash to protect other surfers from stray boards and as a flotation device in cases of severe injury, **d)** use sunscreens to protect from the UV light, **e)** contact lenses in the water if vision correction is required on land, **f)** specific knowledge of the surf, the bottom, and the tides, **g)** surfing with a companion, **h)** avoidance of the path of oncoming surfers when padding out, **i)** avoidance of shore breaks, **j)** caution of your board or other surfers when coming to the water surface after a wipe-out, **k)** avoidance of alcohol and drugs when surfing, and **l)** preparedness for medical emergencies when planning extended surf trips to remote regions (i.e. first aid, water rescue, CPR).

The Surfer's Medical Association

The Surfer's Medical Association is an international organization of surfers committed to helping all surfers be healthier. The organization consists of surfing physicians and other health professionals, scientists, and barefoot doctors (surfers interested in the health and medical aspects of surfing). Every surfer is welcome to join.

The goals and objectives of this organization are **1)** to educate surfers so they can spend minimal time hassling

with doctors and maximal time surfing, **2)** to conduct and support research and educational activities on surfing and health, **3)** to represent the sport of surfing in the fields of medicine and science, **4)** to teach physicians about the unique health problems of surfers, and how to better care for surfers, **5)** to create a network of barefoot doctors and surfing health professionals around the world, and **6)** to protect and preserve the surfers' natural environment: the waves, the ocean and our beaches.

To obtain more information regarding this association write to Surfer's Medical Association, P.O. Box 1210, Aptos, California, 95001-1210 or log on to the web site at www.damoon.net/sma/index.

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A MODEST MENTAWAI PROPOSAL: AN ISLAND HEALTH PROJECT

From: "david jenkins" dajenki@hotmail.com
To: THE SMA MEMBERSHIP

Dear Surfdocs:

Let me introduce myself. I am a Kiwi doc who has been working as a start-up facilitator on various health related projects, the most recent as Asian/Pacific Director of education for General and Cologne Re. In this job I have been implementing new training initiatives throughout the region.

I recently went surfing in the Mentawais and ran a clinic at the local village. What I saw shocked me. And hence Surf-Aid. I know that this scenario is found elsewhere but not to this extent and not to my knowledge 50 meters from luxury yachts carrying thousands/year of middle and upperclass surfers to some of the best surf in the world!

So against the judgement of friends and certainly my accountant, I have gladly taken off my tie, donned on a sarong left the 24th floor of a Singaporean ivory tower and are heading towards Padang/Sumatra. This is not a overly Zealous mission but something that simply needs to be done. My research tells me that surfers DO care but lack a vehicle that adequately expresses it.

And so as my closest related colleagues in vision and passion for our liquid pastime, I invite your comments and support. I have plenty of ideas on how you can support but know just how creative our team are and therefore leave it to you.

I have completed a much more detailed Mentawai Island Health Plan which is currently being edited and improved. I will share it as soon as possible. I have a very big ask. Please do not forward any of this material or talk to anyone other than our group until we have officially launched on JAN 10th 2000 at the New Zealand Champs as we wish to make it clear who and what we are in a certain way.

Meanwhile I will leave you to contemplate how you would like to express your possible support, Surf-Aid certainly needs and welcomes it.

I look forward to meeting you and making new friends
Kind regards
Dave Jenkins

Mentawai Island Health Project Executive Summary - Draft Plan

Mission Statement

To improve over the long term, the unacceptable level of preventable deaths, disease and suffering of the Mentawai Island people.

Background

The Mentawais are a group of islands and islets totaling greater than forty. They are situated 140 km's off the coast of West Sumatra, Indonesia.

The Mentawai Islands are remote. This isolation has resulted in the creation of a unique ecosystem and a unique indigenous culture. Unfortunately, it has also resulted in communities and villages being ravaged by endemic tropical diseases.

Unable to attend the scattered and under-resourced medical services available in four of the villages in the Mentawais, the local people have few options but to suffer. We ask the question why a fertile area 1.2 times the size of Bali has a significantly smaller population base (est. between 60,000-70,000 vs Bali's population of 3.5 mil). The answer is partly due to devastatingly high death rates in children and young adults.

The aim of the Mentawai Health Project is to correct this unnecessary suffering by the coordinated and sustained application of modern medical education, knowledge, skills and technology.

The Medical Needs of the Mentawai People

An initial needs analysis and clinic was organised by Dr Dave Jenkins, Managing Director of Surf-Aid, the parent organisation and facilitator of MIHP. This analysis included the following:

Meetings were held with:

- The Mentawai Council in Pariarman - Western Sumatra
- Dr Manu - 30 years of medical experience in Mentawai
- Chief of Kaitiet Village; Island of Supura - Mentawai
- Juniator Tulus - Mentawai Medical Anthropologist
- Dr Sonny - current Mentawai Practitioner

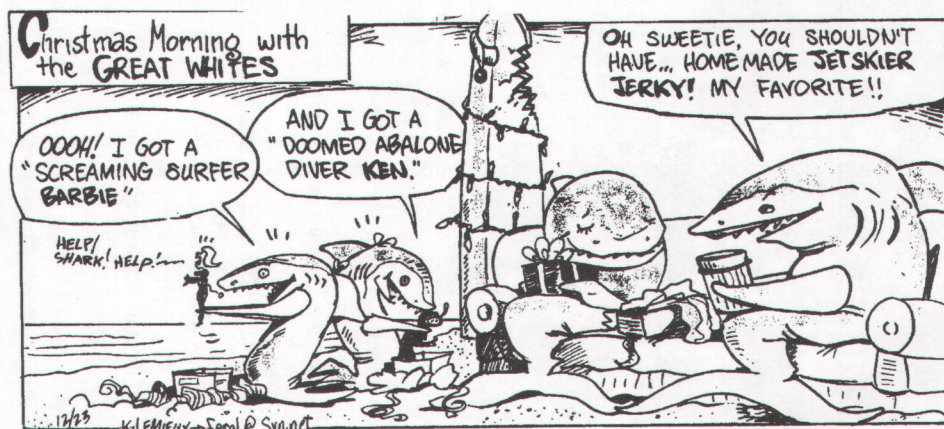
A clinic was held at Kaitiet Village. Villagers were examined and treated where possible. Unfortunately, 80% of patients examined were so sick they would have been admitted to hospital for treatment, if such a facility had been available. Patients were found to be suffering from the following:

- Malaria
- Tuberculosis
- Vomiting
- Diarrhea
- Pneumonia
- Malnutrition
- Endemic scabies with secondary infections

Objectives of MIHP

As a result this initial needs analysis, the following list of most urgent needs has been compiled. This list forms the key objectives of MIHP.

- Immunisation
- BCG TB
- Hepatitis
- Polio
- Measles
- Mumps
- Rubella
- Tetanus
- Nurse deployment in isolated villages
- Floating clinic and evacuation speedboat
- Mentawai Hospital
- Auxiliary services
- Optometry
- Dental
- Agriculture
- Rainforest cure



WHO IS SURF-AID?

Surf-Aid has two full time staff members, Dr Dave Jenkins and Bronwyn Morgan. The Mentawai Project will be facilitated through Dr Manoocher Tahmasebian



and his already established charitable foundation located in West Sumatra.

Surf-Aid is supported by Surfing Medical Association (1000 medics with over ten years experience of charitable projects in surf-rich destinations)

Bronwyn and Dave are supported by a team of professionals from a range of backgrounds, all contributing on a volunteer basis.

SUMMARY

Surf-Aid wishes to acknowledge the growing disparity between the increasing success of the global surfing culture and the worsening health of the indigenous people who own the reefs we profit from.

Most involved in our culture DO care, but lack a suitable vehicle to express this.

Hence Surf-Aid.

Together we can do our best to help. To give back where we have received.

CONTACT DETAILS

Website: www.surf-aid.org
Email: surf-aid@clear.net.nz
Phone: 0064 6 8671379 or 0064 21 2679751
Fax: 0064 6 8677473

Send cheques/money orders to:
Surf-Aid International
PO Box 55, Gisborne, New Zealand

MEMBERSHIP

NOTE: Every year you donate the \$25 subscription fee you go into our draw to win (\$50 gives you two chances etc) a 10 day surfing/sailing/diving holiday in the Mentawais.

I would like to join by donating:

\$ _____ \$25 \$50 \$100 \$200 \$500

I enclose a cheque/money order:

Charge my credit card: Master Card Visa

Cardholder Name: _____

Expiry Date: _____

Card No: _____

Or use your credit card at www.surf-aid.org

- Individual patrons and organisations are invited to adopt a village project in their name.
- I would like to become a Surf-Aid volunteer, helping with fundraising activities.

If you help us reach our targets, approved fundraisers will receive a boat trip to the Mentawais or appropriate compensation for their time.

Name: _____

Address: _____

Phone: (hm) () _____ (bus) () _____

Email: _____



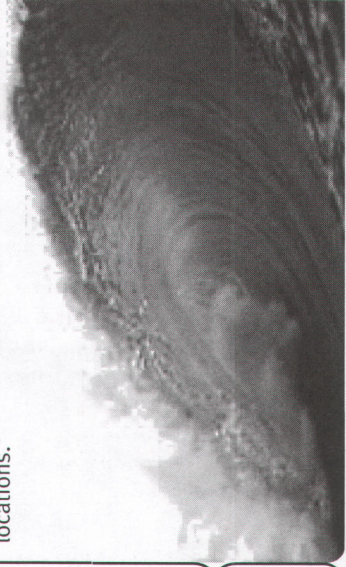
SURF-AID INTERNATIONAL



www.surf-aid.org

MISSION STATEMENT

Surf-Aid is a non profit organisation funded by the global surfing culture. Surf-Aid is medical aid for the poverty stricken indigenous people of remote surfing locations.



SURF MEDICINE AND A MERCIFUL END: THE SMA AT WORK

Graeme Nelson, MBBS
Eden, Australia

I want to convey the story of Peni Niwou (Penietati Nasovasova), who met a number of the SMA members at the 1999 Tavarua Conference. His story gives cause to reflect on the inequitable distribution of medical resources around the world (Fiji being far from the worst in this regard), but also on the strength of support from his community which allowed Peni to maintain his dignity in the most difficult of circumstances.

Peni's presentation and clinical findings are covered in the accompanying letter, which was my initial written contact with Peter Dohrmann, a Neurosurgeon working at the Epworth Hospital in Melbourne. I rang Peter shortly after the Tavarua Conference to explain Peni's plight, and to see if there was any way to assist him. I had known Peter quite well in Medical School at Monash University (Melbourne) in the 1970s, but contact with him in the intervening years had been very occasional. Peter's response to a call from out of the blue from an old acquaintance, about an unseen patient from another country, was fantastic. He said that Epworth could be approached to sponsor such a case, and armed with my letter he proceeded to arrange free treatment for Peni, not only by the hospital, but also by the treating doctors, and the pathology and radiology services. Jon Roseman from Tavarua was more than helpful in co-ordinating the process at the Fijian end, such as providing more information about

Peni lived in Solevu village on Mananuca (Plantation) Island, and worked at the Lakomai Resort on that island though he was on extended leave due to his state of health. His post was as Head of Security to the Chief. He was married, with four children, two of whom had left high school to help look after their father with a cerebellar tumour. The social work department also got involved in arranging accommodation etc. The only proviso made was that Peni would need to agree to be photographed, and for the story of his treatment to be used by Epworth Hospital as they saw fit.

Peni's social circumstances, and helping movement through the red tape of arranging passports and visas as well as finances. Various faxes, e-mails and phone calls ensued, with Peni finally seeing Peter in his rooms on September 14, 1999, from where he was admitted directly

to hospital. Peni's wife was able to accompany him, along with a 4 cm tumour in the right cerebellar hemisphere, with moderate obstructive hydrocephalus, had been diagnosed by CT scan in Suva in December 1998. Fiji having no suitable neurosurgical facilities, and the means not being available to arrange treatment elsewhere, he waited until the SMA Conference, when we were approached to help if possible. Not being served sentation and clinical findings coordinating From Peter's description, it seemed that further deterioration had occurred since we saw him in late June. I went to accompany him. This was helpful for translation as well as for social support. I did not get to meet him in Australia, as my home now is about 600 km from Melbourne. I did keep in contact with Peter Dohrmann about his progress.

Pre-operative MRI confirmed a large multi-lobulated cystic tumour in the right cerebellum and brain stem. Exact diagnosis remained uncertain, and there was still some room to hope that a surgically remedial process was involved. Unfortunately, the tumour extensively involved the brain substance, and it was not possible to perform a radical excision of it. The tumour cyst was decompressed, and biopsies obtained. He tolerated the surgery well and reportedly was in quite good spirits post-operatively.

The final histological diagnosis was high grade astrocytoma. In view of the advanced state of the tumour, further treatment such as radiotherapy was not considered to be likely to be beneficial. Accordingly, he returned home to Fiji after recovery from surgery. His life expectancy was considered to be less than a year, with further deterioration seeming inevitable.

On November 4, 1999, I was contacted by Jon Roseman with news that Peni had died quietly and unexpectedly. I am unsure of the mechanism of his death, and certainly Peter Dohrmann was surprised. I feel that this was a merciful end, and I am glad that it occurred back in his own community, without a protracted final deterioration. Remembering Peni from my brief contact with him some months earlier, I feel sure that he retained his dignity to the end.

Dear Peter:

I enclose further information about this 45 year old man who has an untreated cerebellar mass lesion, as we have discussed.

I was asked, with others, to see Peni, in late June 1999 when I was attending the SMA (Surfers Medical Association) Conference on Tavarua Island. Druku, the chief of the Tavarua

and Nabila villages was requesting assistance if possible for Peni, as there were no facilities in Fiji to treat his condition. Peni is from a neighbouring island, and had come over by boat to see us. He was unable to walk the short distance from the Tavarua Fijian Village to the resort, and we attended him in the village. He had been advised in Nadi and Suva that he would need treatment overseas. Druku said that money could be raised sufficient for his transport to Australia, but that costs of hospital treatment for Peni were beyond the means of his community. Hence the 7 month delay without a definitive diagnosis or treatment.

Obtaining a detailed history was difficult due to a combination of Peni's limited English vocabulary, and dysarthria due to his condition. Druku was able to translate most information. Peni's comprehension seemed to be quite good. Peni became unwell in the second half of 1998, with severe headaches and deterioration in functioning to the point of being unable to walk at all. His vision in the right eye had severely deteriorated. After his CT scan (report previously forwarded) he was treated with dexamethasone 2mg b.d. This had resulted in some improvement in his condition. He was able to walk short distances with assistance, and the headaches settled. There has apparently been little change in his condition since then.

Features noted on examination (assisted by the presence of a neurologist, Mike Rowbotham, and an ophthalmologist, Chris Allaman, both from USA) included gross ataxia, dysarthria, nystagmus, partial right third nerve palsy and cerebellar signs, particularly on the right side. He was virtually blind in the right eye (hand waving detected), with optic atrophy along with bilateral papilloedema. Atrophy of lower limb muscles was present. He was a tall man, undoubtedly previously a man of impressive strength and presence. I was impressed by his quiet dignity and bearing, regardless of his present disabilities.

I feel that Peni is very much deserving of what ever assistance can be provided. Certainly his extended community would be very grateful if the Epworth Hospital was able to facilitate his treatment.

I also am sending some information about the SMA, in the form of some pages from its journal, Surfing Medicine. As you will see, the SMA's interests extend beyond surfing to include medicine in isolated communities, with specific projects being undertaken in this part of Fiji.

With Regards
Dr Graeme Nelson

A COUP IN FIJI:

THE YEAR 2000 SMA TAVARUA CONFERENCE

Ward Smith, SMA Central
Aptos, California

A coup as defined by The New American Webster Handy College Dictionary is a sudden strategic move, a blow, or a stroke. In many ways this trip was a coup for the SMA. The first weekers scored great surf and all participants were able to witness great nighttime talks and inspiring visits to the villages.

THE DEPARTURE

As we were about to depart from SMA Central, in the redwoods of Aptos, Paula decided to check the SMA email one last time. There was one final missive from Simon Leslie, a dedicated Tavarua traveler who was not able to attend this year due to a previous commitment: the SMA boat trip to the Mentawis. Being the seasoned Tavarua traveler that he is, Simon had a final thought for us: "The surf is always better during a coup". With that Paula and I left the solitude of the redwood forests in Aptos, jumped on a plane in San Jose, and flew to LA to meet many of the other dedicated souls attending the 2000 SMA Tavarua Conference.

Upon our arrival to LaLa land, we found a contingent of dedicated souls by the Air New Zealand counter. After introductions, and some quick talk story, we were greeted with a pesky written document. The government of New Zealand was telling their citizens not to travel and Fiji and recommending that citizens living in Fiji should either leave or design a plan for a quick withdrawal. Oh well, nothing many of us haven't encountered before.

After settling in at the airport and talking some more story, we were bombarded with our second hit of the night. In an effort to minimize their time spent in the Nadi airport, New Zealand Air was extending our layover in Honolulu from 1 1/2 to 4 hours. That is a great tactic to deprive us of more of the necessary sleep needed to charge Tavarua on the following morning. Those of us who were properly prepared slept right through the layover.

When we arrived in Nadi, the airport was almost vacant and there were no problems.

The advantage of the layover and late arrival time was that we went straight to the boat launch for Tavarua. We were able to bypass the dingy Dominion, the hotel where we usually chill and have breakfast prior to the boat ride out to Tavarua.

The only evidence of the coup that we saw was one roadblock manned by Fijian police with machine guns. We sailed through; after all, we are the SMA.

SURF

Upon our arrival on the island, Cloudbreak was breaking a hefty head high with a few sets a shade over. It also was pretty windy but that did not dampen anyone's spirits. Two boats went out with 19 people and a good time was had by all.

The next day the surf was a tad smaller, but it was extremely glassy and boats came and went out all day. The only crowded session was the dawn patrol. After that it was common to surf with only 7 to 9 people. By sunset every surfer was extremely satisfied. What the surf lacked in size, it made up in quality.

The following day, Monday, north winds picked up and howled. The only crew that really scored was the dawn patrol and those who went out to the rights before sunset. On Tuesday Cloudbreak was firing with sets approaching double overhead and restaurants was going off at about head high with the occasional overhead set. There were very few surfers that didn't log serious water time. Wednesday was a repeat of Tuesday. By late Wednesday afternoon many of us were watching perfect, unriden, machine-like barrels at restaurants. Of course many were suffering minor aches and pains as well as sea lice allergies. It was shaping up to be a coup for the SMA. Thursday proved to be as good if not better and was a shade bigger and more consistent. Restaurants was firing as well as Cloudbreak- a coup indeed. Friday followed suit; the surf was great again. On Friday night Lono, a boatman/life guard, who had been on the island for two months, said our first week was the best week of surf since he had arrived. Rick, one of the owners, said: "The SMA always gets waves".

Although it had dropped, the surf was still good on Saturday when the new conference attendees arrived. They were quite satisfied after their first day of surf. Unfortunately the surf continued to drop; and by Tuesday it was flat. It stayed flat on Wednesday as well. On Thursday we had a glassy day with a little pulse. The sets were barely overhead. Friday dropped again and was horribly windy. It just goes to show you: "You should have been here last week".

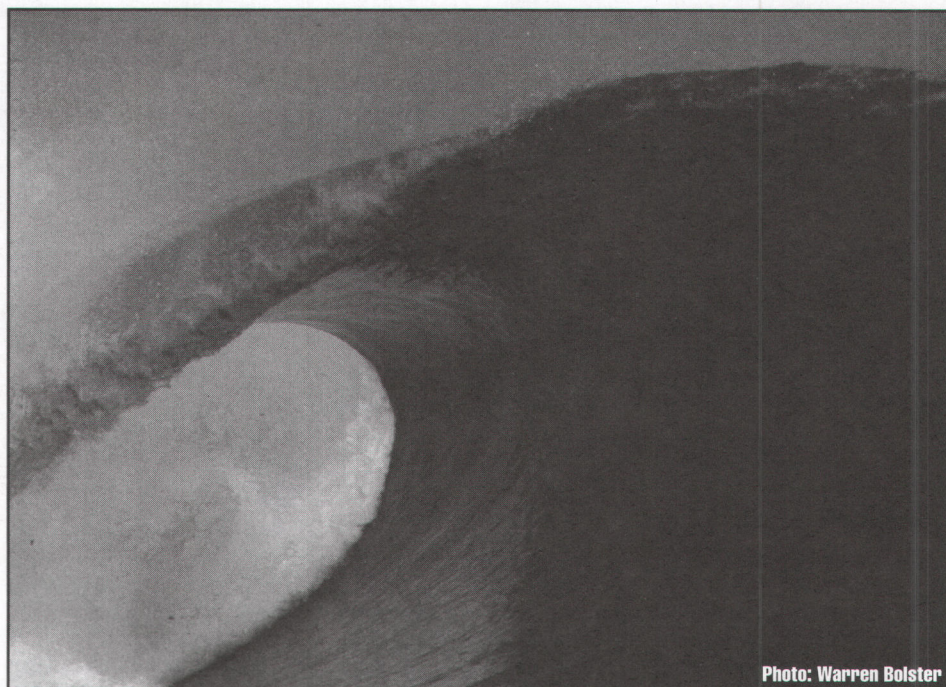
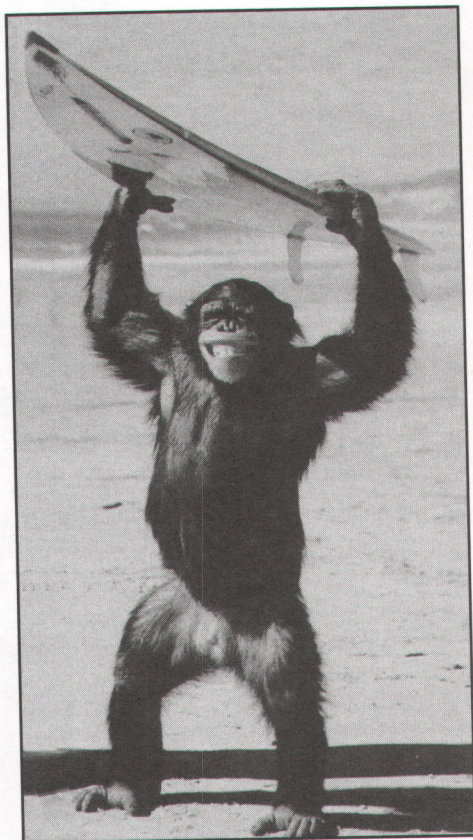


Photo: Warren Bolster

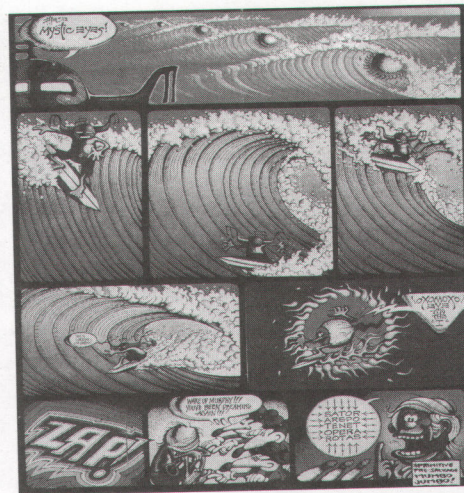


THE VILLAGE VISITS

I coordinated the visits to Nabila while Tom Holthus coordinated the visits to Momi. On Tuesday we went to Nabila and had just as special a time as ever. When we arrived, they were celebrating the ground breaking of a new house. Many of the villagers were crowded into the community center drinking kava and singing. It was truly a megacelebration. We were easily assimilated into their celebration.

After some serious celebrating, the doctors convened in the dispensary. I took a group that included several teachers off to the school. Our goal was to set up a series of activities and a slide show for Thursday.

Unfortunately when Thursday rolled around, we were told the school was closed because five people were shot in Suva on Tuesday. The schools were closed indefinitely on Wednesday. As a result we cancelled our visit and made other plans. As luck would have it, the schools were opened on Thursday and we went to the school on Friday. We had a very enjoyable, satisfying, and productive visit. We brought more than 400 toothbrushes and 200 containers of floss. We also brought books and



a variety of needed school supplies. The teachers and students were very grateful and expressed their gratitude in a wonderful performance of singing and dancing. We also brought pen pal letters and made paper chains that included the name, age, and favorite school activity of school children from Santa Cruz. They in turn made paper chains with the same info that we took back to the schools in Santa Cruz. We also brought back Responses to the pen pal letters. The school is always a wonderful place to visit.

THE TALKS

I organized the talks and was responsible for moderating the first week. The talks were very well received by the conference attendees. They covered a wide variety of topics that were of interest to both doctors and lay people. Topics included Malaria, recommended vaccinations for children for 2000, recommended vaccinations for traveling surfers, EMTALA law and how it affects doctors in a negative way for the purpose of protecting patients, the rationale for home births, gene therapy, and diving medicine. Shay Bintliff was the hit of the week for me. She brought "Surfing for Life" an extremely inspirational video that chronicles the stories of senior surfers and how they have stayed both healthy and stoked. Shay is one of the stars of the video. She also gave an inspirational talk on a wellness tool for adults that we all should consider examining as a guide to better health. It measures 5 components to help you assess your wellness. We had a first as well. Eric Allaman, a composer who scores movies and TV, brought a movie that he had recently finished. He described what he did and proceeded to screen the movie that was scheduled for release in August. It was definitely an interesting experience watching a movie while playing particular attention to the music. It was movie night on Tavarua. The talks were truly a coup for the SMA.



Photo: Warren Bolster



SMA FIELD REPORT: TRAUMA IN COSTA RICA

SMA members Joel Steinberg and Bob Speers got an unexpected opportunity to utilize their ER skills when they were first responders to the crash of a small plane near Pavones.

Joel and Bob had just spent a week surfing the legendary left point and checking out the nearby Tiskita Jungle Lodge for potential as the site for a future SMA conference. As their return flight came in, the single-engine commuter plane overshot the grass runway and slammed into some low trees. [Apparently, this was the inexperienced young Tico pilot's first attempt at landing on this short airstrip.]

Rushing to the crash scene, Drs. Steinberg and Speers found the plane to be a twisted wreck with blood splattered all over the interior of the cabin. Getting the injured out safely was the first priority and beach towels were pressed into service as emergency stretchers. Joel examined each of the victims [several young students on a field trip] and was able to triage cases needing immediate attention. Bob assisted the traumatized survivors and helped the Lodge personnel to co-ordinate transport of those needing urgent care to the regional hospital.

First aid supplies were ripped out of backpacks [reminding us again of the importance of being medically well prepared on any surf trip; you never know what you're going to have to deal with]. Bleeding was controlled, sterile dressings applied and fractures stabilized.

Miraculously, there were no fatalities. The most serious injuries involved broken noses and teeth, deep lacerations into faces and knees, and some possible internal organ hemorrhaging. Several victims clearly were in shock with low blood pressure and weak pulses. Amazingly also, there did not appear to be any significant CNS trauma.

After treating as much as was possible and getting the hospital-bound safely off, Joel and Bob went back to the runway to wait for another attempt at a return flight. This one proved to be [fortunately] uneventful. A later report confirmed that all the injured did well in recovery.

The sobering experience left the SMA'ers with lasting visual images of a blood-smeared heap of aluminum and a new appreciation of the hazards of air travel.



NOTES FROM SMA CENTRAL

Paula Smith, Aptos, CA, USA

1. We'd like to thank those who have generously donated to the Steve Baser Memorial Scholarship Fund over the past few years. Steve was an SMA member who died prematurely in 1993 and this fund is part of his legacy as one who loved both waves and the kids of Fiji.

Thank you:

Jack and Dorothy Baser
Janet Baser
Michael Baser
Paul and Rhonda Blaze
Geoff Booth
Colin and Barbara Brockman
Morris and Renee Brockman
Frances and Bill Cammer
Grant and Mindy Davis
Mike and Kim Douglas
Debbie Dorsey and Terry Smith
Richard and Merilee Ferdinand
Andrew Gault
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Andrew Hallam
Alex Kaliakin
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Rich and Laura O'Neil
Bill and Ann Padilla
Rym Partridge
Tony Peckham
Ron Pepitone
Bill Petersen
Louis and Linda Postma
Mark Renneker and Jessica Dunne
Sam and Ilene Rotenberg
Mike Rowbotham
Sick Surfers (courtesy of Mark Renneker,
Kevin Starr, and Geoff Booth)
Ward and Paula Smith
Jo Stroud
Al Ventzek
Norm Vinn
Ethan Wilson
The Brannan Family Foundation

Our "over & above" thanks to:

Michael Baser
Jack and Dorothy Baser
Geoff Booth
Frances and Bill Cammer
Grant Davis
David Millar

Ron Pepitone
Tony Peckham
Bill Petersen
Mark Renneker and Jessica Dunne
Mike Rowbotham
Ward and Paula Smith
Kevin Starr
The Brannan Family Foundation

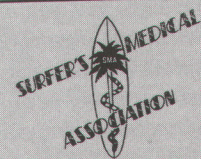
And our very special thanks to those in Fiji who have helped us administer the scholarships:

Sunia Vuniyayawa
Lorima Torosi
Rick Isbell
Jon Roseman

2. Thank you to all who have contributed to this year's Village Projects Fund. We have receive enough in donations to completely cover the cost of the meds on both village wish lists!

3. Members, Please check over your listing in the directory and notify Paula of any error in your listing.

Thanks, Paula
831-684-0916
SMACentral@aol.com



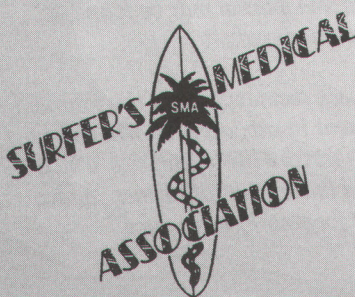
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Rules for Submission:

1. Send material in early — next deadline March 1st 2001.
2. Include pertinent references.
3. We'll love you forever if you put your material on a Mac disc, using Microsoft Word.
4. Include any graphics and photos (especially surf pics, particularly if they are of you).
5. Proof-read your stuff a couple of times — have your kids correct your spelling and punctuation.
6. We'll publish anything sent in that looks good and passes peer-pier review (we pass it around to SMA members and other derelicts hanging out under the pier; if it meets their rigorous standards, it's in).
7. Mail to: Editor, Surfing Medicine, 2396 48th Ave., San Francisco CA 94116 USA





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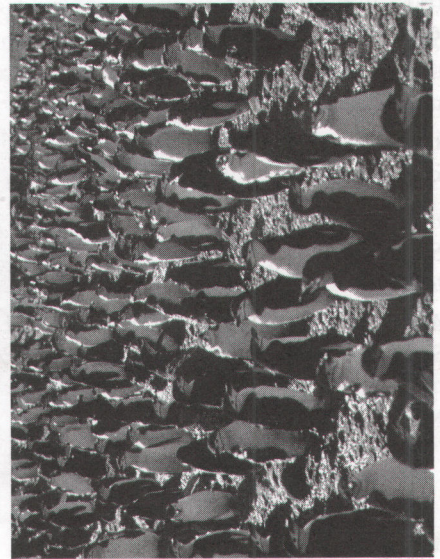


Photo by Mark Remaker, MD