Title

Incidence, Diagnosis and Management of Injury in Sport Climbing and Bouldering: A Critical Review

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Abstract

Competition climbing as an Olympic sport will debut at the 2020 summer games in Tokyo. The aims of this article are to critically review the incidence of injury in sport climbing and bouldering; the pathophysiology and presentation of finger and shoulder injuries; and the diagnostic and therapeutic algorithm for finger injuries. A semisystematic approach in reviewing literature on incidence was applied. Articles were identified after searches of the following electronic databases: Discover, Academic Search Complete (EBSCO), PubMed, Embase, SPORTDiscus, and ScienceDirect. Despite methodological shortcomings of the included studies, we estimated the mean ± standard deviation of the incidence rate of injury in sport climbing and bouldering from the eight studies to be 2.71 ± 4.49/1000hrs. Differential diagnosis and the clinical management of finger and shoulder injuries in climbers is challenging. An updated diagnostic and therapeutic algorithm for the clinical management of finger injuries in climbers is presented.
1.0 Introduction

Competition climbing as an Olympic sport will debut at the 2020 summer games in Tokyo. The competitive disciplines are sport lead climbing, speed climbing and bouldering. Sport lead climbing utilises a belayed dynamic rope that is attached to the climber. The belayed rope is connected to pre-fixed anchor points during the ascent by the climber and acts as a safeguard in the event of a fall. Speed climbing utilises a mechanically assisted belay device from above to protect the climber in the event of a fall. Climbers attempt to complete the 15 metre standardised route in the fastest time. Bouldering involves movement sequences performed on a pre-determined direction of travel, without a rope, at a relative short distance from the ground. Safety mats safeguard the climber in the event of a fall. The popularity and professionalism of climbing is likely to result in an increase in climbing related injuries as part of the caseload presenting to sports injury physicians and other health care professionals (1).

Previously we conducted a critical review of the incidence and risk factors for injury in rock climbing (2). Analysis of 11 studies found the mean incidence of injury irrespective of climbing behaviour to be 5.81/1000h (SD ± 11.19), with a point prevalence found to vary between 10% and 81% irrespective of cause. The most commonly injured structure was the annular pulleys of the fingers and we reported evidence to suggest epiphyseal fractures in adolescent sport climbers was increasing. The aims of this article are to critically review research on the incidence of injury in sport climbing and bouldering; the pathophysiology and presentation of finger and shoulder injuries; the diagnostic and therapeutic algorithm for finger injuries originally presented in 2016 (2).
2.0 Methods

An electronic search of the following electronic databases was performed on 9th February 2018: Discover, Academic Search Complete (EBSCO), PubMed, Embase, SPORTDiscus, and ScienceDirect. Combinations of the MeSH headers ‘mountaineering’; ‘risk factors’; ‘athletic injuries’, and free text terms ‘rock climb*’ (Boolean Phrase); ‘climb*’ (Boolean Phrase); ‘injury*’ (Boolean Phrase) ‘risk factors*’ (Boolean Phrase) were used in the search. One reviewer (GJ) reviewed titles and abstracts for relevance according to the following eligibility criteria: A primary study on sport climbing and/or bouldering that reported an estimate of the incidence of injury.

3.0 Incidence of Injuries

We found eight primary studies with data to estimate the incidence rate of injury per 1000 hours of activity (Table 1). The maximum incidence rate was 13.04/1000hrs (3) and the minimum incidence rate was 0.02/1000hrs (4). We estimated the mean ± standard deviation of the incidence rate of injury in sport climbing and bouldering from the eight studies to be 2.71 ± 4.49/1000hrs. The mean ± standard deviation incidence rate of injury from five prospective studies was 3.40 ± 5.54/1000hrs (3). The mean ± standard deviation incidence rate of injury from three retrospective studies was 1.56 ± 2.50/1000hrs {Limb, 1995 #82, 4-9). The mean ± standard deviation incidence rate of injury from six studies that sampled injuries from indoor climbing environments was 2.83 ± 5.14/1000hrs (3-7, 10). The mean ± standard deviation incidence rate of injury from two studies that sampled injuries from indoor and outdoor climbing environments was 2.32 ± 4.00/1000hrs (8, 9). The mean ± standard deviation incidence rate of injury from two studies that sampled injuries that occurred during competition climbing was 1.92 ± 1.67/1000hrs (5, 7). One study estimated the incidence rate
of injury during competitive sport lead climbing as 0.29/1000hrs, competitive speed climbing as 0.00/1000hrs, and competitive bouldering as 1.47/1000hrs (5). Confidence in the precision of these estimates of the incidence rate of injuries is undermined because of heterogeneity in the methodology of the primary research studies including inconsistency in the use of injury terminology, level of injury reported, data collection procedures, calculation of exposure and operational measures of performance. There is a need to consolidate reporting standards for epidemiological cohort studies in rock climbing.

[Insert Table 1 here]

4.0 Shoulder Injuries in Climbing
The shoulder typically accounts for 17% of all climbing related injuries (3, 11). Sport climbers and boulderers are particularly susceptible to the development of shoulder injuries due to prolonged and repetitive upper limb movements on vertical or overhanging terrain. A cross sectional cohort study of 201 climbers found the shoulder injuries to be positively related to the frequency and difficulty of indoor and outdoor sport climbing and bouldering (12). An evaluation of injury trends in sport climbing and bouldering over a four-year period found superior labral anterior posterior tears and impingement of sub-acromial structures to be the most common diagnosis (11). The aetiology of impingement is often multifactorial with a complex biomechanical interaction between active and passive anatomical structures within the shoulder (13) with some authors now preferring to describe the condition as Subacromial Pain Syndrome. Definitive diagnoses may include thickening of the coracoacromial ligament, partial or full thickness tear of the supraspinatus, bursal hypertrophy and tendinopathy. Literature refers to structural narrowing of the sub-acromial space and dysfunction as ‘primary’ impingement and dynamic instability as ‘secondary’ impingement. Internal impingement refers to the entrapment of soft tissue such as the
supraspinatus, infraspinatus, long head of the biceps tendon and joint capsule between the glenoid rim and the humeral head (14). Internal impingement may be further classified as posterior superior impingement or anterior superior impingement (14). Determining a differential diagnosis and the severity of pathophysiology of shoulder impingement can be challenging. A systematic review found insufficient evidence to support the use of physical tests to diagnose shoulder impingements and local lesions of bursa, tendon or labrum (15). Although simple physical tests, such as the painful arc, can provide valuable diagnostic information especially in remote settings (16). The British Orthopaedic Association patient care pathway recommends conservative treatment including injection therapy in the primary care setting and should a patient require referral to secondary care services the integrity of the rotator cuff may be assessed using ultrasound and/or magnetic resonance imaging (17).

Surgery may be considered when conservative treatment fails and for individuals with significant or consistent pain and/or loss of function. Arthroscopic repair of acute and chronic tears of the rotator cuff (Simon, et al., 2017) and Superior Labral Anterior Posterior repair with primary long biceps tenodesis (18) have produced favourable functional outcome with participants returning to high level climbing performance.

5.0 Epiphyseal Growth Plate Fractures of the Fingers in Adolescents

The average age of competition climbers has decreased significantly in the last 10 years (1). Adolescent competitive climbers engage in structured training programs designed to improve performance but paradoxically places large amounts of stress on an immature skeleton. There are few studies on adolescent climbing populations, although initial data suggests an increase in epiphyseal fractures of the promixal interphalangeal joint (2, 11, 19, 20). A secondary analysis of adolescent climbing data found 50% (13/26) of all reported injuries were fractures
of the growth plate (19). A case series of 22 injuries found a higher proportion of growth plate fractures in adolescent male climbers (n=14) than adolescent female climbers (n=4) with the middle finger to be affected in 95% of cases (20). Early identification of such injuries is desirable to avoid serious complications such as premature closure of the growth plate leading to asymmetrical deformity of the finger.

The risk of growth plate fractures is suggested to be associated with unrestricted use of dynamic finger training apparatus, failure to monitor training and competition load (2). Non modifiable risk factors may include growth velocity and hormone regulation (20). Clinical examination may reveal localised swelling, pain and/or tenderness on the dorsal aspect of the proximal interphalangeal joint usually of the middle or ring finger. Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) should be used to confirm diagnosis as plain radiographs may not ‘rule out’ a fracture (21). The most common fracture presentation reported in adolescent climbers to date is a Salter-Harris type III (21,22). Conservative measures for non-displaced fractures usually allows most climbers to return to pre-injury activity levels. However, complications may arise due to injury severity (Salter-Harris type IV or V) and in cases of non-union. Surgical intervention using percutaneous spot drilling epiphysiodesis has shown encouraging results (23).

6.0 Annular Pulley Injuries
The annular pulleys of the fingers are the most commonly injured structures in climbing (11). Climbers usually present with pain and tenderness on the palmer aspect of the finger and an audible ‘pop’ may be reported to have occurred at the time of injury. When the finger is flexed discreet bowstringing of the tendon may be indicative of multiple pulley rupture (A2, A3 and A4). Ultrasound imaging confirms diagnosis of A2 and A4 pulley rupture when
dehiscence between tendon and bone is greater than 2mm (24). Anatomical variation in the origin of the A3 pulley means a threshold dehiscence greater than 0.9mm between volar plate and tendon is predictive of A3 pulley rupture (24). Climbers with chronic degenerative change to the annular pulleys have been found to have a dehiscence greater than 2mm in absence of rupture (25). MRI may be considered in cases of high-grade injuries and when ultrasound is inconclusive (21). Surgical reconstruction using the loop and a half technique with an auto graft of the palmaris longus muscle is currently the preferred method for repair of the A2 and A4 pulleys in climbers (26). A new transosseous variation of this repair has recently undergone a feasibility study with the authors concluding favourable outcomes as it reduces the likelihood of extensor tendon irritation with the extensor hood (27). Of note, conservative management of triple pulley rupture (A2, A3, and A4) using thermoplastic rings has also produced positive results (28). Treatment using thermoplastic rings should commence immediately, providing tendon bone distance can be satisfactorily reduced, and confirmed by ultrasound.

**7.0 Diagnostic Algorithm for Finger Injuries**

In 2016, we developed a diagnostic and therapeutic algorithm for finger injuries in climbers for the identification of annular pulley injuries and epiphyseal fractures in adolescents (2). We have updated the algorithm (see Figure 1) to reflect the latest research and practice based evidence including new surgical options for epiphyseal injuries, differential diagnosis consideration for chronic tendonitis and preference of MRI rather than plain x-ray for growth plate fractures.

[Insert Figure 1 here]
9.0 Summary

The findings from our critical review provide an estimate of the incidence of injury in sport climbing and bouldering. We estimated the mean ± standard deviation of the incidence rate of injury in sport climbing and bouldering from the eight studies to be 2.71 ± 4.49/1000hrs. Differences in injury terminology, data collection procedures, calculation of exposure and operational measures of performance used by authorship teams’ likely accounts for the variance found. Differential diagnosis and the clinical management of finger and shoulder injuries in climbers is challenging. In particular, early identification of growth plate injuries in adolescent climbers is paramount.
References


Captions

Table 1: Incidence rates and commentary of reviewed studies

Figure 1: Diagnostic and therapeutic algorithm for suspected annular pulley and epiphyseal injuries
Table 1: incidence rates and commentary of reviewed studies

<table>
<thead>
<tr>
<th>Reference</th>
<th>Survey duration</th>
<th>Survey method</th>
<th>Sample type and number</th>
<th>Type of injury</th>
<th>Site of injury</th>
<th>Injury incidence rate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limb, (1995)</td>
<td>Retrospective</td>
<td>Postal survey requesting data over a specified 2 year period from each climbing wall on significant injuries that resulted from indoor climbing and referral to an A&amp;E department.</td>
<td>Location: 90 indoor climbing facilities Behaviour: indoor sport climbing Sample Size: 1.021 million indoor climbing visits</td>
<td>Impact and No Impact Acute trauma</td>
<td>Any site</td>
<td>0.027/1000hrs</td>
<td>Calculation of incidence rate by Shoffl et al (2010) for a secondary analysis. Authors based calculation on data reported in the study.</td>
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<tr>
<td>Shoffl &amp; Winkelmann (1999)</td>
<td>Prospective</td>
<td>Data was collected from 10 climbing walls over a 6 month period. Exposure was calculated at time spent at the facility.</td>
<td>Location: indoor climbing facilities Behaviour: indoor sport climbing Sample Size: 25,163 registrants</td>
<td>Impact and No Impact Acute Trauma</td>
<td>Any site</td>
<td>0.079/1000hr</td>
<td></td>
</tr>
<tr>
<td>Schoffl &amp; Kuepper (2005)</td>
<td>Prospective</td>
<td>Data recorded during the course of the world championship finals by medical team.</td>
<td>Location: indoor climbing world championship Behaviour: indoor sport climbers Sample Size: 443</td>
<td>Impact and No Impact Acute Trauma</td>
<td>Any site</td>
<td>3.1/1000hrs</td>
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<tr>
<td>Neuhof et al (2011)</td>
<td>Retrospective</td>
<td>Cross sectional, 5 year recall, Self-reported electronic survey. Authors analysed the five most significant injuries as reported by each participant</td>
<td>Location: internet survey site Behaviour: indoor sport climbing Sample Size: 1962</td>
<td>Impact and No Impact Acute Trauma</td>
<td>Any site</td>
<td>0.2/1000hrs</td>
<td>Study surveyed the 5 most significant injuries. Injuries classified according to International Climbing and Mountaineering Federation MedCom classification</td>
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<tr>
<td>Schoffl et al. (2013)</td>
<td>Prospective</td>
<td>Single site study. Over a 5 year period. Climbing exposure was recorded as time spent from entry to the indoor climbing wall to leaving (capped at 5 hours maximum)</td>
<td>Location: indoor climbing facility Behaviour: indoor sport climbing &amp; indoor bouldering Sample Size: total number of climbing wall visits 515,337</td>
<td>Impact and No Impact Acute Trauma</td>
<td>Any site</td>
<td>0.02/1000hrs</td>
<td>Injuries classified according to International Climbing and Mountaineering Federation MedCom classification</td>
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<tr>
<td>Authors</td>
<td>Study Design</td>
<td>Study Details</td>
<td>Location</td>
<td>Behaviour</td>
<td>Sample Size</td>
<td>Sample Frequency</td>
<td>Injuries Classified According To</td>
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<tr>
<td>Schöffl et al (2013)</td>
<td>Prospective</td>
<td>Series of 22 indoor world cup climbing competitions. Injuries assessed and reported by medical team present at each event.</td>
<td>Indoor climbing facilities</td>
<td>Indoor sport climbing</td>
<td>Not stated</td>
<td>3405 hours; bouldering: 2707.5 hours; speed climbing: 637.5 hours</td>
<td>Impact, No Impact</td>
</tr>
<tr>
<td>van Middelkoop et al (2015)</td>
<td>Prospective</td>
<td>Initial self-reported baseline questionnaire. One year follow up study with data collection every 3 months by self-reported questionnaire</td>
<td>Indoor climbing facility</td>
<td>Recreational indoor climbers &amp; indoor boulderers</td>
<td>426</td>
<td></td>
<td>Impact, No Impact</td>
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<tr>
<td>Woollings et al (2015)</td>
<td>Retrospective</td>
<td>Cross sectional, self-reported questionnaire, 12 month recall period</td>
<td>Indoor climbing walls</td>
<td>Recreational &amp; competitive indoor &amp; outdoor sport climbers &amp; boulderers</td>
<td>116 youth climbers</td>
<td></td>
<td>Impact, No Impact</td>
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</table>
Aetiology of Injury

Acute trauma
sudden onset symptoms

Dynamic loading of digit

± Audible 'pop' ± Pain ± Swelling ± Tenderness palmar aspect of A2, A3 or A4

Discreet bowstringing of flexor tendon

Suspect high grade injury, (triple pulley rupture)
Confirm: Ultrasound ± MRI

Consider conservative management using 'thermoplastic ring' and rehabilitation

Surgical intervention and rehabilitation

Return to full climbing activity in approx 6 months

Chronic overuse (adult)
insidious onset

± Pain ± Swelling ± Tenderness palmar aspect of A2, A3 or A4

Suspect pulley strain
'rule out' Tenosynovitis
Confirm: Ultrasound

Conservative management

Return to full climbing activity in approx 6 weeks

Chronic overuse (adolescent)
insidious onset of symptoms

± Pain ± Swelling ± Tenderness palmar aspect of A2, A3 or A4

Suspect epiphyseal fractures of the PIP joint

MRI to confirm ± CT scan

Conservative management

Non-union of fracture
refer orthopaedic assessment

Progressive return to full climbing activities with training guidance and 'load monitoring'

Surgical preference: high grade injuries

Chronic overuse
insidious onset of symptoms

± Pain ± Swelling ± Tenderness palmar aspect of A2, A3 or A4

Suspect pulley strain
'rule out' Tenosynovitis
Confirm: Ultrasound

Surgical intervention and rehabilitation

Return to full climbing activity in approx 6-12 weeks

does not respond to conservative management
refer orthopaedic assessment

Conservative management

Progressive return to full climbing activities with training guidance and 'load monitoring'

Surgical preference: high grade injuries

Chronic overuse
insidious onset of symptoms

± Pain ± Swelling ± Tenderness palmar aspect of A2, A3 or A4

Suspect pulley strain
'rule out' Tenosynovitis
Confirm: Ultrasound

Surgical intervention and rehabilitation

Return to full climbing activity in approx 6 weeks