Medical Aspects

Of

Amateur Boxing

The Medical Commission of
The Amateur Boxing Association
Of England Limited

5th Edition 2006
I. Introduction

This booklet is a summary of the rules, recommendations and advice relating to the medical aspects of amateur boxing in England. It is an attempt to present relevant information in a single cover to aid club and ABAE officials and medical officers in the care of their boxers and the promotion of the sport. It includes an introduction to the sport of boxing for the benefit of doctors newly involved with the sport. We hope it will help them to appreciate its ethos. Similarly, the section on general medical matters is directed towards coaches and other officials of ABAE, to give them some advice on the treatment of specific injuries, general hygiene, diet and so on, and to inform them of the various medical facilities so that they may make better use of them. It is a guide and it is not comprehensive.

A. GENERAL PRINCIPLES

Boxing is a contact sport in which points are scored by landing blows with force on the opponent. Inevitably there is a risk of injury to those who box. The objective of the medical scheme and those who operate it is to minimise that risk of injury. The care and welfare of the boxers is the most important aspect of amateur boxing.

Many officials have a responsibility for the care of the boxer. These include the coach, the competition secretary (who arranges the bouts), the referee, the tournament medical officer and his assistant, the official-in-charge, the recorders and the medical officers of the clubs, associations and the ABAE. The ultimate responsibility rests with the executive council, where the rules are made and attitudes in the sport are determined. The highest standard of medical care can only be attained if all those concerned carry out their duties with the greatest sense of responsibility and in a spirit of co-operation.

B. CONFIDENTIALITY

It must be remembered by all those concerned with the training, care and administration of a boxer’s career that medical information is confidential and must never be divulged to any person, within or outside the sport, who does not have proper reason to be informed of it. A boxer gives information about himself on this understanding, and is entitled to expect that such personal information will be handled with due care and respect.

The General Medical Council holds confidentiality to be a central pillar of medical practice and regards any breach of it to be a very serious offence. Breach of confidentiality is an abuse of privilege conferred by custom. A patient grants a doctor privileged access to confidences. Good medical practice depends upon the maintenance of trust between doctors and patients. A doctor must exercise great care and discretion in order not to damage this relationship. The medical officers of the ABAE and its associations and divisions rely on other officials paying this same regard to the confidentiality of the medical information that they hold, so that proper medical care may be provided for boxers. If it is desired to pass on such confidential information to a third party, the boxer or other person to whom the information relates, should be asked to give their consent for this to occur. It could be argued that this should be done even when two officials are in legitimate discussion about the case (e.g. local and central records officers), but in such cases it can be assumed that consent is given when voluntarily submitting to ABAE rules and regulations, such as when joining an affiliated club. This principle, however, should not extend beyond the correct transfer of personal medical information indicated in this booklet. Breach of confidentiality is serious and undermines the effectiveness of any medical care, whether part of amateur boxing or not.

This has been a fundamental pre-requisite in the establishment of the secure database and website for collation and transmission of ABAE records, both medical and sporting.
All officials holding documents or computer records containing medical information have a
duty to ensure that they are securely held and are not made available to any person who
does not have legitimate access to them. If any official is in doubt about his position
regarding the confidentiality of information he holds, advice may be sought from the medical
officers of his association, from the medical commission, or from the legal adviser to the
ABAE.

All computer-held information must be held in accordance with the Data Protection Act of
1998 and any subsequent amendments thereto. The controller of such records must be
registered with the information commissioner and medical information must be held within
sections of such computers protected by security codes. Medical records will be destroyed
after a boxer has retired from boxing in accordance with the then current government
guidelines regarding data retrieval for medical records. Non-individual identifiable medical
information may be kept in perpetuity for research and statistical analysis.
II. An introduction to the sport of amateur boxing

Amateur boxing is a unique sport in which the ability to land legal blows with force on the target area of the opponent is balanced against the skill in avoiding them. It caters for those with a particular combination of physique, physical skills and psychological make-up. It attracts persons who wish to learn this form of self-defence and who desire to test themselves in this most arduous form of individual combat. In addition, an essential part of the sport is the open exhibition of skill and fortitude in front of a crowd.

Females may now participate in amateur boxing and so all references to “He/his or boy” with regard to boxers (or officials) should also be accepted as referring to females as well.

Boxing demands a high standard of physical fitness. The few minutes spent in a ring are a climax to many hours of hard physical training. It provides a healthy and enjoyable form of training for life and an excellent opportunity to develop discipline and self control. This is carried out in a friendly yet competitive atmosphere, in which mutual and self respect is acquired, together with a sense of social responsibility.

After joining a club, a boxer trains in the gym for a time – usually many months – until ready for that first contest. During this period the basic skills and discipline of the sport are learnt and physical fitness is developed. Those who persevere progress to competitive bouts, where their own skill, ability and inner resolve are put to the test.

A competitive bout consists of three or four rounds, each of which may last from 1½ minutes in schoolboy contests to 2 minutes at senior level. During this time the boxer must demonstrate to the judges an ability to deliver blows to the front of the opponent’s head and trunk above the belt (the target area). To score points, these blows must be delivered with the knuckle part of the gloved hand and must land “with force”.

Generally a computer-operated scoring system is now used by ringside judges in amateur boxing. They have a small machine with a red and blue button which is pressed when either the red or blue boxer scores a correct blow on the opponent. When three or more judges press the button within one second of each other, a scoring blow is registered. The final score is the total number of points scored by each boxer when averaged out by the central computer. The winner is the one with the highest score but if equal then the computer then finds the winner by calculating back on all points awarded by every judge (‘countback’).

Three judges (or five, if computer scoring is used) score each bout independently, sitting immediately outside the ring. Each sits on a different side, and thus has a different angle of view from the others. They watch for blows carefully to assess which are legal and count towards the score. If a true computer scoring machine is not available then hand-held AIBA calculator scoring machines are often used and the individual judges give their own score for each round. These are then added at the end of the bout to give the final result.

Traditional, non-computer scoring is rarely used now, but in this system each round is scored separately, the winner being given 20 points. If 2, 3 or 4 legal blows more than his opponent have been landed, the latter is awarded 19 points; if the difference is 5, 6 or 7 blows the score is 20-18 for that round, and so on.

If the bout is very one sided, the referee should stop the contest early on, ruling the opponent outclassed.

The majority of bouts are decided on points – the boxer who gains the highest aggregate score being the winner. With this system, if points are equal at the end of three rounds, then the bout is awarded to the boxer who has done most of the leading off or who has shown the better style, or, if equal in that respect, who has shown the better defence. Each judge must nominate a winner.
A boxer is considered ‘down’ if any part of the body other than the feet touches the floor, or the boxer is hanging helplessly on the ropes. In this situation, the referee will start to count. If the boxer is not recovered and ready to box again in 10 seconds, this is a ‘knockout’ and the bout is awarded to the other contestant. The referee will halt the boxing and start a count if he considers that one boxer has received a particularly hard blow. However quickly the boxer recovers, the minimum count is eight seconds. If a boxer receives three such counts in one round, or four such counts in the entire contest, then the bout is stopped in favour of the opponent (this varies in junior and female bouts). Contests may also be decided by disqualification, by one boxer consistently fouling the other, by voluntary retirement, or if one boxer sustains an injury which in the referee’s opinion renders that person unfit to continue.

At some contests adjudicators are present. These are senior ex-referees who sit at the ringside and monitor the performance of the judges and referees. This is essential for the maintenance of standards in refereeing, and thus for the safety of the sport. Other officials present at a tournament include the timekeeper, who regulates the number and duration of rounds and the interval between them, and the official-in-charge who has the ultimate responsibility for all aspects of the tournament and has powers commensurate with this.

The referee remains inside the ring throughout the bout and is in sole charge of the contest once it is underway. He moves with the boxers and is in the best position to see that they are protected from unnecessary injury and that the rules are adhered to. He can order contestants to box, to stop, or to break. He can caution a boxer who infringes the rules, warn if these infringements are serious or repetitive, and institute a count if there is a knock-down or if he considers the nature of a blow indicates a short recovery period is required.

Contestants are matched by the competition secretary, usually an experienced official of the host club, who has to match the pair who will face each other in the ring. He tries to select two boxers who are to all intents and purposes equally matched. Age, weight and experience are the factors to be considered. All boxers between the minimum age of 11 years and 17 years are divided in categories of 12 months, and, other than for exceptional open class boxers, a 17 year old may not box an opponent aged 19 years or over. Weights are classified into bands of about 3 kilograms (2kg in schoolboys) and only a certain amount of weight may be conceded. Senior boxers are classed as novice, intermediate or open, but for a youth, the competition secretary must take account of the number of contests, the standard of any opponent, and especially the calibre of the individual boxer. Matching is a most important task as real skill can only be shown when boxers are evenly matched. Good matchmaking is an important factor for maintaining safety in the sport.
III. General Medical Matters

A. MEDICAL SERVICES

1. The General Practitioner

Continuing medical care of every person in this country is provided by the general practitioner (GP – the family doctor). The GP should always be the first person to be contacted in cases of illness or non-urgent injury. The GP holds the medical records of the patient, is familiar with the patient, the family and social circumstances and will undertake the diagnosis and treatment of the majority of medical problems. In this, simple investigations (such as X-rays and blood tests) may be arranged in the local hospital and the GP can also call upon the health visitor, district nurse, chiropodist and a range of social services for assistance.

2. The Accident and Emergency Department

The other facility to which patients have direct access is the hospital accident & emergency department. Its function is described in its title, and must not be abused. It has close links with X-ray and physiotherapy departments and is equipped to carry out minor surgery such as suturing lacerations and incising small abscesses. It is able to deal with a whole range of accidents from a simple cut to a major road traffic accident as well as the initial diagnosis and treatment of serious and sudden medical illness or collapse. The A&E department is not an alternative to the GP for routine care. It has been established to deal with accidents and emergencies and not long-standing conditions or minor medical problems. At the earliest opportunity, the patient will be referred back to the GP or, in more serious cases, to the care of a hospital specialist.

3. The Hospital Specialist

Patients do not have direct access to hospital specialists but can only be referred to them by the GP or the A&E department. They may do this for a number of reasons – the diagnosis of difficult cases, for advice on treatment, for specialist treatment or rehabilitation, or for special nursing care. Unless the patient is admitted to hospital under a specialist, the GP retains control of the situation and is in frequent contact with the specialist to whom the patient the patient has been referred.

4. ‘Boxing Doctors’

Doctors who give their time to examine boxers, to officiate at boxing tournaments, to undertake the role of club doctor, or who take part in the administration of the sport, do so outside the provision of the National Health Service. Appointment as a medical officer to the ABAE or one of its associations is honorary, though travelling expenses are refunded. Payment to doctors acting in other capacities is by mutual agreement between the doctor and club or organisation. There is a standard BMA scale of charges for carrying out a full medical examination and for a doctor’s presence throughout a long evening tournament. A charge of £150 is not excessive (BMA sessional rates are far in excess of this). However, it is hoped that a doctor who offers his/her services to amateur boxing will recognise that many boxers are not well-off and that many clubs have small revenue, and so he/she may moderate their charges accordingly.

This also applies to boxers’ medical examinations and clubs should have arrangements with their own doctors to ensure adequate recompense for the time and expenses incurred. £10-25 per medical is not unreasonable when BMA rates for one medical may be in excess
of £90. Clubs should ensure that their doctors are respected and well looked after and should co-operate in order to minimise any disruption to the doctor’s normal schedule.

5. First Aiders

First aiders do not necessarily have medical training, but have a current first aid certificate issued by a reputable approved organisation. They are normally members of St. John’s Ambulance Brigade or The British Red Cross Society. These are both voluntary organisations and their personnel give their time freely. They perform a great deal of valuable work, both in the community and internationally, which is all funded by gifts from the general public. If clubs make use of their services at tournaments, then a donation to their organisation is appropriate. The first aiders themselves are competent to deal with an accident or medical emergency within their training qualification and also to decide whether or not further medical care is necessary. There are many more highly qualified personnel working for these organisations. They have advanced skills that can be used in more serious situations. The appropriately qualified first aiders for the event would be decided by their organisations and the event medical officer. The ABAE has a scheme for officials and coaches to undertake first aid training in order to administer care with their doctor using ABAE approved medical bags.

B. FIRST AID ADVICE

This can only be a brief introduction to some of the problems that might arise in the gym or at a tournament. Injuries are as likely to result from normal activities as from boxing and to officials and onlookers as to boxers. In using first aid techniques there is no substitute for practical experience. All officials, but particularly coaches, referees and officials-in-charge, are very strongly recommended to undertake formal training in first aid and to maintain a valid first aid certificate.

Everyone assisting an injured person should be aware of the risk of infection from body fluids and therefore disposable gloves should always be worn when giving any first aid care. This is imperative when dealing with a bleeding wound.

1. Bruising and Swelling

a) Swelling is usually caused by bleeding under the skin; the closer to the surface it is, the sooner it will appear as bruising. Both should be treated as soon as possible with ice packs and firm pressure. If the injury is to a limb, this should be elevated. Ice packs can be repeated frequently over the first 48 hours, during which time any form of heat or massage should be avoided as this will increase the bleeding. After this period, alternating applications of ice packs and hot compresses can be applied, a minute or so for each over a period of half an hour, repeated every few hours.

b) Swellings which are tender to touch should be treated with care because a more serious injury to muscle, ligament, bone or joint may be present beneath. If in doubt, medical opinion should be obtained.

2. Sprains and Strains

a) A sprain usually occurs at a joint when the ligaments and tissues around the joint are wrenched or torn. Some sprains are minor but others can cause extensive damage to the tissues and are difficult to distinguish from fractures. When in doubt, treat as a fracture. A strain occurs when a muscle or group of muscles is overstretched and possibly torn by a sudden movement.

b) Initial treatment for sprains and strains is the same as for bruising and swelling; rest, ice, compression and elevation for the first couple of days. After this period, gentle mobilisation may be started and gradually increased with time. It is important not to
progress too quickly, otherwise further injury will occur. A good maxim is that if pain or swelling increases as mobilisation proceeds, then progress is too fast. Many sprains and strains require some splintage or support in the early stages, and supervision during healing. If they appear at all serious, then medical advice should be sought.

3. Fractures and Dislocations

a) These injuries are serious and demand medical attention, but fortunately are rarely caused by boxing. They are more likely to occur as a result of general activities rather than those specifically associated with boxing. In boxing, the hands and jaws are most frequently involved. A very heavy blow might fracture a rib. Pain is severe and localised to the injury. Swelling and bruising are usually marked, and the bone is very tender to touch at the site of injury. Any use of the injured part is very painful. Signs which leave no doubt about such an injury are: an abnormal shape, an open wound in which the bone can be seen, and a coarse grating sound if the limb is moved. If there is a complete absence of movement below the injury, numbness of the skin or gross swelling, then there is also injury to nerves and/or blood vessels and emergency medical care is required.

b) The injured person must be given nothing by mouth (not even a sip of water) in case an anaesthetic and operation may be needed. An injured limb should be supported in the position in which it lies. The casualty should be transported to hospital as soon as possible, unless the injury is such that he/she cannot be moved. In this case, be reassuring and call an ambulance.

4. Lacerations

a) The only thing that should be applied directly to a cut is sterile gauze and the gauze should be held firmly in place until the bleeding has ceased. Adrenaline must not be used as it is readily absorbed and is a dangerous stimulant to the heart. The cut must not be rubbed with a wet sponge or towel. This will increase the bleeding, damage the wound edges, deepen the cut and probably infect it. This all leads to prolonged healing and a weak scar subsequently.

b) Small, clean and superficial lacerations may be treated as above, and the wound edges may be brought together using micropore, steristrip or butterfly sutures. More serious wounds (and in any case of doubt) require the attention of a medical practitioner for suturing or the use of specialist medical glues, such as dermabond.

5. Bleeding

a) Disposable gloves must be worn when dealing with any wound, especially if bleeding.

b) Bleeding will usually stop with adequate direct pressure on the wound and elevation of the limb (if applicable). If the wound contains a foreign body, then a ring pad should be made to exert pressure around the wound and not directly upon it. If the bleeding point is inaccessible, bleeding may be reduced by exerting pressure upon the major artery of the limb (deep in the groin crease for the leg, and on the inner side of the upper arm – feel for the pounding of the pulse). This pressure needs to be maintained until proper medical care is available. A Tourniquet should not be used.

c) To arrest bleeding from the nose, squeeze the soft part firmly between thumb and finger for at least 10 minutes whilst sitting with the head leaning forwards. During a bout, a boxer suffering from persistent bleeding from the nose must be brought by the referee to the ringside MO, who will decide whether to terminate the bout. If bleeding is from inside the ear cover the orifice with a clean dry dressing and seek medical help. Do not plug the nostrils or external ear – you are more likely to cause further
damage than control the bleeding. To stop bleeding from the tongue or lip, squeeze the edges of the wound together using a dry sterile gauze swab.

d) Blood loss of more than a pint is potentially dangerous and leads to shock which is a serious medical condition. This can be recognised by pale, cold and sweaty skin, a fast pulse which may be weak and thready (the normal pulse rate is 60-80 beats per minute), confusion, thirst and anxiety. It is unlikely to arise from a skin laceration, but is a potential complication from a severe scalp laceration or nose-bleed, or internal bleeding from lungs, liver or spleen (if damaged from a fractured rib, for instance). If shock is suspected, there must be no delay in transferring the patient to hospital by the quickest means available.

e) Rarely, a blow to the back or the loin may bruise a kidney with the result that blood gets into the urine. When passed, the urine is ‘smoky’ or may even appear actually bloody. If this occurs the boxer should be taken to hospital. He may need to be observed until his urine becomes clear.

6. Low Blows

Blows to the testicles are illegal and uncommon in boxing. These organs are exquisitely tender and the slightest of blows will impede the concentration and movement of the boxer. If more severe, consideration should be given to retiring the boxer from the bout. Some ease in the discomfort will be gained by supporting the testicles and flexing the knees while the boxer lies on his back. After the bout, if the pain increases in severity, and especially if this is associated with swelling of the testicles, medical advice should be sought without delay since urgent scanning and surgery may be required.

5. Eye Injuries

a) Eye injuries may occur in boxing and may be serious. They are usually caused by the thumb of a glove hitting the eye. Ophthalmology is a specialist subject, so if in doubt about any painful or red eye, always seek specialist medical advice.

b) In the absence of any symptoms or other abnormal appearance, a subconjunctival haemorrhage (a bright red patch on the white of an eye) is inconsequential and will resolve in 1-2 weeks.

c) Corneal abrasions (grazing of the transparent front surface of the eye) may be caused by the glove brushing across the open eye, or dragging of long hair into it. The eye feels gritty and irritable, the sclera (white of the eye) looks red and inflamed and vision may be blurred because of excessive watering. There may be a degree of photophobia (literally ‘fear of light’) but if pain is not severe then these usually heal without specialist treatment.

The following conditions are serious and need urgent hospital referral:

(i) Bleeding may occur within the eye itself. If this occurs immediately behind the cornea, then a thin layer of blood may settle. Serious bleeding into the back of the eye can only be suspected by its severe effect on vision, which may be almost completely lost in the affected eye.

(ii) The retina (the light-sensitive lining within the eye) may become torn, and then peel away from the wall of the eye. This is painless. The initial tear may cause a period of bright flashing lights, and the subsequent separation is typically likened to a dark curtain progressing across the field of vision.
(iii) Other injuries can occur. They cause visible damage to the eye and/or seriously affect vision. If any eye injury is suspected, and especially if there is any pain or disturbance of vision in the eye, then a medical opinion must be sought urgently.

8. Unconsciousness and Concussion

a) Strictly, there is no single state of unconsciousness but a graduated change in responsiveness. This passes from the normal alert state through a dull wakefulness to a state in which there is no spontaneous movement and no response to any stimulus. If a boxer is rendered unconscious, it is important to assess initially and then frequently monitor the level of responsiveness (level of consciousness). This is done by grading the clarity of speech and the stimulus that is required to make the injured person open their eyes and move the limbs according to the following scales:

(i) Eyes open - spontaneously  
- in response to speech  
- in response to pain  
- remain closed.

(ii) Movement - in response to spoken command  
- in response to pain  
- remains still

(iii) Speech - normal  
- confused  
- inappropriate words  
- incomprehensible sounds  
- no attempt at speech

(A painful stimulus can be applied by pinching the skin of the earlobe or back of the hand.)

b) In boxing, unconsciousness rarely lasts more than a few seconds, and recovery is very rapid. If full alertness is not recovered immediately, steps must be taken, without delay, to maintain the boxer’s airway. This may be obstructed by the gum shield, the tongue falling into the back of the throat, or vomiting. The referee is the closest person to provide care in the ring and will, ideally, be trained in the techniques of immediate first aid care. The gum shield must be removed from the mouth immediately and an index finger swept around the mouth to put the tongue forwards. If necessary, the tongue should be held forwards with a piece of clean gauze. The doctor or resuscitation team personnel should be summoned into the ring and the boxer should be rolled onto their left side with great care, supporting the head and neck, to get into the recovery position so that the airway is kept open. If recovery is at all delayed, the doctor or resuscitation team personnel take over and an ambulance should be called. The boxer must not be moved from the recovery position until the doctor or resuscitation team personnel have decided on the appropriate further care. That may include stretcher out of the ring and immediate transfer to hospital by ambulance.

Fully qualified paramedics, as well as the doctor, must be in attendance at all major championships, internationals and major tournaments. They have to be fully equipped for full airway resuscitation and have an ambulance on stand-by at the venue. Local hospitals and the nearest neuro-surgical unit must be warned prior to the tournament and the OIC should have direct line telephone numbers available so that immediate contact can be made if required.

c) The risk of a cervical spine (neck) injury is small, unless the boxer falls outside the ring, but the grave potential of this injury must be borne in mind. If suspected, then the head, neck and trunk should not be moved at all. If it is absolutely necessary to move the boxer in whom a spinal injury is suspected, then special techniques,
including using a cervical collar and a spinal board, are required so that the head is supported and not moved relative to the trunk. This should only be done under instruction from the doctor or resuscitation team personnel. Unskilled lifting or moving of the boxer or his head may cause paralysis of limbs and further damage to the spinal cord. Once caused, these disabilities are usually permanent.

d) It is important that the boxer’s level of response is regularly monitored even after he has recovered. Return of unconsciousness after apparent recovery indicates the possibility of bleeding within the skull. This condition is recognised by deterioration in the level of response and may be associated with the occurrence of a fit and/or inequality of pupils and unequal power and co-ordination in limb movements between right and left sides. This condition is of the utmost urgency for death may occur in minutes rather than hours. If suspected, an ambulance must be summoned immediately and the ambulance control station informed of the urgency of the situation. The first aid treatment does not differ from that outlined above, although those in attendance should be prepared to commence resuscitation as this may become necessary to maintain life.

e) Most boxers who are knocked out recover consciousness rapidly. Even so, the boxer must never be left unattended and should be escorted home or to hospital. If any headache, disturbance of vision (such as blurring or double vision), vomiting, a period of forgetfulness or drowsiness subsequently occurs, hospital care must be sought without delay.

f) After a knock-out, or even an exceptionally hard bout, the boxer may suffer a post-concussive state. This may cause headache, difficulty in concentration, slight mental slowness or forgetfulness, vague visual disturbance, a degree of in-coordination, nausea or lethargy. If these symptoms are at all evident, medical opinion should be sought rapidly. They usually settle over a few days.

g) Knock-out (KO or RSCH) carries a mandatory rest period of at least 28 days clear, which includes training, sparring and competitive boxing. During this period the boxer must be observed very closely. If there is any evidence of incomplete recovery, then return to the ring should be further delayed. Further medical opinion will be needed if this is the case. Repeated knock-out carries longer periods of mandatory rest of up to 1 year.

9. First Aid Boxes

a) At a tournament, the medical officer should provide at least a minimum of first aid equipment. However, injuries can be sustained in the gymnasium or elsewhere during training and all coaches are advised to ensure that their club possesses first aid equipment. This may be purchased from the voluntary aid societies or retail chemists. The contents of first aid boxes (as sold) are now regulated by health and safety at work legislation and, depending on their size, may contain little more than sterile dressings and bandages of varying sizes and numbers. No medicines or tablets of any kind are allowed in such kits (adrenaline solution is totally forbidden). The only solution allowed for cleansing wounds is either sterile water or sterile salt solution (saline).

b) The legislation is, however, inconsistent in that it does not preclude other substances being available from a separate ‘non-legal’ first aid box. Such a box might usefully contain the following:

A small packet of cotton wool balls
A small packet of sterile gauze (5cm sq) or larger
2.5cm, 5cm and 7.5cm gauze bandages
3 x 7.5cm elastic adhesive bandages and crepe bandages
A selection of elastoplast-type sterile wound dressings
Dumbbell sutures or steristrip
Sachets or bottles of sterile water or saline
A bottle of cetavlon (cetrihide) 1% (for cleaning table surfaces and wounds
(This is not for eyes)
Sterile disposable gloves; dressing scissors.

c) When dressing a wound, personal hygiene is very important. Hands must be
scrubbed well with soap and water and dried with a clean towel. Sterile disposable
gloves must be worn. Dressing materials should be laid out on a surface of stainless
steel or (unscratched) laminate which has been swabbed down with surgical spirit to
render it sterile. The patient should be relaxed (ideally lying on a couch) and the room
should be clean, airy and well lit.

d) The ABAE has approved a standardised resuscitation bag for use by clubs and at all
tournaments. It is supplied by BOC on a lease system so that regular inspection and
maintenance is ensured. An integral part of this includes the training of personnel to
be competent in the care of the unconscious boxer, airway management and the use
of the equipment in the bag.

C. HYGIENE AND GENERAL HEALTH

1. Hygiene

a) High standards of personal hygiene reduce the spread of infectious disease, both
from person to person and from contact with urine, blood and faeces. The methods
are simple, and should become second nature to all concerned with boxing. They
should be part of every sportsman’s education and are one of the standards by which
the sport is judged. Simply put, it is ‘always be clean’.

b) During a bout, standards of hygiene are on public display and must be exemplary.
Each boxer must have their own towel and, if a water spray is not used, then they
must have their own disposable plastic cup as well. The days of the ‘club sponge’ are
well past. The coach should wash his hands between every bout and should try not
to touch any part of the ring or floor with one hand. This will keep that hand clean, for
the removal of the boxer’s gumshield, or when dealing with a laceration during the
bout. Sterile disposable gloves should be worn when dealing with any bleeding
wound and ideally should be worn at all times.

c) Training kit should not be used for normal wear, should not be shared, and should be
frequently washed, as should towels. Boxers and coaches should be encouraged to
shower or bath after each training session or bout. Stale sweat is an excellent culture
medium for bacteria.

d) The gym should be kept tidy, be regularly swept out, and periodically washed down
with a mild solution of disinfectant such as Dettol. The toilet and wash basin should
be cleaned after each training session and supplies of toilet paper and soap should
never be allowed to run out. Paper towels are more hygienic, but must be regularly
replenished. There must be an adequate waste bin for them, which is regularly
emptied. Cloth towels must be regularly laundered.

2. Viral Illness

a) Viral illnesses are common and cause general aching in muscles and joints, lethargy,
sore throats, loss of appetite and reduced exercise tolerance. More severe infection
may produce a rise in body temperature with spells of shivering and may be
associated with more specific symptoms such as nausea and vomiting, diarrhoea and
abdominal pain, cough and shortness of breath, or a generalised skin rash. If such an illness is suspected, the boxer should not train and must be banned from the gym – there is no advantage in giving it to everybody else – and be aware that vigorous exercise may be fatal in such circumstances due to heart muscle damage.

b) It is very important that a boxer is not entered for a competitive bout suffering from such an illness. His physical fitness will be much less than may be apparent and this alone will slow his reaction time. He will not do himself justice and may make himself very ill indeed if he exercises excessively.

c) After such an illness, training should be started gently and the boxer must not be rushed into a competitive bout. If there is any doubt about his fitness, his condition should be discussed with the medical officer at the tournament or his own club doctor. A boxer’s performance in training is often a more accurate guide to his state of health than his appearance at the brief pre-bout inspection, where facilities may not be ideal. Do not try to ‘catch the doctor out’ by presenting him with an ill boxer – at best it creates ill-feeling and disrespect, and at worst is positively dangerous for the boxer.

3. Skin Infection

a) Many adolescent boys, especially those with a greasy skin, develop acne. If there are any pustules about the face and shoulders, this may lead to failing a pre-bout medical inspection. The pustules may burst, and carry infected matter into the boxer’s own eyes, or contaminate his opponent.

b) There are simple and effective treatments for this condition and the correct course of action is to send the boxer to his GP when the condition starts, not after he has failed a pre-bout inspection. In severe cases, this will prevent obvious scarring on the face, to the benefit of the boxer’s appearance and his boxing (and often his confidence as well).

4. Dental Care

a) Good dental care is also important for the boxer. The jaws and teeth are in the centre of the target area and dental disease renders the teeth weak and liable to break under impact. Significant dental caries (decay) in the front teeth will fail a boxer at the pre-bout inspection. Even a good gum shield cannot protect a weak tooth. In the high state of activity during a bout, a broken piece of tooth can easily be inhaled into the lungs. This is a serious condition. Untreated dental caries will sooner or later cause an abscess in the jaw. This is a very unpleasant condition which may cause long term problems.

b) Inspection of the teeth should be carried out at regular intervals by the boxer’s dentist and between times if any decay is noted. Severe dental caries may lead to loss of infected teeth, which in turn may lead to difficulties in securing a good fit with the gum shield.

c) No boxer is allowed to box or spar in the gym, wearing a dental plate or any form of bridge-work or dental brace, unless the boxer also has a custom made mouth guard supplied and fitted by the orthodontist who fitted the dental brace or bridgework. AND

The dentist must supply a formal letter, on their own professional headed notepaper, stating he is happy for that person to box and considers the mouth and teeth are at no greater risk than in any other person participating in boxing. (See appendix i)

d) A well fitting gum shield (mouth guard) is mandatory for all sparring and boxing. Ideally the gum shield should be custom made and fitted by a dentist. The colour
must **not** be red, pink or orange. It should be available for inspection at every medical examination.

5. **Hair**

a) Long hair is not permissible unless completely covered by the head guard. A fringe in front must not extend below the level of the eyebrows. Hairnets may be used to keep hair inside a head guard but no pins or clips may be used.

b) Boxers must be clean shaven when attending for medical inspection and at any contest. A moustache is allowed provided it does not extend below the lip angles.

c) Beards are not allowed unless required by religion and **must** then be covered by a hair net or similar device within the head guard. (Note: AIBA rule is NO beard)

D. **DIET**

(a) The general rules of a good diet are essential for those in heavy training. A well-balanced diet should provide all the requirements without the need for vitamin and mineral supplements. Exceptions to this may be either if a boxer is vegetarian, in which case more careful attention must be paid to meeting certain dietary requirements, or when a boxer is making the weight. Since food intake is often restricted at this time, various vitamin and mineral requirements may not be met. A multi-vitamin preparation is not very useful, as these tend not to be well absorbed. The need for individual supplements should be identified and recommended by the appropriate medical staff (nutritionist and/or doctor).

There must be an adequate energy supply, which is best obtained from carbohydrate rich foods (such as bread, rice, pasta, potatoes, low-fat breakfast cereals, low fat yoghurts, milk and fruit) rather than fatty ones. Food should be grilled, steamed or baked whenever possible. Boiling food causes the loss of many vitamins, and fried food should be kept to a minimum due to its high fat content. The consumption of large amounts of fatty foods can lead to increases in body fat levels and weight gain which not only affects performance, but also long-term health. A high-fat diet will not fuel the high intensity effort needed for boxing performance. Around 60-70% of the energy intake should come from carbohydrate in the diet.

A boxer’s diet should contain sufficient quantities of protein from low fat food sources such as lean meat, fish, cottage cheese, yoghurts, milk and vegetarian meat alternatives such as tofu, lentils, beans, soya proteins or textured vegetable proteins. Plenty of fruits and vegetables should be consumed to ensure that vitamin intake is adequate. Fibre is also important to keep the bowels regular. Good sources of fibre include cereals, grains, fruit and vegetables (particularly their skins). Fibre is only to be avoided if, towards the end of weight making, bloating due to excess wind and fluid retention are undesirable.

(b) Food intake will normally balance energy expenditure during training. The average energy requirements of a boxer in training will vary considerably depending on his weight, job, training schedule and lifestyle. A common problem is an unexplained lethargy and lack of sharpness and power. This is often due to a boxer consuming inadequate amounts of carbohydrate. The problem is made worse for two reasons: i) Often boxers train late at night and do not eat adequately to recover; ii) Appetite is frequently suppressed after hard training. It may take up to 48 hours after a day of hard training to completely replenish carbohydrate stores in the muscles. It is therefore essential that the boxer and coach understand the importance of resting and of eating plenty of carbohydrate and moderate protein, to support training, in order to allow energy stores to be refuelled between sessions.
c) The severe restriction of a boxer’s diet and/or fluid intake to keep at a low weight will impair performance and is potentially dangerous. Sensible, safe weight-making strategies should start well in advance of the contest and should involve gradually losing body fat by reducing energy intake, (starting with cutting down on fat in the diet) or by a combination of reducing energy intake and increasing energy expenditure. This approach will help to reduce weight from body fat rather than muscular stores.

d) Since the boxer will still be consuming carbohydrate, energy levels to continue with normal training should therefore be maintained. Weight loss through fluid restriction has no place during routine training and severe dehydration to “make weight” is to be discouraged since not only does it have a detrimental effect on performance, it is also dangerous.

e) Ideally, training for the two days before a contest should be light and restricted mainly to skills. The carbohydrate content of the diet should be maintained whenever possible so that the boxer has maximum energy stores prior to the contest. Boxers who have problems with fluid retention may want to avoid wheat-based carbohydrates, such as bread, pasta and cereals at this time, choosing rice, rice cakes and potatoes instead. Having made the weigh-in, the last meal should, ideally, be eaten 3-4 hours before the bout. This should have high carbohydrate content with protein and fat kept to a minimum. Some boxers may prefer at this stage to be having liquid only meals such as sports drinks (NB Sports drinks are not to be relied upon in the long term for energy provision as they lack the complete variety of nutrients that whole foods provide). After this time, only small high-carbohydrate snacks (such as wine gums, jelly babies or jelly beans) or sips of sports drinks should be consumed. This will ensure that the stomach is not full and that energy levels are high. It is important that boxers do not consume foods or drinks unfamiliar to them close to competition as these may cause stomach upset. Wind-producing high fibre foods such as beans, dried fruit and very high fibre cereals (such as All-Bran) should be avoided, as should spicy or unfamiliar foods, since the bowels become more active as anxiety increases without further encouragement. Examples of pre-contest meals would be a moderate portion of potato, pasta or rice with tomato based sauce, honey and banana sandwiches or low-fat breakfast cereal and skimmed milk. High protein and fatty meals such as steak and eggs or cooked English breakfast will not be useful at this time and should be avoided. Other high-carbohydrate choices may include crumpets, bagels or tea-cakes with jam or honey.

F) Boxers should be encouraged to refuel as soon as possible after a bout. This is particularly important if they are competing or training again the next day. Sports drinks can be useful for this purpose if appetite is suppressed or there will be a time-delay in the boxer’s access to food. Losing weight gradually becomes of real importance when boxers have to make repeated weigh-ins. Losing body fat gradually, rather than undergoing sudden severe diet or fluid restriction, will ensure that the boxer’s body weight does not increase so much between weigh-in and competition that making weight for subsequent rounds requires drastic (dehydration) methods.

E. PHYSICAL FITNESS

a) Supreme physical fitness is of the utmost importance to the boxer, and much of the training in the gym is directed towards this. If a boxer is not fit, he will not be able to display his skills, and is much more likely to receive unnecessary blows and injury. As a boxer tires, sharpness and concentration deteriorate so that defensive skills suffer first, especially if he comes under concerted attack. A boxer who is not fully fit will be aware that he is under-performing and may lose heart. It is irresponsible of a
coach, and potentially dangerous, to enter a boxer for a contest knowing that he is not fit.

b) Fitness training should develop flexibility, stamina, power and speed. To make best use of 'skills' training, the boxer must be warm, relaxed, fresh and alert. A light meal should have been taken a few hours beforehand. In general, each training session should start with a period of gentle exercise designed to loosen-up all parts of the body (e.g. stretching and bending), progress to skills training and end with a power/stamina programme (circuits, weights, runs, etc). Muscle injuries occur most commonly at the start of a session when it is cold and the warm-up period has been too short.

c) It is easy to forget that the muscles of the back, trunk, and (especially) the neck need to be trained as well as the arms and legs.

F. SMOKING AND ALCOHOL

a) No sportsman should smoke. Smoking narrows the airways and severely reduces the efficiency of the lungs. It also reduces the amount of oxygen that can be carried in the blood to the muscles and brain, and therefore has serious effects on the level of fitness and exercise tolerance of the boxer. A person who smokes is more likely to suffer a chest infection and such an infection is more likely to be severe and prolonged. Smoking is also strongly associated with lung cancer, heart disease, narrowing of the arteries, and peptic ulcers.

b) It is strongly recommended that smoking be totally banned in the gymnasium and at all boxing tournament arenas. The smoky atmosphere is detrimental to the boxer's performance at the time and to overall health. No official should smoke near the ring. Fortunately, as of 2007 smoking will be banned in all public places in England.

c) Taking alcoholic drink in moderation is not harmful, but when a boxer is in training this should be discouraged and none should be consumed in the 36 hours before a contest. Even very low alcohol levels slow the reflexes. Beers are highly calorific, and this must be remembered when reviewing the diet.

d) Alcohol must not be consumed by anyone officiating at boxing tournaments and no glasses are permitted at the ringside.

e) It is strongly recommended that alcohol sale and consumption be totally banned in the gymnasium and at all boxing tournament arenas.

(It is acknowledged that items b) & e) are impossible at 'dinner shows' but every effort should be made to educate the audience and reduce it as far as possible)

G. ENVIRONMENT

Amateur boxing is an extremely active sport, and the boxers should be given the best conditions possible in which to compete. Venues for tournaments should be chosen and the ring sited to give the best light, space, and ventilation. Temperatures should be equable and the air should be smoke-free. Undue rowdiness amongst spectators detracts from the sport and is dangerous when it prevents the boxers hearing the referee's instructions. Boxing late at night, when boxers and officials alike are tired, is to be strongly discouraged. Boxing should not take place after 10.30pm for juniors and midnight for seniors. Organisers of dinner shows should be particularly aware of this and plan the programme accordingly. There must be adequate and clean dressing rooms, toilet and washing facilities for both males and females. There must also be a separate private well-lit area where the doctor may work if necessary.
H. ILLEGAL SUBSTANCES

1. Drug Abuse

a) The taking of (or encouragement to take) any illegal substance by those involved in boxing is absolutely forbidden by the regulations of the sport, and cannot be condoned under any pretext. Solvent sniffing, smoking, sniffing or injecting heroin, cocaine or other opium derivatives and the taking of stimulants (marijuana, LSD, ‘smack’, ‘crack’ and others) all ruin physical fitness, mental ability, and family and social life. The side effects of all these substances are serious and sometimes fatal. Breaking drug dependence is very difficult indeed. Drug taking is illegal in amateur boxing.

b) Drugs taken to enhance performance or the effects of training (steroids, beta-blockers, diuretics etc) have their own medical risks and are illegal in amateur boxing in accordance with AIBA and WADA regulations. These regulations are on the UK Sport (www.uksport.gov.uk) and WADA (www.wada-ama.org) websites.

c) A person suspected of taking prohibited substances (unless prescribed by a doctor for a medical condition) presents a difficult problem as he is unlikely to admit to it, and a false accusation could destroy good relationships within the club. All discussions must be in absolute confidence and only with responsible individuals who would have reason to be concerned, such as club doctor, association medical officer, or the GP of the individual concerned. If any medication is prescribed by a doctor then a TUE form is essential if the medication is on any WADA list.

2. Drug Testing

a) Drug testing occurs at major events, backed-up by random testing at training camps, squad training sessions, at home or place of work. Testing for a wide range of drugs occurs at major events, and will become more frequent in the future. Responsibilities for drug testing were assumed for all sports by the doping control unit of the sports council in 1988. UK Sport have complete control over the frequency and randomness of drug testing. The ABAE adheres totally to the WADA code for drug control and testing in accordance with the Olympic Games principles.

b) Many of the drugs which are prohibited are present in small quantities in medicines and tablets which may legitimately be bought ‘over the counter’ by the boxer. A variety of stimulants and/or opiates are present in small quantities in proprietary cold cures, hay fever treatments, pain killers, and sleeping tablets and so on. All boxers are strongly advised to discuss with their club doctor or GP the contents of any preparation they wish to buy directly from the chemist or which is prescribed for them by a doctor. Unless really necessary, no medication or dietary supplements of any kind should be taken. Particular care should be exercised when considering the use of dietary supplements for building muscle strength.

c) Any medication prescribed by a doctor must be checked against the latest WADA list and a Therapeutic Use Exemption (TUE) certificate must be sought if any medicine in the WADA list is used. Even with a TUE many prescribed medicines may remain illegal. It is the boxer’s personal responsibility to ensure that they are not taking any prohibited medications.

d) If a boxer is selected for drug testing at a tournament, it is essential that he declares all medicines, tablets, sprays or other substances which he has taken in the previous few weeks, whether or not they have been prescribed for him by his doctor. If his urine is found to contain illegal substances which can be explained by their proper therapeutic use, due allowance can then be made.
e) Any boxer who is requested to do so must submit to drug testing. Refusal will be interpreted as a positive result and if a boxer withdraws from a contest after he has been selected for testing, he will still be tested. Any boxer who is found to have illegal substances in his urine, which cannot be explained by their proper therapeutic use, will automatically be suspended under the rules of the International Olympic Committee (IOC) and WADA.

f) The substances regarded as illegal by the ABAE are those contained in the list of banned substances published by WADA and the medical commission of the International Olympic Committee. This list may be obtained from Sport England and as substances are changed or added yearly they appear on Sport England, UK Sport (www.uksport.gov.uk) and WADA (www.wada-ama.org) websites they are not listed here.

g) The ABAE fully endorses all the WADA recommendations in line with the protocols of the British Olympic Association. As a result, all disciplinary procedures and penalties to be instituted after the detection of an illegal substance in a boxer registered with The ABAE are in accordance with BOA & WADA rules. The standard penalty is a two year ban from boxing for the first offence.

I.  TETANUS PREVENTION

Tetanus (Lockjaw) is fortunately now rare, but still occasionally kills in this country. It is caused by a bacterium which lives almost universally in soil, the faeces of man and animals, household dust and clothes. If the organism is allowed to enter the skin through a cut or other defect, then infection may occur. This can be prevented by regular inoculation. It is recommended that boxers discuss this matter with their GP, who will be able to provide the necessary tetanus prophylaxis. This is routine care.

J.  HIV AND HEPATITIS

HIV and Hepatitis are becoming increasingly common blood-borne viral infections. It is for this reason that medical opinion insists that a greater care must be taken when dealing with the management of any bleeding injuries. Disposable gloves should be worn when dealing with any injury that bleeds.

All soiled gloves and swabs should be placed in the bags in the ring corner and subsequently be disposed of appropriately. Coaches should be reminded that all boxers should have their own towel, spray or cup. All kit, including training kit, should be regularly washed. All boxing gloves should be cleansed with disinfectant after each bout. Care must be maintained in the gym as well as at boxing tournaments.

K.  FOREIGN TRAVEL

a) This causes problems of jet lag, altered diet, exposure to unusual infections, different social customs and more mundane (but no less significant) problems such as uncomfortable beds and sleep disturbance. Consideration should be given to time of arrival so that an initial period of rest is possible and there is time for altered meal and sleep patterns to be accommodated. Sudden changes in diet, especially to spicy foods, may cause gastro-intestinal upset.

b) Immunisation for specific diseases may be necessary (not currently for travel in Western Europe). Advice on this is available from the local immunisation centre or the team manager, who will be advised by the medical officers.
c) If the stay is more than a day or two, it is essential to maintain physical and mental fitness in what is often a holiday environment. The official-in-charge of the party has an especially onerous duty to ensure this, and he must be able to motivate those in his charge in the unfamiliar surroundings to maintain fitness and focus on the forthcoming competition.
IV. Safety Aspects

A. GENERAL POINTS

1. Injuries occur in all sports and the safety of amateur boxing compares very favourably with other contact sports and sport in general. Injuries in boxing are now carefully recorded, and examination of the pattern of these over the last 10 years reveals a very safe sport indeed. Most injuries are minor abrasions and lacerations, and these are usually the result of an accidental collision of heads.

2. Fractures are uncommon, but most frequently occur to the hands, nose, cheek and jaw. Dislocations are even rarer, and usually affect the shoulder or fingers. All of these injuries, and also bruising, sprains and strains, eventually heal, usually without major problems, although soft tissue injuries may take a surprisingly long time to settle down completely. Proper initial medical care will reduce longer term risk or disability.

3. Injuries to the retina (the light-sensitive part of the eye) and brain fall into a different category because these tissues do not repair and perform at their previous state if they have been structurally damaged. Retinal tears and detachments are much more likely to occur in eyes that are short-sighted. This is because the eye-ball is misshapen. It is because the basic eye-ball shape is not changed that no one is allowed to box after any surgery may have corrected the visual acuity. AIBA rules also forbid boxing after any intra-ocular surgery (such as retinal repair). This is why visual acuity is such an important part of the initial medical examination and re-examinations. Such eye injuries are uncommon.

Serious acute brain injury is extremely rare in amateur boxing. The current debate about the safety of amateur boxing principally concerns the risk of developing long term brain damage from the accumulated effects of blows to the head. Because many of the rules of boxing, and regulations concerning the medical scheme, are designed to minimise the risk of chronic brain injury, the following brief discussion of this problem is included.

B. CHRONIC BRAIN INJURY

1. Defining the Problem

a) That brain function is sometimes temporarily disturbed is undeniable. Knockouts and concussion occur as a result of blows received whilst boxing. What is not known is whether or not small degrees of structural damage occur at the same time (or as a result of even less forceful blows which apparently do not disturb the brain function at the time) which, over a period of time, may add up to a significant and irreversible degree of brain damage. It has been reported that chronic brain injury has occurred in the past in professional boxing. However, it must be said that the boxers concerned were active long before medical controls were instituted, had taken part in large numbers of contests, and other causes of chronic brain damage could never be ruled out with certainty. Similar conditions have also arisen in people who have never boxed in large numbers of contests and in those who have participated in other sports.

b) It is probable, however, that repeated brain injury – even though each individual injury may be minimal – may cause brain damage which is permanent. It is this possibility which has fuelled the recent pressure from many medical organisations to limit or ban the sport. The essential question is: does amateur boxing in England, with its current high standards of supervision, refereeing and coaching, expose the participants to the
risk of chronic brain injury? Recent psychometric investigations and research carried out in England and abroad for the International Olympic Committee have confirmed that, with strict medical and safety regulations, amateur boxing is safe from neuropsychological damage. The following references show no evidence of long term brain damage from Amateur boxing:

**BUTLER R. J.** British Journal of Sports Medicine  September 1994  
Neuropsychological testing. Amateur boxers v controls

**PORTER et al.** Clinical Journal of Sports Medicine  1996  
Neuropsychological testing in amateur boxers

**Various Authors** Acta Neurologica Scandinavia  
Various papers October 1990 to 1991

**PORTER M.** Clinical Journal of Sports Medicine, 2003 vol.13, no. 6, pp. 339-352  
A 9-year prospective neuropsychological assessment of amateur boxing.

c) The decision to support or condemn a sport, in which the objective is to land blows on the opponent with force, is a matter of personal philosophy, as is one’s opinion about the right of the medical profession to control an individual’s voluntary activity. These questions of opinion and philosophy are separate from those of injury risk and are for each individual to consider personally.

d) The Medical Commission of The ABAE does not accept the occurrence of chronic brain injury from modern amateur boxing, as has been confirmed by recent scientific studies in England, Europe and America. That said, the potential for this type of injury in boxing (as in many other sports) must be acknowledged, and its prevention must be of prime concern to all those who govern and promote the sport.

2. **Mechanisms of Brain Injury**

a) Head injuries occur throughout life, and only some of the mechanisms by which they occur are understood. The brain may be likened to a stiff jelly floating in water. This is contained within a rigid box (the skull) which is internally divided by sheets of tough fibrous tissue. When the head is struck, the skull is rapidly accelerated, but the brain lags behind due to the inertia and softness of its own mass and its lack of firm connection to the skull. This sudden movement between the brain and its encasement can tear blood vessels on the surface of the brain and lead to bleeding within the skull. This is a serious and urgent condition because the blood cannot escape and pressure within the skull rises. Unless released by an operation, bleeding will compress and destroy the brain. This is one of the ways in which sudden brain injury can quickly lead to death.

b) The surface of the brain may be bruised as it impacts against the interior of the skull and/or its fibrous divisions. This may cause temporary disturbance then recovers.

c) Another mechanism may destroy small groups of nerve fibres deep in the base of the brain. This comes from a blow that suddenly rotates the skull, and the inertia of the brain causes an initial lag and then over-rotation, tearing cells and fibres within it. These injuries may cause no immediate problems or may cause a temporary loss of consciousness or a period of concussion. If repeated over a period of time, the effects of many small areas of damage may add up to produce a significant loss of brain function. This has been seen in the past, in professional boxers with a large number of contests. There is no evidence of long term damage in amateur boxers.

c) Certain blows to the face and head can cause to-and-fro movement of the brain in the skull. A frontal blow may not only cause injury to the front but also to the back of the brain. This is called the ‘Contra-coup’ injury.
3. Head Blows in Boxing

a) In boxing, rotational injuries are most likely to occur from a blow to the jaw, as this is the furthest point from the axis of rotation and will cause the greatest angular acceleration to the head and therefore the brain.

b) In all cases, the risk of brain injury will be very much reduced by protective contraction of the neck muscles, which will limit the initial movement of the skull and absorb much of the force of the blow. This can only occur if the boxer is alert to the blow being delivered and sets himself to receive it (or to parry or avoid it altogether).

   To retain this ability throughout the bout requires supreme physical fitness. As the boxer tires, concentration and speed of reaction are the first factors to suffer. For this reason, the medical commission believes that the best protection against the potential risk of brain injury in boxing is the maintenance of physical fitness and an emphasis upon defensive skills, so that the majority of such blows are avoided altogether.

c) The potential for damage from the accumulative effects of many such blows is further reduced by good refereeing. A standing count enables the boxer to gather his defences once more (or the bout is stopped) before an excessive number of blows has been delivered to the unprotected head.

d) Coaches also have a responsibility not to present boxers for competition if they are known to be unfit or unwell, and to retire a boxer if he becomes dangerously tired.

e) Medical officers and other officials have a responsibility to ensure that the necessary controls regarding medical examination and mandatory lay-off periods are enforced.

f) Medical officers should also order a suspension if it is their considered opinion that the boxer has sustained sufficient injury to warrant the suspension even if the official result may not require a mandatory suspension. This is particularly important where a bout may have been stopped (RSC) and the losing boxer may have sustained a series of head punches, none of which required an individual count, yet accumulatively may warrant a rest period. Usually the referee will have given the decision RSC(H) in these circumstances (with the mandatory 28 day minimum rest period being issued) but it remains the doctor’s responsibility to ensure that the boxer’s safety is maintained and so a rest period could still be necessary.

g) Head guards are discussed later but probably do not greatly affect the incidence of acute or chronic brain injury.
V. Equipment

A. THE RING

The boxing ring is a minimum of 3.66m (12 ft) square and a maximum of 6.10m (20 ft) square. The floor is of canvas with a specified thickness of underfelt, and must extend at least eighteen inches beyond the ropes. The quality of the ring has an important bearing on safety. Inadequate felting seriously increases the risk of head injury if a boxer strikes his head as he falls, and a small ring inhibits free movement of the boxers. The larger the ring, the more possible it is to make full use of defence skills; a small ring penalises the skilful boxer and renders him much more liable to injury. The ring apron must be kept clear during the round. Glasses and other potentially dangerous objects must not be kept on tables used by officials. Officials are forbidden from drinking at the ringside. The ring must be clean and unstained at the start of any competition and each day for multi-stage tournaments. The canvas must be non-slip.

B. GLOVES

1. AIBA approved gloves are of standard design and padding and for competitive bouts weigh 10 ounces. For sparring in the gym, heavier gloves should be used. One compartment of the glove houses the four fingers, a separate compartment the thumb. The move towards joining the thumb to the rest of the glove (the ‘thumbless glove’) has resulted in fewer eye injuries and is to be encouraged. Heavier (12 oz) gloves are used in some junior competitions and at international cadet tournaments.

2. Some boxers prefer to bandage the hand inside the gloves to give a buttressing effect, and reduce metacarpal and metacarpo-phalangeal joint (knuckle) injuries. The types and size of bandage which may be used are strictly defined in the rules of amateur boxing. Bandaging of hands is mandatory in AIBA contests.

3. The main function of the glove is to protect the hand throwing the punch. For the opponent, the area of contact is increased without significantly altering the force of the blow. The result is that there is a minimum of local damage.

C. FOOTWEAR

Footwear is an important item. Good footwork technique is essential if a boxer is both to punch his full weight, and to avoid or parry his opponent’s blows effectively. There should be good friction between the sole and the canvas of the ring, and the shoe itself should be light, with no heel, yet enclose the ankle and lower part of the leg to give good support.

D. GUM SHIELDS (Mouth guards)

1. Gum shields are obligatory in all classes of boxing (youth and senior) and must fit well. They should be worn during all open sparring as well as in competitive bouts.

2. Ideally they will be made by a dental surgeon or specialist company from a dental impression and this type is strongly recommended as they fit well and provide true protection. A good gum shield will not be noticed when worn and will not slip out when the mouth is opened if it has been moulded and fitted correctly.

3. They may also be made from plastic blanks (available from sports shops). The blank is warmed in hot water and then moulded with the fingers to fit the upper row of teeth tightly, and then gently bitten on to give the lower teeth a location as well. The bite should not be so strong that the plastic material becomes minimal between the teeth. They should extend back to the molars (grinding teeth).
4. The degree of protection is increased the better the fit and the compressibility of the material. A well-fitting gum shield will be comfortable and will stay in position when the mouth is open, without tensing the cheek muscles or using the tongue.

5. The purpose of the gum shield is to present the upper teeth and maxilla, with the mandible and lower teeth behind, as a solid block capable of spreading and reducing the local force of a blow.

6. The importance of a good gum shield is evident from the fact that a boxer will be disqualified if it falls out three times during a bout (or less if deliberately spat out). As a result dental injuries are now uncommon in amateur boxing.

7. Red, pink and orange gum shields are prohibited. (They could mask blood)

E. SCROTAL GUARDS

Scrotal guards are compulsory for all boxers. Legal blows do to not land anywhere near the groin, but, as in all contact sports, injury to this region is an accidental possibility and potentially serious.

F. HEAD GUARDS

1. There is currently much debate about the advisability of wearing head-guards. They are mandatory for all contests and the head-guard must be AIBA approved and bear the AIBA stamp.

2. It is very important that a boxer is given ample opportunity in training to experience the effects on vision, balance and comfort from wearing a head-guard.

3. The value of head-guards is still under scientific evaluation. Head-guards, in good condition, should reduce soft tissue bruising and cuts around the eyes and face. If the edge above the eyes has become hardened through over-use, lacerations may occur in the eyebrow region and the head guard should be changed.

4. The overall value of a head-guard in reducing brain injuries is unclear. The energy absorbing material used in the head-guard will reduce the force of the blows, whether from a punch or from striking the back of the head on the ring floor.

5. The argument against head-guards is that they allow more sub-concussive blows and may also increase acceleration in rotation because of the larger mass.

6. It is important that the boxer’s head-guard is in good condition and fits properly so that it does not become dislodged nor distract him in a contest. Care must be taken to ensure that it does not get wet as this reduces the effectiveness of Velcro fastenings and increases the risk of the leather becoming hard. The results may be that the head-guard can no longer be effectively tightened on the head and so may be dislodged easily, and that the edges of the leather may cause cuts, as mentioned above, and the shock absorbing protection may be reduced.
VI. Advice to Coaches at Tournaments

A. MAKING WEIGHT

1. However it is done, rapid loss of weight immediately before a contest is dangerous and causes performance to suffer. Fluid loss and sweating (whether by exercise or heat) have many effects on sodium, water and mineral balance as well as the body’s metabolism. Cardiovascular function may be impaired and body temperature rises excessively during exercise; work capacity is decreased so that exhaustion is reached earlier than when fully hydrated. The greater the amount of weight loss, the greater the loss of performance. Recent research has shown that the loss of fluid around the brain may result in more significant head injury from the same injury mechanism.

2. It is recommended that a boxer be withdrawn from a contest if, after passing urine and opening his bowels, he is required to lose more than 600 grams to make weight. (The advised limit is 500gms for boxers in weight groups over 67kgs and 300gms for all other weights).

6. If weight loss must be done, the least harmful way is probably by inducing sweating through exercise, particularly leg work. Sweating by increasing temperature alone is probably the worst way of rapidly losing weight. If a boxer regularly needs to make weight in this way before a bout, then either his diet is wrong or he is attempting to box at too light a weight. Attention should be directed to these problems rather than the rapid making of weight immediately before each contest.

B. THE MEDICAL RECORD CARD

1. The coach (or team manager) almost invariably looks after the boxer’s medical record card and the boxer rarely has control of this. As a result it is vitally important that the coach ensures that all details are correct and up to date in all of his boxer’s cards.

2. The medical record card (either ME3 & AIBA) is the most important document that the boxer possesses in order to compete. An inaccurate or incomplete card can have the boxer disqualified at the start of a tournament through no fault of their own.

3. The coach (or team manager) must therefore ensure that every section is complete with sufficient space for new entries for the next competition AND that there are no pages missing or loose. If a card is full then a new card must have been issued before attending the competition. If necessary, a new card may be stapled to the first so that in date medical examinations do not have to be repeated and signed by the doctor.

4. The commonest ‘faults’ are out of date medicals, or no doctor signature and no boxer signature or ID photo. A formal medical can not be done at the competition venue.

C. THE PRE-BOUT INSPECTION

1. If a trainer is concerned about the fitness or health of his boxer, he must inform the tournament medical officer of this at the pre-bout inspection. The coach is best placed to appreciate such a problem, and it is his responsibility to tell the medical officer, the medical officer’s assistant or the official-in-charge of his concern.

2. Not to do so could be regarded as negligent, as many young boxers are only too anxious to box under any circumstances, and lack of physical fitness or the effects of recent illness may not be apparent to the examining doctor at the event.
3. For this reason, it is strongly recommended that the coach accompany his boxer(s) at the pre-bout inspection.

D. EMBROCATION AND GREASE

The use of grease, embrocations or spirit on the skin is prohibited prior to or during a bout. Smelling salts contain ammonia (a stimulant) and may increase nasal haemorrhage; they have no role in bringing round a boxer who is concussed, and must not be used during the rest period between rounds.

E. INSTRUCTIONS

Instructions must not be given to a boxer while a bout is in progress. They distract the boxer’s attention and leave him open to attack.

F. DRESSINGS

The use of dressings or applications on the face, neck or scalp is forbidden during a bout. The rules do not forbid the use of dressings on other parts of the body but permission should first be sought from the official-in-charge before they are used.

G. THE MINUTE REST PERIOD

It is important that the boxer adopts a position that is restful. The normal position of ease is with arms flexed and the legs extended, but often a relaxed sitting position with the hands resting on the thighs is preferred. The gum shield should be removed and washed with water, and cool water may also be used to rinse out the mouth. A spray is more hygienic than a sponge, and may be used to advantage to cool the face and shoulders. The boxer should not be over-stimulated by excessive massage or movements during the rest period, nor by excessive use of water or spray.

H. THE BOXER IN DIFFICULTY

The coach is in the best position to recognise the moment his boxer is in difficulty. He knows his level of fitness, his boxing ability and his mental aptitude better than the referee or any other official. If he sees that his boxer is outclassed, or loses heart, then he should retire his man by throwing in the towel or not allowing him to come out at the start of a round. This is not a sign of weakness, but is the proper exercise of the coach’s responsibility to care for his boxer. It will prevent the boxer taking unnecessary blows and possibly suffering a loss of confidence.

I. AFTER A HARD BOUT

1. The rules and regulations define the minimum periods of rest between competitive bouts. It must be emphasised that these are minimum periods and that if a boxer has had an exceptionally hard contest, win or lose, he should be given an adequate period of rest. This could well be longer than the specified minimum.

2. The medical officer is always willing to discuss this with the coach, should he be concerned about the timing of a forthcoming contest.

3. Other than in a few specified exceptions there is a period of rest for three clear days following a contest.

4. It may be longer if recommended by the doctor and, if the boxer receives a KO or RSC(H) decision terminating the bout, there are mandatory minimum rest periods of 28 days. The rest period also prohibits hard training and sparring.
Common sense should prevail in all circumstances. Mandatory medical suspensions are designed to protect the boxer and should be looked at from that point of view and not as a punishment. A good coach will take the same approach and, even if an official medical suspension has not been given, the coach should not allow his boxer to compete again until he is sure that the boxer is fit to do so.

Once a medical officer has given a medical suspension it is final. It can **not** be subject to negotiation by coaches or other parties at the event. The abuse of the MO in this respect is unacceptable and will result in disciplinary action.
VII. The Referee

1. The referee is entirely responsible for the conduct of the bout once it has started, and he/she has the necessary powers to carry out these responsibilities. It is crucially important that these powers are used correctly to protect a boxer from unnecessary injury.

2. If in doubt about the severity of any injury and the risk to the boxer of continuing to box, the referee should consult the medical officer, who should always be sitting at the ringside. To do this is not a sign of weakness but is a proper course of action.

3. The referee’s most important task is to recognise concussion immediately it occurs. The signs include a glazed expression (indicating difficulty in fixing the eyes on a target), loss of muscular tone, which may be transient (resulting in buckling of the knees or an inability to keep the arms raised), unsteadiness and loss of balance, confusion or disorientation when challenged with a simple question.

The desire of a boxer to continue may persuade the referee that he is fully recovered after a count of eight, but the referee should be alert to any change in the degree of control and co-ordination of footwork, any imbalance or clumsiness, loss of speed (particularly in defensive work), and inaccuracy in punching. All of these suggest that the boxer is concussed and the bout should be stopped forthwith.

4. If a boxer is rendered unconscious, the referee must know the immediate action to be taken to protect the airway. It is usually obvious immediately when the boxer will not be fit to continue, and in this situation the referee should not continue to count him out before attending to him or requesting the medical officer to enter the ring.

5. The referee has a duty to draw to the attention of the official-in-charge, and/or the medical officer, directly he perceives any injury or medical problem in a boxer.

6. The referee has a duty to determine correctly the mode of termination of a bout. He must resist the temptation to stop a bout as a simple RSC when it should be RSC(H). Even a winning boxer may have taken severe punishment to the head, and the referee is in the best position to recognise this. In such cases he should make this known to the official-in-charge and a 28 day rest period should be mandatory.

7. When dealing with any bleeding nose or wound, the referee should wear disposable gloves and this is advisable at all times. The referee should terminate a bout if there is significant bleeding although usually this decision should be made by the ringside doctor.

8. A boxer suffering from a persistent nose bleed must be brought by the referee to the ringside medical officer who will decide whether to terminate the contest.

9. It is strongly recommended that all referees hold a current first aid qualification.

10. The referee must be fit to officiate at all bouts. For AIBA events there are set medical standards covering physique, cardiovascular system, eyesight and hearing.
A. THE MEDICAL SCHEME

1. General Principles

a) The ABAE has a national medical scheme for the protection of its boxers. All associations must operate this scheme and they are responsible for its full and correct implementation.

b) The scheme is organised at divisional/association level where it is under the supervision of the local records officer (medical registrar). The central registry of the ABAE receives copies of all documentation from the divisions/associations and this registry is administered by the ABAE central records officer under the supervision of the secretary of the ABAE and the medical commission. From season 2006/7 most of this will be done electronically.

c) The scheme provides for:

i. An initial medical examination, including an ophthalmic examination, of every entrant before being allowed to box competitively (ME1).

ii. The medical re-examination of every boxer at intervals not exceeding five years. It is recommended that the eyes of every boxer be re-examined by an ophthalmic practitioner every three years (this can be a qualified optician).

iii. The medical re-examination of every boxer at yearly intervals from the age of thirty years.

iv. The compulsory retirement of every boxer who reaches the age of thirty-four years.

v. Full documentation of every boxer’s career, including his injuries. The following records are defined:

   - ME1 - Medical officer’s medical examination notification form.
   - ME3 - Boxer’s medical record card.
   - ME4 - Medical officer’s assistant’s report form.
   - ME6 - Tournament record form.
   - ME6a - Medical officer’s (tournament) report form.

vi. The administration of the scheme by local records officers and central records officers.

d) No boxer shall be allowed to compete at any tournament without producing a complete and valid medical record card (ME3).

e) Every boxer must pass a medical inspection before being allowed to take part in any and every bout.

f) A medical officer’s assistant shall be appointed to be in attendance and administer the scheme at each and every tournament and guide the doctor, if required, should the doctor be new to ABAE medical rules and regulations.

g) A fully GMC registered doctor of medicine must be present at every boxing competition.
2. Enrolment

a) The honorary secretary of the entrant’s club shall complete the initial section of the medical examination form (ME1). Where the entrant is under 18 years of age, he shall also ensure that consent for the entrant to box is obtained from the boxer’s parent or guardian and that this is indicated by the parent/guardian’s signature on the ME1. Proof of date of birth is also required.

b) It is the responsibility of the honorary secretary of the club and/or the entrant to arrange for the initial medical examination to be carried out by a registered medical practitioner. The entrant should take the form ME1 to the doctor together with a stamped envelope addressed to the local records officer. The doctor should be requested to complete this form after the examination and return it in the envelope provided (a guidance form for the medical is also provided for the examining doctor).

c) On receipt of the form from the examining doctor, the local records officer will enter the information on-line and either issue the ME3 if all is in order, or will seek further medical advice.

d) It is recommended that the initial medical examination be carried out no less than four weeks before the intended first bout for the boxer.

e) If no contests take place within ONE year of the initial medical it is no longer valid and a new full initial medical is required. The ME3 will then either be endorsed to this effect or a new ME3 will be issued.

3. The Local Records Officer (Medical Registrar)

a) Each division, or its parent association, shall appoint a local records officer (LRO - also known as medical registrar) who shall be responsible for the confidential and secure administration of the medical scheme within that division/association.

b) If the medical registrar is unable to act, the responsibilities shall be subsumed by the honorary secretary of that division/association.

c) Enrolment of new boxers:

On receipt of the form ME1 from the examining doctor, the medical registrar will stamp it with the association stamp. If there are any items on the form that are not normal or clear, the advice of the association medical officer or the ABAE medical commission must be sought.

When the details on the form are complete one of two things will happen:

i. If all the details on the ME1 are satisfactory and have been entered on the central computer database, the ME3 is issued. The central database will issue a unique registration number that the medical registrar will enter on the new ME3 only after the boxer has paid his registration fee. This is a temporary registration. Once the form ME1 has been sent to the central records office and has been scanned onto the central database full registration occurs.

ii. If the examining doctor declares the boxer unfit, (or the medical registrar feels further advice should be sought) the ME1 will be sent to the central records officer for consideration by doctors of the medical commission who may overrule or uphold the decision of the examining doctor. When the medical registrar is informed by the central records officer that a boxer is unfit, the boxer’s club must be informed of this decision (but not the reason).
The boxer is also informed privately of the reason. If the boxer is under 18 years of age, then the parent/guardian must also be informed of the reason why that person is unfit to box.

In some cases the unfitness to box may be due to a temporary condition, or may be a provisional decision pending referral to the general practitioner for further information, or to a specialist consultant for that condition, or a medical officer of the division or association for a more detailed examination and opinion.

A second opinion may be arranged through the doctor who undertook the initial examination, or by the club doctor, the boxer’s general practitioner or a medical officer of the division or association. The resulting report should be returned to the medical registrar, who must note the information, and then send it to the central records officer for a decision by the ABAE medical commission and only subsequently act upon their instructions.

If a second opinion has been sought then the new information must go to the medical commission for assessment prior to issue of the ME3. In this circumstance, the medical registrar is **NOT** allowed to issue an ME3 until approval has been given by the ABAE medical commission. As of the 2006/2007 season, all of this may be done electronically but the hard copies of all correspondence and the ME1 must be sent to the central records officer.

d) Continuing supervision of a boxer’s career:

i. After every tournament, the tournament record sheet of bouts (ME6) and the medical officer’s assistant’s report form (ME4) are sent by the official-in-charge of that tournament to the secretary of the division. Both of these forms (ME4 and ME6) are in duplicate. The honorary secretary of the division will send the top copy of each form to the central records officer and retain the second copy for their own information. The central records officer will then inform all medical registrars of any injury, compulsory lay-off period or requirement for medical re-examination which has resulted from that tournament and affects any boxer in that division. This mechanism ensures that all medical registrars are informed of medical problems arising in their own boxers who may have boxed outside their own division/association. It is the duty of the medical registrar to ensure that the instructions and information received from the central records officer are entered on their own records and then acted upon, by advising the club secretary, the medical officers of the division/association, or other official as necessary. As from 2006/7 season this will be done electronically directly via the ABAE central database.

ii. It is often convenient for the medical registrar to be informed directly by the division/association secretary of injuries and lay-off periods affecting their boxers. Provided that the requirements are clear, and it has been checked against the previous history of the boxer from the local records, the medical registrar may take the necessary action on his own initiative. Should there be any doubt, he must await the decision and advice of the central records officer. Should the central records officer require a different course of action to that initiated by the medical registrar, the central records officer’s instructions must be followed. All entries must go onto the central database.

iii. It is the duty of the medical registrar to institute such measures as are necessary to ensure that the information recorded from the central records officer is accurately entered in the ME3 of each boxer registered by their division/association. As a minimum, all injuries, lay-off periods, and the dates and results of medical examinations entered on the boxer’s ME3, should be
checked against the medical registrar's own records each time the boxer is medically re-examined.

iv. A boxer's bout history may indicate the need for special consideration, for example after repeated RSC or KO results or long lay off.

v. It is recommended that such cases be discussed with one of the association's medical officers and, if indicated, should be referred to the council of the association. In such cases, the council may wish to consult the honorary secretary of the boxer's club, the club doctor, an association medical officer, or any other source it deems necessary, and decide upon one of the following:

- To take no action
- Or
- To advise as to the future of the boxer;
- Or
- To prevent the boxer from competing until medically examined;
- Or
- To prevent the boxer from competing for a given period;
- Or
- To prevent the boxer from competing for the rest of his life.

vi. The medical registrar may receive from the official-in-charge of a tournament the ME3 of a boxer in which the tournament medical officer has failed to indicate an injury and/or compulsory lay-off period. In this case, the medical registrar shall complete the boxer’s ME3 from the medical officer’s assistant's report form for that tournament, if this is available from the divisional secretary, or from information provided by the central records officer. The details must also be entered on the central database. The medical registrar must retain the boxer's ME3 and inform the honorary secretary of the boxer's club of the situation. Before boxing again, the boxer must be examined by his club doctor or a medical officer of the association. The examining medical officer will issue a certificate of clearance when he is satisfied the boxer is fit to continue boxing, or report otherwise. When the certificate is received by the medical registrar, he can release the boxer’s ME3 to the club secretary, and forward the certificate and all other relevant information to the central records officer.

e) Replacement and duplicate medical record cards:

i. The medical registrar shall issue a boxer's replacement ME3 to the club secretary on receipt of a card in which there is no further space to enter details of contests, or which has become severely damaged. When issuing a new card, the medical registrar must enter the following details on the new card.

- The total number of contests, wins and losses, to date, and any rest periods;
- The date and result of the previous medical examination.
- The date and details of any injury, illness or lay-off period which might carry forward and affect the length of any lay-off stipulated for a future injury. This especially applies for KO(H) and RSC(H).

The full or damaged card must be sent to the central records officer after the medical registrar has completed his own records from it.

ii. The medical registrar may only issue a duplicate boxer's ME3 when he is satisfied that the original card has been genuinely lost (normally 28 days must have elapsed from the date of report of the loss). In this case, he must clearly mark the card 'duplicate' with the date of issue, and enter the details listed in
(i) above from his own records as far as is possible. The details must also be entered on the central database.

iii. If, having issued a duplicate ME3, the original card is found, this must be returned with the duplicate card to the medical registrar who must amend the original card to include all the details of contests recorded on the duplicate card and return the original card to the club secretary. The duplicate card must be sent to the central records officer, after the medical registrar has completed his own records from it. The details must also be entered on the central database.

f) Change of club:

i. The medical registrar will receive the form of application for membership and the boxer’s ME3 from the secretary of the club to which the boxer wishes to transfer.

ii. The medical registrar must ensure that the boxer satisfies the residential requirements for his prospective club and confirm that the form of application for membership is properly completed – especially endorsement C which states that the original club is prepared to release the boxer. The medical registrar must record the change of club in the boxer’s ME3 and in his own records and enter the details on the central database, before sending the ME3 card to the new club.

iii. A boxer may not be considered to be a member of his new club until the club secretary has received the boxer’s ME3, suitably amended.

iv. In cases of dispute, the matter shall be referred to the council of the respective association or to the council of The ABAE for judgement.

g) Medical re-examination of boxers:

i. The medical registrar must maintain his records so that he can inform the club secretary when a boxer requires medical re-examination. This will also automatically be flagged up on the central database records.

ii. Every boxer must be re-examined by a doctor at maximum intervals of five years. Ideally, a boxer should also be examined on changing from youth to senior. On attaining the age of thirty years, every boxer must receive a full medical examination which must then be repeated annually until retirement.

iii. The administration and documentation of the medical re-examination of a boxer is identical to that used for the initial medical examination.

iv. The boxer’s ME3 must be returned to the medical registrar with the new ME1 after each medical re-examination, so that the medical registrar can check the entries on the ME3 against his own records and correct them as necessary. The details must also be entered on the central database.

h) Retirement:

i. The medical registrar must keep his records in such a way that he is aware when a registered boxer reaches his 34th birthday. This will also automatically be flagged up on the central database records. If the honorary secretary of the boxer’s club has not returned his ME3 by that time, the medical registrar
shall inform the club secretary that the boxer is now compulsorily retired and request that the boxer’s ME3 be returned to him. If the club secretary fails to return the boxer’s ME3, the medical registrar shall report this in writing to the honorary secretary of his association.

ii. When he has completed all his records for a retiring boxer and entered the details on the central database, the boxer’s ME3 and any other relevant documentation must be forwarded by the medical registrar to the central records officer.

iii. At the request of a boxer who has retired, the ME3 may be returned to him once the medical registrar and central records officer’s records have been completed and entered on the central database. In such a case, the card must be clearly ruled-off immediately below the last contest and the words RETIRED FROM AMATEUR BOXING must be clearly inserted with the date of retirement clearly printed beneath.

4. The Central Records Officer and His Duties

a) The central records officer of the ABAE is appointed by the board of directors to maintain central records of all boxers and tournaments.

b) Enrolment and routine medical re-examination:

i. The central records officer will receive the ME1 from the local records officer after the boxer has been medically examined. As from 2006/7 season this may be done electronically directly via the ABA central database. The effect of any medical condition reported on the form must be carefully considered with reference to the guidelines for the initial medical examination (see the relevant section below). The central records officer must refer the case to the medical commission if there is any doubt about fitness to box, and in any instance where the opinion of the examining doctor is contrary to the guidelines issued by the ABAE.

ii. If the decision is definitely ‘unfit’, the central records officer shall inform the local records officer of this and ensure that no ME3 is issued.

iii. In cases of doubt, the following may be required:
   More information from the boxer’s parent/guardian or GP
   Or
   Referral for specialist examination
   Or
   Examination by a medical officer of the division/association, or by a member of the ABAE medical commission.

iv. The central records officer will inform the local records officer of the requirement to be followed, giving the names and addresses of suitable medical officers, so that the local records officer can make the necessary arrangements. The result of these investigations will be returned to the central medical records officer who shall further consider the case (taking the advice of the medical commission) and inform the local records officer of the final decision on the applicant’s fitness to box. As from the 2006/7 season issue of the ME3 approval will be done electronically directly via the ABAE central database.

c) Follow-up:
i. After every ABAE authorised tournament the central records officer will receive from the divisional secretaries, the following documents authorised by the divisions/associations:
The tournament record sheet (ME6); The medical officers’ assistant’s report form (ME4) and separate injury forms. As from 2006/7 season this will be done electronically directly to the ABAE central database.

ii. The central records officer may also receive other reports of injury, illness, periods of lay-off or other information relating to the boxer.

iii. Injuries, illnesses, lay-off periods, dates and results of the initial medical examinations and the medical re-examinations, and changes of club must be entered on the boxer’s record card and on to the ABAE central database.

iv. If such entries reveal a breach of regulations, or otherwise give cause for concern, the central records officer must either instruct the local records officer accordingly, or refer the case to the medical commission for consideration.

v. Having completed the records from the documents that have been received from the divisional secretary, or from other information received, the central records officer must determine the correct course of action for the protection of the boxer concerned and inform the local records officer accordingly. In this, the details may need to be referred to the medical commission and/or the board of the ABAE for advice.

d) Retirement and document storage:

i. On the retirement of a boxer, the central records officer will receive all relevant documents from the local records officer and must complete his own records from them and ensure all central database records are correct.

ii. All documents relating to a boxer’s career must be securely stored in an orderly manner for future reference. They may only be discarded with the express permission of the ABAE, who shall seek the advice of the medical commission regarding the need to keep such records for retrospective research. Storage and disposal of records must be by methods which protect the confidentiality of the information they contain and with due regard to data protection regulations for computer records and information.

iii. If a retired boxer has requested that his ME3 be returned to him, this shall be done, provided that the central records officer has completed his records from it and that the card is clearly ruled off immediately beneath the last contest with the words RETIRED FROM AMATEUR BOXING and the date of retirement clearly printed beneath. The card may then be returned to the local records officer who will return it to the boxer’s club.

e) Statistical reports:

i. The central records officer shall maintain the records in an orderly way so that a statistical report of the previous season’s boxing held under the jurisdiction of the ABAE may promptly be prepared.

ii. The annual statistical report shall normally show:

The number of registered boxers
The number of contests, both overall and per boxer

The number of stoppages under each category (KO, KO(H), RSC(H), and RSC, which will also be subdivided: outclassed, retired, unfit to continue, 3/4 mandatory counts, disqualified or injured. KO(H) shall further be divided into classes 1, 2 and 3

The numbers and types of injuries reported and the lay-off periods stipulated

Reasons for failing initial medical examinations and re-examinations

These figures should be available for the ABAE as a whole and also broken down by category of bout (youth or senior) and by provincial association.

iii. The central records system will be used to prepare other statistical reports as may be requested from time to time by the medical commission or board of directors of the ABAE.

5. The Medical Officer’s Assistant and His Duties

a) A medical officer’s assistant shall be appointed by a division or association for each and every tournament it authorises.

b) If for any reason the medical officer’s assistant is unable to act, the official-in-charge of the tournament shall appoint another responsible official to act in his place. If this is not possible and the tournament medical officer is familiar with the rules and regulations of the medical scheme and is willing to accept the extra duties, then the doctor may also undertake the duties of the medical officer’s assistant under the guidance of the official-in-charge. If the tournament medical officer is inexperienced or unwilling to act in this way, then the official-in-charge must himself act as medical officer’s assistant.

c) The function of the medical officer’s assistant is to administer the ABAE medical scheme at the tournament for which he is appointed. In this, he will work closely with both the tournament medical officer and the official-in-charge, and must provide the pathway for communication between them. In practice, there is often a sharing of duties between these three officials, but it remains the particular responsibility of the medical officer’s assistant to ensure that the requirements and documentation of the medical scheme are met.

d) The pre-bout medical inspection:

i. The medical officer’s assistant shall assist the tournament medical officer at the pre-bout inspection of boxers. He shall ensure that adequate facilities are available: the room need not be large, but should be warm, well lit and quiet, with a table and chair provided. A toilet, and sink with water, soap and towel should be nearby. He should meet the medical officer on his arrival, introduce him to the official-in-charge and show him to the examination room.

ii. The assistant should gather together in an orderly fashion all boxers taking part (preferably in the order in which they expect to box), each wearing his gum shield and carrying his ME3. The assistant should introduce each boxer in turn to the medical officer and examine his ME3 to ensure it is valid and also draw to the attention of the medical officer any pertinent fact recorded therein (such as recent bouts and results, suspensions and medical exams).
iii. As the inspections are completed, the assistant must retain the ME3 of every boxer inspected until after each has competed. He must ensure that the medical officer records all injuries, the reason for failing an inspection, and any medical suspension or follow-up requirement, before the card is returned to the boxer or the coach. The ME3 is a confidential document.

e) Assisting the medical officer at the ringside:

i. The medical officer’s assistant should ensure that a seat is provided for the medical officer at a neutral corner near the side of the ring. He should introduce the medical officer to the referees and ensure that they know where the medical officer is seated.

ii. Any request for the medical officer to examine a boxer (outside of the ring) during or after the tournament should be directed through the assistant, who will arrange for the boxer to be brought to the examination room at an appropriate time during the event. Any decision made by the doctor regarding treatment or referral of the boxer must be arranged by the assistant. If the doctor wishes to discuss the case with the boxer’s parent/guardian, companions or coach, the assistant should direct them to the doctor in the examination room.

iii. The medical officer’s assistant should ensure that all relevant forms have been completed by the medical officer before they leave the tournament.

f) Documentation:

i. The medical officer’s assistant is responsible for ensuring that all relevant documents are properly completed.

ii. The boxer’s ME3 must be fully completed with particulars of all injuries and compulsory periods of lay-off. These details may be entered either by the medical officer or the officer-in-charge, according to the circumstances.

iii. When a bout has finished and all necessary details have been properly entered, the assistant should confirm with the medical officer and official-in-charge that no further examination of the boxer is necessary. The assistant may then return the ME3 to the boxer or responsible club official.

iv. A boxer’s ME3 should be retained by the official-in-charge when an injury has occurred which has not been examined by the medical officer, or he has not made the necessary entry regarding a lay-off period. In this case, the medical officer’s assistant must give the ME3 to the official-in-charge for return to the local records officer, who will in due course return it to the club secretary. Every effort should be made to complete the documentation fully on the day of the tournament.

vi. The medical officer’s assistant must ensure that his report form (ME4) is properly completed. This form records the boxers who are not passed fit to box at the pre-bout inspection and the reasons for this, as well as particulars of all injuries and the periods for which a boxer is compulsorily prevented from competing. In every case, the boxer to whom this information applies must be identified by his name, his registration number and his club. For members of HM Forces, the boxer must be identified by his service number, his name and the full designation of his unit and its location. It is not sufficient simply to record ‘Royal Navy, Army or Royal Air Force’.
vii. The medical officer’s assistant will ensure that all information is passed to the local medical registrar so that (from 2006/7 season) all this information will be entered electronically directly to the ABAE central database.

g) The medical officer’s assistant must be familiar with the rules and regulations of the ABAE and must advise the medical officer on them if the need arises.

h) When the services of qualified paramedics have been arranged, the medical officer’s assistant should introduce himself and the medical officer to them.

6. The Official-in-Charge (OIC)

a) General responsibilities:

i. The official-in-charge has overall responsibility for the administration and safe progress of that tournament and must have passed the ABAE examination to fulfil this important role.

ii. The medical scheme has greatly increased the work of the official-in-charge, but without his whole-hearted co-operation and support it can only be partially successful. Most of the duties have some impact on the safety of the sport. They include responsibility for ensuring that the correct equipment is available and in a satisfactory condition, that boxers wear the necessary protective items of dress, and that all tournament officials carry out their duties to the highest possible standard. The latter is particularly important with respect to the standard of refereeing. The official-in-charge has the authority (and the responsibility) to report to the division/association secretary any referee who is not adequately protecting the boxer.

iii. He must ensure that regulations regarding the matching of boxers are rigidly adhered to.

iv. He must be totally familiar with the rules and regulations of the sport and apply them impartially. In cases where he must use his discretion and judgement, he must always decide on the course of action that will be safest for the boxers. A good official-in-charge will carry the respect of all concerned and the public will see the sport to be competently and safely administered.

b) Specific duties within the medical scheme:

i. The official-in-charge has overall responsibility to see that the medical scheme is adhered to at the tournament. In this, his main duties are delegated to the medical officer’s assistant, in whom he should be able to have complete trust. He must ensure that the duties of the medical officer’s assistant are properly carried out as defined in the section above.

ii. If the official-in-charge believes, in his opinion, that a boxer has sustained an injury, he must bring this to the attention of the medical officer either directly or through the medical officer’s assistant.

iii. If a boxer receives an injury, or a large number of blows to the head, the official-in-charge may retain the boxer’s ME3, if necessary, pending medical advice. The card must then be sent, together with the tournament record sheet and the ME4, to the local records officer (medical registrar).

iv. If the official-in-charge observes or is informed of anything that may have a bearing on the medical fitness of a boxer, beyond the tournament, it is his duty
to inform the local records officer of this. The local records officer will then take the necessary action.

v. At the tournament, it is the medical officer’s duty to make decisions regarding injury or illness of a boxer. If the situation appears to be at all serious, the contestant should be conveyed to hospital, by ambulance, accompanied by a responsible person. The official-in-charge should arrange this and send with them a brief note (or the approved form C) addressed to the casualty officer on duty, giving the boxer’s name, home address (and telephone number if known), the venue, the nature of the illness or injury and any other relevant information (such a letter will normally be written by the doctor). In cases of knock-out or RSC(H), an indication of the number and severity of blows, and the length of period of unconsciousness or amnesia (loss of memory), is important. In other cases of KO(H) or RSC(H), form B must be completed and handed to the boxer with instructions to consult his GP within 24 hours.

vi. It is advisable to send every boxer who suffers from concussion, or amnesia, after a boxing contest to hospital for examination. If the official-in-charge is in any doubt he should take this action immediately. No hospital will mind referrals if there is cause for concern. It is, however, negligent not to refer a boxer who has a serious or potentially serious condition. This action will normally have been instigated by the tournament medical officer.

vii. The official-in-charge must follow the medical advice of the medical officer. It is the responsibility of the promoting club to provide transport where necessary and to ensure that an injured boxer is accompanied to his home if this is advised by the medical officer. In such cases, the boxer’s trainer, a club official, or member of his family should be informed that if symptoms persist urgent medical attention should be sought or the boxer should be taken to hospital. If the boxer has suffered a knock-out or RSC(H) and appears well, he should still be given form D which advises on the care of a patient with minor head injury.

7. The Club Secretary

a) The honorary secretary of an amateur boxing club is the point of contact within the club for the Medical Registrar. The club secretary may carry out the following duties himself, or delegate them, as is convenient, to other officials within the club. Often these duties will be shared with or undertaken by the coach.

b) The club secretary must arrange for the initial medical examination and medical re-examinations to be carried out as required by ABAE regulations or the local records officer or central records officer, e.g. following illness or injury. In these duties, the club secretary may expect advice and assistance from his club doctor, the medical officer(s) of the division or association and the local records officer, as applicable.

c) The club secretary is responsible for the safe and confidential keeping of his boxers’ ME3 cards. Whenever a card becomes full, damaged or lost, a replacement must be requested from the local records officer (medical registrar).

d) When a boxer wishes to join a new club, it is the duty of the secretary of the receiving club to arrange for the secretary of the previous club to complete Endorsement C of the membership application form, confirming willingness to release the boxer and also to provide the boxer’s ME3. Both documents must then be sent to the local records officer to complete the transfer with entry on to the central database.

e) When any of his club’s boxers reaches the age of 34 years, or retires from the sport for any other reason, the club secretary must return the boxer’s ME3 and any other
pertinent documents to the local records officer. The card may be returned later to the boxer, on request to the local records officer or central records officer.

f) When his club is promoting a tournament, it is his duty to arrange for the following:

i. The attendance of a tournament medical officer and resuscitation personnel as required by ABAE rules. This should be done when the initial permit is sought and official-in-charge is appointed. If the doctor is new to the sport, his duties must be made clear to him at the initial agreement and a copy of this booklet should be given to him to study before the tournament. Any fee should be agreed in advance to save possible embarrassment later.

ii. A suitable medical examination room with at least a table and chair must be available. It should be clean, warm, light and airy and also quiet and private. Clean washing and toilet facilities should be nearby. If the medical officer intends to suture a laceration, then these facilities are the minimum and a table or couch for the boxer to lie on, and a clean hard surface which can be swabbed down for use as an instrument table will also be required.

iii. Transport and a responsible escort to take an injured boxer home, or to hospital.

iv. The immediate availability of a working telephone or mobile phone.

g) Together with the coach and other officials and members of the club, the secretary has the responsibility to provide all facilities necessary for training boxers safely, and to ensure that these are well and hygienically maintained. He should become familiar with the club’s boxers and their backgrounds and support the efforts of his coach in demanding high personal standards within the club, so leading to a responsible, mature and healthy approach to the sport.

8. The Boxer’s Medical Record Card (ME3)

a) General information:

i. The ME3 is the critical document in the operation of the medical scheme. For this reason, these cards must be kept most carefully and entries made meticulously. The loss of a card must be reported immediately to the local records officer. Duplicate ME3 cards can only be issued by the central records officer.

ii. Medical record cards will **not** be issued to boxers who are under eleven years of age. Boys may be examined for fitness to box at nine years of age and after, but the ME3 must not be issued until the boxer reaches the age of eleven. (It must be borne in mind that the initial medical is valid only one year if a boxer has not competed, so, sensibly, no medical is done before age 10)

iii. An ME3 only to be issued through the club of which the boxer is a member.

iv. The ME3 of any boxer joining HM Forces or the British police must be returned to the local records officer who will forward it to the central records officer. The central records officer will ensure that the details are forwarded to the secretary of the service boxing association that the boxer has joined. A boxer or his club may request that the ME3 be returned, in which case it must be ruled off immediately under the last contest and the words **CANCELLED – BOXER ENTERED HM FORCES/POLICE** and the date must be printed clearly beneath. The ME3 may then be returned to the boxer/club.
v. 28 days notice is required for the issue of a duplicate ME3, application for which must be made on the form supplied for this purposes. If the original card is subsequently found, all the cards in the possession of the club and/or boxer must be returned to the local records officer. Duplicate cards will only be issued when the initial medical examination card is held by the central records officer and valid details are on the central database.

vi. To be valid, a boxer’s ME3 must be complete (all pages are numbered), have all personal details of the holder correctly entered, include a photograph of the holder (which must be a true likeness and be updated at least every five years), be signed by the boxer; and it must also bear the medical stamp of the association and a current (annual) registration stamp.

b) Entries:

i. Full details of every contest must be recorded on the card. This is the responsibility of the medical officer’s assistant and the official-in-charge. When English boxers are competing outside the area of jurisdiction of the ABAE, the card must be completed by the team manager or person in charge of the ABAE boxers (usually in this situation the boxer holds an AIBA medical record card that will be used. This must also be fully completed, in date, and signed, medical exam records and sufficient space for all anticipated bouts to be contested at that competition).

ii. For each contest, the following information must be recorded:

Date of contest, opponent’s name, opponent’s registration number, result (in full detail – won/lost, (and if stopped, the reason and round); knock-outs must be fully classified as KO or KO(H) (and if KO(H) as class 1, 2 or 3), nature of injury, rest period specified, doctor’s signature.

iii. When a new ME3 is started, the following information must be entered at the head of its first page:

The total number of contests, wins and losses to date;

The date and result of the previous medical examination;

The date and detail of any injury, illness or lay-off period which might carry forward and affect the length of any lay-off stipulated for a future injury, especially for KO(H) and RSC(H).

If the new card is a duplicate, this must be clearly marked as such, together with the date of issue.

iv. When a boxer is medically re-examined, the date and result of the examination must be clearly indicated on the ME3.

v. On the retirement of a boxer, his ME3 must be ruled off immediately under the last contest and the words RETIRED FROM AMATEUR BOXING and the date of retirement printed beneath. On request, the card may then be returned to the boxer, provided that the Local Records Officer and Central Records Officer have completed their records from it.

B. THE MEDICAL COMMISSION
1. The Medical Commission is the senior body of medical opinion within The ABAE. It consists of up to seven medical practitioners who are honorary medical officers of The ABAE. They are approved at the annual general meeting of The ABAE, following nomination to serve on the commission from their region. The commission may appoint associate members to the commission.

2. The medical officers of The ABAE shall: “…advise the association on all matters which come within their province”.

3. The medical commission elects a chairman from its members who serves for a period of five years, and is eligible for re-election. The chairman calls meetings of the commission which normally take place 2 or 3 times a year, and he is the pathway for communication between the commission and other sections of ABAE. Communication with medical committees of boxing associations from other countries is directed through the chairman. He should also be the England representative on EABA & AIBA medical commissions when England has a member on these.

4. The medical commission is responsible to the executive council and board of the ABAE for the administration of the medical scheme. It is the final arbiter in decisions regarding an individual boxer’s fitness to box and works closely with the central records officer.

5. The medical commission has a duty to advise The ABAE upon the programme of testing for illegal substances that is overseen and wholly run by UK Sport in accordance with WADA protocols.

6. The medical commission has a duty to advise The ABAE upon all rules that have any medical basis (and see 9 below)

7. The medical commission will organise a medical symposium which is open to all doctors with an interest in boxing. The purpose of this symposium is to foster communication between these doctors, to learn of difficulties experienced and advise accordingly, and to develop a consensus of opinion on medical matters which are under current discussion. By means of invited talks from specialists in their own field, the symposium also serves an important educational role and affords an opportunity for recruitment of new doctors into boxing.

8. An Olympic squad support group has been formed (performance plan), consisting of a physiotherapist, nutritionist, psychologist and physiologist. The objective of this group is to study training methods and advise on the preparation of the England squad for the Olympic Games and other major championships in the hope that resulting improvements in training methods will be disseminated to all involved in the sport. The group works closely with the national coach (performance director), and is responsible to the medical commission, one of whose members is on the performance commission and acts as its co-ordinator and advisor on general medical matters.

9. The medical commission has a duty to review continually the statistics generated by the central records officer and discuss ways in which the safety of the sport may be improved. From these statistics any recommendations for changes in the medical rules and regulations of the ABAE are fully considered from medical, legal and boxing aspects before they are sponsored by the medical commission. Recommendations for changes, if approved by the commission, will be put to the board but can only be adopted by the ABAE at an executive council meeting.

C. ASSOCIATION AND DIVISIONAL MEDICAL OFFICERS
1. Each association and division may appoint up to four honorary medical officers to advise it upon medical matters. Such appointees serve ex-officio on the council of the association or division which has appointed them.

2. Association and divisional medical officers are expected to officiate at representative tournaments and stages of national championships which take place within their geographic area.

3. Association and divisional medical officers shall advise the local records officer (medical registrar) on the fitness to box of individual members. In this way they may wish to examine a boxer themselves, or discuss the medical history of a boxer with his general practitioner, or seek a specialist consultation and opinion.

4. Other duties are unspecified, but it is recommended that the honorary medical officer arranges informal meetings with other doctors who give their services to boxing clubs in their area to discuss matters of mutual interest and concern.

5. Honorary medical officers of associations and divisions should make every effort to attend the symposium organised by the medical commission and to qualify as ringside physicians. Once qualified as a ringside physician they may be eligible to be nominated by their association to serve on the ABAE medical commission.

D. THE CLUB DOCTOR

1. Many amateur boxing clubs have a relationship with a local doctor who will carry out medical examinations on the club's boxers and act as the tournament medical officer for the club's shows. This may be a formal appointment or an informal attachment and the conditions of the relationship are entirely a matter between the club and doctor concerned.

2. The club doctor should be encouraged to take an interest in the welfare of the officials and boxers in the club (in some cases he may be their general practitioner). A copy of this booklet must be made available to him, and he should endeavour to become acquainted with the rules and regulations governing those aspects of the medical services which he is expected to provide.

3. The club doctor is in an excellent position to recognise medical problems in boxers at an early stage. In such situations, appropriate advice, if given early, may prevent or minimise the effects of illness and injury. By knowing the trainers and gaining their confidence, the club doctor can help to educate them and their boxers on the reasoning behind the medical regulations of the sport, and on the safety value of good defensive technique and physical fitness. He may also be able to give advice on hygiene, diet, first-aid, and the likelihood of medications being taken by the boxer affecting the results of a drug test. Such a condition will be facilitated if the club doctor can attend training sessions from time to time.

4. For those contemplating an appointment as a club doctor it is an interesting and rewarding experience. It gives an excellent opportunity for the doctor to meet and become part of a group of people who give their time to the training and development of youngsters, many of whom are socially or economically disadvantaged.

5. Club doctors are encouraged to become involved as association/divisional doctors and to gain qualification as national ringside physician as they progress after officiating at national and international boxing tournaments held in England. They may then be invited to act as team doctors on overseas events and to serve on the medical commission and then qualify as continental and ultimately as international
ringside physicians (these are EABA and AIBA recognised and controlled appointments).
IX. Medical Examinations

A. GENERAL POINTS

1. These are similar to the routine examinations carried out for insurance purposes. It must be remembered that the objective of these examinations is to decide upon fitness to box, which demands a very high standard of physical fitness to be maintained over a period of time, with short periods of extreme activity. The presence of a condition preventing the attainment of full physical fitness that is not detected at the examination will, at best, result in under-achievement and increase the risk of potential serious injury at worst. The examination must include all systems and the aim is to identify those individuals with a significantly higher-than-average risk of suffering injury or illness through congenital defect, previous injury or disease process, and select them out of boxing.

2. Every abnormal finding on the initial medical examination must be recorded on the medical record form (ME1). This is the vital document that must be accurately and completely be completed by any doctor who examines any potential boxer.

3. The examining doctor is required to give an opinion regarding fitness to box. The medical examination forms the basis of this opinion and no guidelines can be comprehensive. If the examining doctor is unable to form a definite opinion from the examination, this should be made clear on the form, stating the reasons. This will then be taken up by the local records officer (medical registrar) when the form (ME1) is received, and further information or advice will be sought as necessary. Some doctors who may disapprove of boxing may not wish to declare someone as ‘fit to box’. They can still do the medical examination and declare ‘not found unfit to box’.

4. If the examining doctor is unable to declare that the potential boxer is definitely fit to box, this should be disclosed to the boxer and, if under eighteen years of age, also to the parent/guardian. Disclosure of this information to the boxer’s general practitioner should also be given serious consideration. If further information is required from the boxer’s general practitioner, or a special investigation, or a specialist’s opinion is advised, this should be discussed with the boxer and/or his parent/guardian so that they are fully informed of his health, do not suffer undue anxiety, and are encouraged to co-operate with the referral and any advice and treatment which may result from it.

5. The importance of these full medical examinations cannot be over-emphasised. The officials in the sport, the boxer, and the tournament Medical Officer all rely on the fact that a thorough medical examination has been performed, and any abnormality likely to expose the boxer to an unacceptable risk of injury has been detected.

B. THE INITIAL MEDICAL EXAMINATION

1. General Requirements

a) This must be undertaken prior to any entrant being permitted to box. It is strongly recommended, and, if the boxer is under eighteen years of age, it is essential, that the parent/guardian also attend the examination so that a full family history and personal medical history can be obtained. This is as important as the physical examination. If the examining doctor feels that the history is uncertain, he must indicate this on the form, and request that information be sought from the general practitioner.

b) The initial medical examination must take the form laid down by The ABAE and contained on the ME1. The following section gives some specific advice and indicates
the nature of the examination required and is available at Appendix iv as a doctor information sheet. ME1 and doctor information sheet are downloadable from the ABAE website (www.abae.org.uk)

c) Good ethical medical practice **must** be maintained with regard to chaperone/parental supervision when conducting all medical examinations.

2. Guidelines

a) Height, weight and general physique:

Obesity does not debar unless suggestive of hormonal imbalance, in which case further investigation is required. Departure beyond the 20th and 80th centile for height and weight requires special consideration.

b) Family history:

i. A family history of tuberculosis requires a chest X-ray and information from the general practitioner regarding its current activity in the family.

ii. Conditions with a known genetic inheritance (e.g. Huntingdon’s Chorea and Ehlers Danlos Syndrome) **must** be recorded and most will debar from boxing.

iii. A family history of epilepsy, insulin-dependent diabetes, asthma, sickle cell anaemia or trait, or any other blood dyscrasia, will require further investigations into the boxer’s physical condition, to assess whether he is similarly affected.

iv. A family history of death in a first degree male relative below the age of 40, or female relative below the age of 50, from heart disease warrants further investigation to exclude hypertrophic cardio myopathy.

c) Personal medical history:

A history in the boxer of the following conditions renders him **unfit** to box:

i. Epilepsy, infantile or other convulsions or fits (other than a simple febrile convolution that has been fully investigated), blackouts or any history of fainted of unknown cause: skull fracture or other severe head injury, frequent migraine, meningitis, encephalitis or other major disease of the central nervous system, intracranial bleeding or any form of brain surgery.

ii. Insulin-dependent diabetes.

iii. Congenital heart disease, rheumatic heart disease. (Untreated)

iv. Severe asthma, spontaneous pneumothorax, tuberculosis;

v. Sickle cell anaemia (not the trait), coagulation disorders (haemophilia etc.);

vi. Bilateral deafness requiring regular use of hearing aids;

vii. Significant congenital abnormality of the genito-urinary system, renal calculus, recurrent nephritis;

viii. Proven infection with hepatitis B (Australia antigen) & C or HIV (Aids virus);
ix. Active peptic ulceration, pancreatitis, gall stones, severe inflammatory bowel disease;

x. Active malignancy of any sort;

xi. Tropical infectious diseases or infestation not fully cleared by treatment;

xii. Liver disease and recurrent jaundice;

xiii. Nephrectomy, orchidectomy, transplant or other major surgery.

d) Eyes and eye-sight:

i. Visual acuity must be assessed separately for each eye by the Snellen method, WITHOUT contact lenses or spectacles being worn. Visual acuity which is worse than 6/12 in the better eye and/or worse than 6/24 in the poorer eye automatically renders a boxer unfit to box.

ii. Squint or visual defect requires referral for a specialist ophthalmological opinion. (This may be a qualified high street optician but if they remain concerned then a consultant ophthalmologist will need to give an opinion)

iii. The eyes must be ophthalmoscopically examined for evidence of corneal scarring, cataract and retinal tears, detachment or haemorrhage.

iv. History of retinal detachment, glaucoma, cataract or corneal or intra-ocular surgery (and this includes all laser surgery) is a bar to boxing (previous squint surgery that has given a good result is allowed).

e) Ears and hearing:

i. Significant bilateral deafness debars from boxing whatever the cause.

ii. Unilateral deafness in itself does not prohibit boxing, providing hearing is adequate in the other ear.

iii. Otitis externa, otitis media, mastoiditis, a moist or discharging perforation of the pars tensa, and the presence of a grommet all prevent boxing until the infection has fully resolved, and any grommets are removed. An attic perforation and/or cholesteatoma permanently debar, but a simple dry perforation in itself does not.

iv. A ‘T’ tube present in a dry drum is acceptable if the boxer has a letter from his ENT consultant confirming that the consultant gives their approval for boxing.

f) Nose:

Gross nasal deformity, including septum, leading to severe nasal obstruction debars from boxing. Hay fever, if severe, might debar, as might a large polyp. Sub-mucosal resection (SMR) or other nasal surgery requires special consideration as does a history of recurrent nose bleeds.

g) Mouth and throat:

The following debar from boxing:

i. Excessively protruding front teeth or malocclusion such that the lower incisors cannot gain location in and support from a gum shield.
ii. Active dental sepsis, excessive caries of the incisors and/or canines.

iii Fixed braces or any other form of orthodontic treatment, unless a custom mouth guard is provided by the orthodontist treating the boxer together with a formal letter, provided by that specialist, stating that he has supplied both braces and mouth guard and he is happy for the boy to box and considers him to be at no greater risk than anyone not fitted with dental brace.

(Note: see Appendix i for approved letter format)

iv. Tonsillitis (until resolved).

v. Repaired cleft palate may need referral for specialist opinion if a defect still remains.

h) Chest: (Note: special rules for females. See Section XII)

i. A deformity of the chest wall which compromises ventilation would debar.

ii. If there is evidence of obstructive airways disease then full details, including peak expiratory flow and all medication, must be recorded.

iii. Evidence of parenchymal lung disease will require referral for specialist opinion.

i) Cardiovascular system:

i. Cyanosis, evidence of cardiac failure, cardiomegaly, dysrhythmia and valvular disease and coarctation all debar from boxing.

ii. In cases of doubt, exercise testing may be necessary as part of a specialist cardiological opinion which may also be required for persistent tachycardia;

iii. Blood pressure should be average for age; in senior boxers, a systolic pressure higher than 140 and/or diastolic higher than 90 mm Hg requires further investigation. Examination of the fundi may be helpful in deciding whether marginally raised blood pressure is due to anxiety or organic disease.

j) Abdomen & GU: (Note: Special rules for females. See Section XII Page 83)

i. Full examination of the abdomen must be performed but rectal examination is not required. Hepatomegaly, splenomegaly, absence of or undescended testis and hernia (inguinal, femoral or incisional) all debar from boxing.

ii. A soundly-healed surgical scar does not in itself prevent someone from boxing, but the examining doctor should satisfy himself of the nature of the operation and that there is no residual disability.

iii. Abnormally delayed puberty should be referred for investigation.

iv If there is doubt, all details should be recorded and further information sought from the general practitioner.

k) Central nervous system:
i. Full examination of the CNS is required – pupils, power, tone, reflexes and co-ordination. Speech and higher functions will be appreciated during the course of the examination.

ii. If any abnormality is found it must be recorded and the boxer must be referred for a neurological opinion.

iii. Formal psychological examination is not required, but the examining doctor should be alert to and record grossly subnormal intelligence, obvious personality disorder, or any suggestion of the abuse of drugs or solvents.

iv. Tremor and abnormal gait must also be investigated.

l) Spine and limbs:

i. Significant spinal deformity (scoliosis, kyphosis) or stiffness debar from boxing. Spinal surgery or previous fracture/dislocation also debar.

ii. Any deformity in the limbs (congenital or acquired) must be recorded. Abnormally reduced or excessive mobility of the joints may prevent boxing.

m) Skin:

Problems with the skin rarely lead to long-term unfitness to box. Severe pustular acne, impetigo, infected eczema with marked excoriation, fungal dermatosis, herpes and unhealed inoculation scars all debar until the condition is adequately controlled or healed.

n) Urine:

The urine must be passed at the time of the examination and tested by dipstick. A trace of albumin can be ignored, but sugar, blood, significant albumin or ketones all require further investigation. Ideally full blood count and serology will also be done.

C. MEDICAL RE-EXAMINATION

1. This must be carried out with the same degree of thoroughness as the initial examination. It is always possible that an important condition or injury was missed at an earlier examination, or the boxer might previously have been unaware of his own or his family’s medical history. The guidelines and procedures outlined above for the initial examination apply equally for medical re-examination.

2. It is particularly important to look for conditions which might have newly arisen since the previous examination, as well as for significant injury. Visual acuity must be re-examined critically as myopia may continue to worsen throughout adolescence and into adulthood (note: especially if the eyesight has changed dramatically as the boxer may have had undeclared laser surgery). Degenerative conditions are unusual in the age-range of boxers, but, towards the end of a long career, especially if the family history is suggestive, such conditions as ischaemic heart disease and spinal degeneration may appear.

3. AIBA medical examinations (for international competitions) must be repeated annually and the initial examination requires additional tests to be done (e.g. FBP & ECG). It is also essential for these examinations that the doctor signs and dates the boxer’s AIBA medical record card and authenticates it with an official stamp.
4. Medical re-examination is required after any medical suspension. This may be a reduced examination provided that any system ‘injured’ is fully assessed. Great care is required to ensure that any hospital consultant’s recommendations are adhered to as the MO at the previous tournament who issued the suspension may not have had full information regarding the final diagnosis (e.g. a fracture may have been suspected but not proven at the time a suspension was entered into the ME3).

5. Full ABAE medicals are required every 5 years until age 30 and then annually until compulsory retirement at age 34. Ideally - and especially if it has been more than 2 years since the previous medical - every boxer should have a new medical at age 18 on changing to senior status.
A. PRELIMINARIES

1. The tournament medical officer will be assisted in all his duties by the medical officer’s assistant:- an official appointed specifically for this task. He will be familiar with the medical rules and regulations of boxing and is responsible to the official-in-charge for the administration of the medical scheme at the tournament. If the medical officer is dissatisfied with the facilities available for examining boxers, he should inform the assistant who will do everything possible to rectify the problem. Where necessary, the assistant will direct the medical officer in the proper performance of his duties, as required by the rules and regulations. In all things, the medical officer’s assistant provides liaison between the medical officer and the official-in-charge, trainers, boxers and other officials.

2. Upon arrival at the venue, the tournament medical officer should be met by the medical officer’s assistant who will introduce him to the official-in-charge, the referees and other officials. It is not his responsibility, but it is recommended that the medical officer inspects the ring in company with the official-in-charge, particularly to ensure that there is adequate and effective under-felt and that the ropes are properly taut and tied together. If the medical officer is unhappy about the state of the ring, then he should report this to the official-in-charge. The medical officer’s assistant should then lead the medical officer to the examination room for the pre-bout inspections.

B. THE PRE-BOUT MEDICAL INSPECTION

1. General Points

a) Inspecting the boxers immediately prior to a contest is the first duty required of the tournament medical officer by the regulations. If he is unavailable for this, the boxing tournament cannot take place.

b) In some specific championships, boxers are permitted to compete twice in the same tournament. It is a regulation that the boxer undergoes a medical inspection before every bout if he takes part in more than one bout at a tournament.

c) The medical inspection is, of necessity, brief and cannot attempt to be a full clinical examination of each boxer. The purpose of the inspection is to detect recent illness or injury and to assess its risks for the boxer and his opponent.

d) Although the boxer will have been given a thorough medical examination within the previous five years, the tournament medical officer must be alert to the possibility that significant disease or injury has developed since then, or might have been missed at that examination. It is not the purpose of the pre-bout inspection to search for such conditions (indicated in a previous section), but if he observes any of them, then it is his duty to prevent the boxer from competing. He must inform the boxer and the coach of the problem as well as the official-in-charge, so that the local records Officer may take the necessary action and the boxer may seek further medical care as required.

e) The usual guiding principle prevails; a condition affecting general fitness renders the boxer open to receiving unnecessary blows. If in doubt, the boxer must be protected by refusing to pass him fit to box.
f) It will be seen from the guidelines which follow that the description ‘medical inspection’ is well chosen. Apart from auriscopic examination of the ears and auscultation of the heart and lungs, the process is one of taking a brief history and then observing the boxer in an orderly fashion. Time is often short, and it is recommended that the medical officer develops a fixed routine for this inspection.

g) The medical officer’s assistant should have gathered the boxers together in an orderly manner each with his gum shield in place and carrying his ME3.

h) If, after the medical inspection, a boxer has been declared unfit, the reason for this, and recommendations regarding lay-off period or follow-up, should be entered on the boxer’s ME3 by the medical officer. This information must also be entered on the medical officer’s assistant’s report form (ME4), which will be provided by the Official-in-Charge. It is the duty of the Assistant to ensure that this documentation is complete and he must advise the Medical Officer as necessary if the doctor is unfamiliar with the forms.

2. Guidelines

The following represents the recommended procedure for the medical inspection and gives some indication of findings which should prevent a boxer from being passed fit to box.

a) Medical Record Card (ME3):
   i. The boxer’s ME3 must be inspected to confirm the following:
   ii. That it is valid and bears a current registration stamp.
   iii. That it relates to the boxer being examined with a recent photograph that looks like the boxer.
   iv. That the boxer has been medically examined within the stipulated period (five years up to thirty years of age; one year between thirty and thirty-four years of age).
   [NOTE: if an AIBA card then it must have annual medicals recorded]
   v. That the boxer is not in a period of compulsory lay-off from previous injury or illness.
   vi. That the minimum prescribed time has elapsed since the previous contest, whatever the result. Specific injury or illness will be documented and, if recent, should direct the tournament Medical Officer to pay particular attention to that region in the inspection.
   vii That the boxer has not had more than the maximum number of contests for that year as prescribed by the rules.

b) History:
   i. In practice, the history is perhaps the most valuable part of the inspection. It will direct the Doctor’s attention to recent specific problems and may alert to more generalised illness such as viral illness.
   ii. Boxers are always very keen to box and may deny any recent injury or illness. For this reason it is strongly recommended that the boxer’s coach accompanies him to the medical inspection and reports on the boxer’s recent performance in the gym.
iii It is useful to ask if there has been recent illness or injury, recent loss of time from work or school, absence from regular training sessions or recent visits to the General Practitioner or hospital.

c) General Condition:

i. A few seconds should be taken to stand back and look at the boxer who should appear well, be mentally alert and desiring to box. Pallor, lethargy, mouth-breathing in association with a runny nose, or cough should alert the Medical Officer to recent or continuing illness.

ii Colds and sore throats, whilst having little specific effect on a boxer’s skills, will take the edge off his alertness, concentration and performance and will generally lead to the decision “unfit”.

iii More significant viral illness (cervical and axillary lymphadenitis, pyrexia and rash are pointers, in addition to any specific effects) definitely prohibit boxing and a minimum lay-off period of two weeks is suggested. In these conditions, performance is well below par, and the risk of extreme exercise in the possible presence of viral infection that may affect the heart or lungs is not justified.

d) Skin:

Severe pustular acne, impetigo, open cold sores and unhealed inoculation scars all prevent boxing because of the risk of spread of the infection (to the eye of the opponent). Other open wounds also debar.

e) Face:

i. The periorbital regions are common sites for laceration and should be closely inspected. The scar of any recent laceration should be well healed – two weeks is the absolute minimum time required before boxing again after such an injury. (and then only in the course of a major competition, after explaining the potential risk of chronic problems to the boxer, trainer, and after alerting the referee to the possibility that a cut may re-open).

ii. Minor recent bruising and older bruising in the absence of swelling do not necessarily debar from boxing. (The eyes must be able to open fully)

iii. The hair must not be so long as to be drawn into the eyes by a punch. Long hair may be enclosed in a hairnet provided it remains completely covered inside the headguard. [NOTE: a boxer with long hair MUST provide their own hairnet to keep the hair inside the headguard]

iv. Boxers shall be clean shaven and their hair shall be completely covered by the head guard, with the exception of a fringe in front which shall not extend beyond the level of the eyebrows.

f) Eyes:

i. The boxer should be specifically asked if he has suffered any recent change in his vision. If he has, then testing of visual fields and full ophthalmoscopic examination as well as a test of visual acuity is mandatory. Whatever the outcome, it would be difficult to allow someone to box with such a history, and the boxer should be referred to an optician or ophthalmologist.
ii. Otherwise, a superficial inspection of the eyes is required, specifically looking for conjunctivitis, large subconjunctival haemorrhage (as indication of more serious injury to eyeball or orbit), evidence of injury to the cornea, iris or sclera, or hyphaema. Full ocular movements and light reflex are checked.

iii. No boxer may spar, or box in a competitive bout, wearing spectacles or contact lenses (this applies to all types of contact lenses).

g) Nose:

i. A discharge or obstruction should be assessed.

ii. A fracture of the nose should be healed, with no swelling, bruising or tenderness, and the nasal airways should be clear.

h) Gumshield:

i. The gumshield must be closely examined in position in every boxer. It must extend well beyond the premolars on each side and fit well. It should not fall out when the facial muscles are relaxed and the mouth is open. It must not be red, pink or orange in colour.

ii. Many gumshields are moulded from plastic blanks after warming in hot water. If one of this type does not fit well at the inspection, it may be reheated and the fit improved by further moulding. The boxer must return with it fitting well.

i) Mouth and Pharynx:

i Dental caries of a degree that will weaken the anterior teeth prevents boxing, as does tonsillitis and marked pharyngitis.

ii Fixed orthodontic braces and bridge-work debar, except where the orthodontist has fitted the mouthguard and also provided written permission to allow the lad to box. The boxer must bring that letter to every weigh-in.

iii Pharyngeal erythema alerts the attention to a viral illness.

j) Ears:

i. Both ears must be examined with the auriscope;

ii. Otitis media (purulent or serous), severe otitis externa, attic perforation or a grommet in situ all render the boxer unfit and require referral to the GP if not currently under review by him;

iii. A boxer may box with a dry inferior perforation and (if he has a letter from his ENT consultant approving it) with a 'T-tube' in-situ; provided that he can hear the referee’s instructions.

k) Heart:

i. The rhythm, rate and force of the pulse should be felt, and the heart sounds auscultated. If indicated, the blood pressure should be measured.

ii. Any suggestion of organic disease automatically renders the boxer unfit and necessitates referral for further advice.
iii. It must be remembered though, that boxers are highly trained athletes and at rest often have a low pulse rate with relatively high pulse pressure. They are also anxious at the pre-bout inspection, as competition is imminent. In some therefore, there may be tachycardia. There should be no disturbance of rhythm, except for sinus arrhythmia which is sometimes quite marked. Gross bradycardia or tachycardia render unfit and require investigation.

l) Lungs:

i. The breath sounds should be auscultated, particularly at the lung bases.

ii. Noticeable loss of air entry or persistent adventitial sounds renders a boxer unfit; if in doubt, pyrexia is a useful indicator of significant infection.

m) Abdomen:

i. The anterior abdominal wall should be inspected for hernia, particularly in boxers employed in heavy manual labour. (This is the one section that may be omitted if time and facilities make it difficult and the boxer is otherwise apparently fully fit)

ii. Beware the boxer who has recently been discharged following abdominal surgery. This may not be regarded as an “illness” and he may truthfully answer “No” to the question “Have you seen your Doctor recently?”.

n) Central nervous system:

Full examination of the central nervous system is not indicated, but lethargy, confusion, disorientation, incoordination and difficulties with balance should be recognised during the rest of the inspection. It must be remembered that minor head injury can occur in training and normal daily activities and may not be indicated on the boxer’s ME3. Any indication of a continuing state of concussion renders the boxer unfit and requires referral for full examination.

o) Hands:

A recent injury, particularly to the metacarpo-phalangeal joints (evident from swelling, bruising and tenderness) must be assessed. Loss of range of movement and pain on clenching the fist are significant in this respect.

p) Limbs:

i. Specific examination of the lower limbs is only indicated if abnormal posture or gait is observed during the course of the inspection, or is suggested by the declaration of recent injury in history.

ii. A crude examination of pectoral girdle, shoulder and elbow joints and associated muscles is provided by asking the boxer to place both hands behind his head and then his back. Any pain or loss of mobility in these actions requires closer examination and probably the decision of “unfit”.

Working with an experienced “Boxing Doctor” will enable a new Medical Officer to learn many short cuts to this formal inspection list which still ensures all systems are assessed (quickly) but without using the rigid system examination suggested above.

C. DURING THE TOURNAMENT
1. General Points

a) The Medical Officer must be present at all times for the duration of the tournament.

b) He is required to sit at a neutral corner of the ring and should be accompanied by the Medical Officer’s Assistant. The Official-in-Charge and referees should be aware of the Medical Officer’s position having been informed by the Medical Officer’s Assistant.

c) The Medical Officer may only enter the ring on the instructions of the referee.

d) The Medical Officer must do nothing to attract the referee’s attention once the bout is underway and has no authority to interfere with the conduct of the bout in any way at all. The MO may speak to the Official-in-Charge during a bout if concerned at all.

Ringside Physicians are being authorised by EABA & AIBA. They are divided into three groups – International, Continental and National according to their experience. The “National” ringside physician status may be granted by the ABAE Medical Commission after doctors have attended national championships and been assessed on their skills and knowledge of boxing regulations. A higher status is approved by EABA (Continental) or AIBA (International) on proposal from the National body (ABAE)

A Ringside Physician will be allowed to stop a bout, so that he can examine a boxer, by contacting the OIC or the Official Jury. The bout will be stopped by a bell being rung and the Medical Officer will then examine the boxer and decide whether the bout is to continue.

e) The Medical Officer must not approach or talk to the judges during the course of a contest.

f) The Medical Officer has a general responsibility for the health and safety of the boxers. He should watch each contest, so that he is aware of the mechanism should an injury occur, and he should also form an opinion regarding the performance of the referees and the closeness of matching of contestants.

g) Regarding referees:

i) If the Medical Officer is of the opinion that the standard of a referee is such that a boxer does not receive proper protection; it is his duty to inform an adjudicator (if present) of his opinion. In the absence of adjudicators, he should make his views known to the Official-in-Charge, who is the only official with authority over the referee. If the tournament Medical Officer is dissatisfied with the response to his complaint, and if the standard of refereeing is, in his opinion, frankly dangerous to the boxers, then he may write to the Honorary Secretary of the Association. It is strongly suggested that the tournament Medical Officer first discuss such a matter with an Association Medical Officer.

ii) Doctors who are relatively inexperienced as tournament Medical Officers should take care not to form an opinion regarding dangerous refereeing too hastily. The effects of many apparently fearsome blows are nullified by good defensive technique, and a boxer who is apparently under sustained attack may be quite in control of the situation. The Medical Officer’s Assistant is usually very familiar with the sport and discussion of these aspects with him could be invaluable.
2. Knock-Out and RSC(H)

a) If a boxer is knocked unconscious, the Medical Officer should immediately prepare to enter the ring. He must remember, however, that even in this situation he can only enter the ring on the instruction of the referee.

b) The immediate requirement is to maintain the boxer’s airway by removing his gumshield and any other obstruction which might be in his mouth or pharynx. A good referee will do this automatically. The level of response must be assessed quickly, and if recovery is at all prolonged, the doctor or resuscitation personnel will be called to give assistance to maintain the airway and the boxer should be carefully turned into the recovery position following normal spinal care procedures. The level of response should be continuously assessed until he recovers, and the time taken for the boxer to completely recover his faculties must also be noted.

c) A boxer must not be moved simply in order to continue the tournament and smelling salts must not be used. After recovery, the boxer should be more thoroughly examined in the examination room.

d) The Medical Officer must decide upon the further care of the boxer. In this, he will be guided by the severity of the blow, the period of unconsciousness, the rapidity of recovery, residual symptoms and signs of concussion, where the boxer lives and who is at home with him. In minor cases, he may be given a head injury card (Form D) and escorted home by a responsible person. In more serious cases, he will need to be escorted to the local Accident & Emergency Department for further assessment and perhaps observation; a letter giving the pertinent details (Form C) should be sent with him. The nearest Accident & Emergency Department in a local hospital and the Ambulance Service must have been advised of the event prior to the tournament taking place. Rarely will an ambulance need to be called but the potential for life-threatening head injury must be borne in mind and the appropriate care arranged. It is the responsibility of the host club to provide transport and escort, and the Medical Officer’s Assistant should help in organising this.

e) Even though a boxer may not be knocked out, the referee may decide that he has received sufficient blows to the head for the decision to be Referee Stopped Contest (Head) [RSC(H)]. The Doctor should arrange to examine any boxer who has lost RSC(H) before he leaves the venue and if necessary, refer him to hospital as above.

f) Regulations:

i A knock-out caused by blows to the head is defined as KO(H), in distinction from being counted out for any other reason (designated simply KO). The KO(H) is further divided into three categories: Class 1 – immediate recovery; Class 2 – complete recovery within 2 minutes; Class 3 – complete recovery delayed for 2 minutes or longer.

ii The rules define minimum lay-off periods for KO(H) and RSC(H). It must be emphasised that these are minimum exclusion periods and prohibit sparring in training as well as competitive bouts; fitness training may be resumed during this time. Class 2 and Class 3 knock-outs may require longer exclusion periods, depending on the circumstances.

iii The minimum exclusion periods are 28 days clear in the first instance, 84 days if this is the second KO(H) or RSC(H) within a period of three months, and one year if this is the third KO(H) or RSC(H) within a period of twelve months. These exclusion periods are counted from the date of the most recent KO(H) or RSC(H).
3. Lacerations

a) A bout should be stopped if any significant laceration occurs. This is to minimise the extent of damage in the wound, which in turn reduces the risk of infection and so promotes rapid and strong healing and the least likelihood of recurrence in the future.

b) Usually, the referee will decide whether or not to stop the bout once a laceration has occurred, but he may be unsure in his own mind, or require the support of the Medical Officer if stopping the bout might be contentious.

c) If the Medical Officer is requested to advise the referee in this way, he must first of all thoroughly examine the wound by removing blood with sterile, dry swabs. Disposable gloves should be worn to do this.

d) He must then consider the position, depth and size of the cut, and the extent to which it is bleeding (particularly if it is above the eye and so obscuring vision). The importance of the contest, the current score and the length of time remaining in it are also factors that may reasonably be taken into account in making the decision.

e) Whether or not the tournament Medical Officer sutures the laceration is for him to decide. This will depend upon personal expertise in minor surgery, the position and severity of the laceration, the equipment carried, the suitability of the facilities at the tournament (minimum requirements are a couch or table for the boxer to lie on, a clean surface which can be sterilised, good light, privacy, and a nearby sink with running water, soap and towel), as well as the proximity of the nearest hospital Accident & Emergency Department.

f) If he decides to suture the wound using non-absorbable sutures, he must ensure that arrangements are made for the sutures to be removed at the correct time, by instructing the boxer to attend his own General Practitioner or the local Accident & Emergency Department. It is courteous to give the boxer a letter requesting the removal of sutures by the General Practitioner or Casualty Officer.

g) The tournament Medical Officer will also need to decide on the appropriate lay-off period and the ME3 and tournament record sheets must have this recorded.

4. Other Injuries

a) Action to be taken regarding other injuries must depend upon the particular circumstances. If there is any doubt about the presence of a fracture (especially of the nose or hand), or a serious joint injury, then the boxer must be referred to the local Accident & Emergency Department with a suitable letter being provided.

b) A provisional medical suspension should be given which may be updated once a definite diagnosis of the injury has been confirmed.

c) Any suspension periods are at the discretion of the tournament Medical Officer; who should err on the side of safety, and bear in mind the strenuous training in the gym as well as the particular risk of re-injury in a competitive bout.

e) If so wished, the MO can require the boxer to be re-examined and passed fit by his own General Practitioner or club Doctor before being entered for the next contest.
5. Documentation

All injuries and lay-off periods must be entered on the boxer’s ME3, The Medical Officer’s Report Form (ME4) and an Injury Form which provides much more detailed information regarding the nature, site and severity of the injury. These Injury Forms provide a very valuable source of information and are helping the Medical Commission to quantify the injury risks in boxing and then make appropriate recommendations. This documentation should be completed by the Medical Officer and countersigned by him; if necessary he will be advised by the Medical Officer’s Assistant.

6. Communication

a) Communication between the Medical Officer, tournament officials and coaches, and the boxers themselves, is very important if the rules, regulations and recommendations regarding lay-off periods and follow-up after injury are to be understood and accepted by those concerned.

b) Any boxer who is referred to his General Practitioner or local Accident & Emergency Department should be given a letter containing the relevant details of injury etc.

c) Reasons for failing the pre-bout medical inspection, and details of injuries sustained and lay-off periods must be entered on the boxer’s ME3, the Medical Officer’s Assistant’s Report Form (ME4) and the separate Injury Form, so that all concerned receive the necessary information. The boxer’s ME3 will be returned to him or his coach when completed; the other two forms are sent by the Official-in-Charge to the Local Records Officer. As of 2006/7 season the Records Officer will enter all such information on-line so that the central records will be updated immediately after any tournament.

d) Fully explaining the decision and requirements for a lay-off period will do much to educate the boxer and coach in the medical aspects of the sport, and to foster a co-operative spirit between all officials.

D. THE DOCTOR’S BAG

The actual items carried by the Doctor in his bag to a boxing tournament will depend on several factors – personal preference and professional expertise, geographic location of the venue and the facilities provided. He must at least have sufficient to examine the boxers, maintain an airway, clean and dress skin wounds, support an injured hand and write a letter. He should bear in mind that he may also be called upon to assist a member of the public who may have collapsed, fallen or otherwise injured themselves.

1. Basic Contents

The following probably represents a minimum if the doctor is not intending to provide airway management cover himself:

a) Stethoscope, auriscope (which can also serve as a nasal speculum and pen torch), ophthalmoscope, thermometer, sphygmomanometer, and tongue depressor.

b) An oral airway. It is advisable to have small and large sizes to cover the younger schoolboys as well as adults.

c) Correspondence paper and envelopes.
d) Sterile gauze swabs, minimum size 5cm x 5cm, cotton wool, Steristrip or butterfly sutures, assorted adhesive dressings, antiseptic such as Cetrimide, sachets of sterile saline (for eye-wash), antiseptic swabs (e.g. Sterets), bandage (crepe or cling), sling.

2. Optional Extras

a) If the Medical Officer intends to suture minor lacerations, he should come prepared to provide all items: soap and sterile towels to wash hands; sterile surgical gloves; local anaesthetic, sterile syringes and needles, sutures; sterile instruments for suturing – e.g. needle holder, toothed forceps; small scissors, gauze swabs, cotton wool balls (or a formal suture pack) and sterile towels or cloths to provide a clean area.

b) Other items the Medical Officer may wish to include are assorted crepe bandages, surgical tape (microcortex is particularly useful), tubular stockinette and elastic adhesive tape for strapping sprains, sterile eye pads, fluorescein to stain corneal abrasions, bactigras tulle, surgical superglue (Dermabond) etc.

c) The application of plastic spray dressings to the face is not recommended, and the tournament Medical Officer should not attempt to introduce a nasal pack unless he is experienced in this technique and the need for it is urgent.

d) Unless the Medical Officer is experienced in their use, there is little advantage in carrying full resuscitation equipment (e.g. laryngoscope, endotracheal tubes, hand-inflation bag, mask and portable oxygen giving set) in urban Western Europe. Some consideration may be given to carrying hand operated suction equipment. The airway management equipment will be provided and used by resuscitation personnel who must be present if the doctor is not personally equipped and confident in the use of this equipment. The doctor will have advised the organisers of this when first asked to attend the tournament.

e) Folding stretcher.

f) A standardised medical bag, approved by the ABA of England and supplied by BOC on lease, equipped for airway management will be provided at tournaments where clubs also have trained resuscitation personnel. This bag contains airways, oxygen administration and suction equipment.

3. Drugs and Medication

a) It is recommended that the carriage of these to a boxing tournament is kept to the absolute minimum. The Medical Officer should not start any treatment which needs to be monitored. This should be left to the boxer’s General Practitioner or the Accident & Emergency Department. Care must be taken to ensure that any medication given will not compromise the result of a drug test should the boxer be selected for this in the near future. The risk of theft must also be considered.

b) The following may be considered: minor analgesics (e.g. Paracetamol), Tetanus toxoid and sterile syringes and needles, chloromycetin eye ointment.

c) If the Medical Officer is the boxer’s General Practitioner, or own club Doctor, then he may well wish to carry a much wider selection of drugs and medications, so that he can initiate and continue treatment for any particular problem. This might include stronger analgesics, non-steroidal anti-inflammatory drugs, oral antibiotics etc.

d) If the Medical Officer is travelling abroad with the team, then obviously he should be fully equipped with a comprehensive diagnostic set and a selection of drugs including anti-emetics, anti-diarrhoeal and anti-malarial drugs, etc as indicated. It would also
be sensible to include some salt and glucose powders such as Dioralyte to prevent dehydration in hotter climates.
XI. Selected Extracts from the Memorandum, Articles of Association and Rules and Regulations of The Amateur Boxing Association of England Ltd and Affiliated Associations, 2006

There is not one rule in the regulations of The ABA of England Ltd. Which does not have some bearing on the safety of the sport. The purpose of this section is to quote those Rules and Regulations which have a direct relevance to the medical aspects of boxing, and to which Medical Officers may wish to refer. It includes amendments passed up to and including March 2006. Reference must be made to the Memorandum itself and Minutes of the Annual Meetings of the National Committee for a full account of Rules and Regulations. Sections I, VI, VII, VIII (Section A), IX and X of this booklet are embodied in Section 18 of the Memorandum, and thus constitute the Medical Regulations of The ABA of England Ltd.

Note: In the following chapter, the paragraph numbering may not be consecutive as the numbers refer to official rules numbers and missing sections are bracketed ( ).

Section TWO – Regulations for Tournaments

Weigh-in

1. At all tournaments a weigh-in will take place and must be overseen by the Official-in-Charge or an official from the Referees & Judges list who has been appointed as Clerk of Scales. Boxers must produce their ME3 at the weigh-in.

2. No boxer will be allowed to take part in a contest where the weight differential is greater than that allowed in his championship weight category.

3. Boxers under the age of 17 must wear shorts or underpants when weighing in.

4. Female boxers must wear shorts and a singlet top when they weigh in.

5. Only one boxer and one coach are allowed to attend the scales.

Medical

1. A qualified Medical Officer must examine intending competitors. No competitor will be permitted to box unless certified as being Medically fit to do so.

2. Any boxer who has been debarred from boxing on medical grounds shall not compete until passed fit to do so by a Medical Officer nominated by his Association/Division.

3. No boxer shall be allowed to take part in a contest if he wears any dressing on a cut, wound, laceration or blood swelling on his scalp or face, including the nose and ears, or have any other open wound.

4. State the classification of the boxer and display on the inside cover the expiry date of his/her medical examination period.

5. Female boxers must sign the official ABAE disclaimer in the presence of the examining doctor.

6. From the date of their 30th birthday boxers must have a full medical examination and complete a new ME1 every year until they reach the age of 34 after which they are no longer allowed to box.

7. Boxers who have not competed for a period of 12 months cannot box until they have completed an ME1 and undergone the full medical process.
A boxer’s 5 year medical [1 year in the case of 30-34 year old] must not take place at tournament. [NOTE: Similar AIBA Medicals can not be done at a tournament]

If the Doctor believes that a bout should be stopped, he/she shall advise the Jury Chairman and/or OIC and, if agreed, the bout shall be stopped to allow the doctor to examine the boxer. The Referee will then be advised if the bout can continue.

Illegal Substances/Drug Abuse
(As laid down in the Medical Aspects of Amateur Boxing) All drug testing is carried out by the Drug Control Unit of UK Sport and according to the IOC protocols for the Olympic Games. These specify the banned substances and the testing methods. As they change from time to time the latest regulations should be sought from UK Sport and WADA websites (www.wada-ama.org) Testing can occur at random and out of training as well as at competition. Refusal to take a test is considered as a positive test. Penalties are applied according to UK Sport regulations. (www.uksport.gov.uk)

Medical Controls
As laid down in the Medical Aspects of Amateur Boxing.

Attendance of Doctor
A qualified Doctor of Medicine MUST be in attendance throughout the tournament. Should a Doctor be called away from the ringside at any time, the tournament must be suspended until a Medical Officer is present.

The nearest NHS Accident & Emergency Unit, together with the responsible Ambulance Station, must be informed of the full address, date and time of the tournament.

Section THREE – Boxing Abroad:
At all tournaments (outside The ABA of England Ltd area,) the Team Manager or person in charge will ensure that all boxer’s International Medical Record Cards and/or ME3 are marked up in all details (details of all injuries to be reported to The ABA of England Ltd).

Section FOUR – Junior Boxers:

1. A Boxer is a Junior, and is eligible to hold an ME3, from their 11th birthday until the date of their 17th birthday.

2. [a] Boxers under the age of 17 years cannot concede more than 12 months in age.

   [b] It is recommended that Junior boxers do not concede age, weight and experience in a contest. The final decision for any contest is the responsibility of the Official in Charge.

3. [a] Boxers under the age of 16 years shall not be allowed to box at tournaments after 10.30pm.

   [b] It is recommended that boxers aged 16 should not box after 11pm.
[c] Boxers up to the season of their 17th birthday are allowed to box a maximum of 14 contests per season, excluding Championships and Internationals.

[d] Boxers in the season of their 17th and 18th Birthday are allowed to box a maximum of 16 contests per season, excluding Championships and Internationals.

5. Skills Bouts
   [a] Only boxers under the age of 16 years who have had less than four competitive contests may participate in Skills Bouts.
   (b-c)
   [d] Boxers taking part in a Skills Bout must have a valid ME3 and pass the doctor prior to entering the ring. Details of the Skills Bout will be entered on the ME3.

Section FIVE – Senior Boxers:

1. Boxers are Seniors from the date of their 17th birthday to the date of their 34th birthday after which they can no longer box. A 17 year old can box a 16 year old provided that there is no more than 12 months difference in their age. A 34 year old boxer must return his ME3 to the Association/Divisional Registrar for cancellation. The cancelled ME3 can be sent back to the boxer if he wishes to keep it as a souvenir.

2. There shall be three classes of senior boxers. The appropriate classification must be stamped on the boxers ME3.
   **Novice**
   A Novice is a boxer who has not competed in an Open Senior Championship. A Novice Boxer must not compete against an Open Class Boxer other than in recognised championships.

   **Intermediate**
   An Intermediate is a boxer who has won a Novice Class ‘B’ [Class ‘C’ in the case of females] title or competed in an Open Senior Championship but has not won an Association Title.

   **Open**
   An Open Boxer is one who has:
   a] Competed in and won a Senior Championship at Regional Association level or above.
   b] Boxed at senior level for his country.

   A Regional Association Executive Committee may up-grade a boxer who, in its opinion, is clearly above the prevailing standard for his current level of classification. Similarly, a Boxer may be downgraded if his ability, in its opinion, is below the standard prevailing in his current classification.

(3)

4. A Senior Boxer may box a maximum of 18 contests per year, excluding Championships and International matches.

Section SIX – Championships:

(1-2)

3. A boxer aged 17 or 18 can choose to box in either the Junior or Senior Championships – **but not both.** The ME3 must be clearly marked (to show this).

(4-10)

11. In the preliminary stages of the Championships it may be necessary for a boxer to box more than once on the same day or within three days. In these circumstances the 3 day rule will be waived. No boxer in any Championship may box more than twice within a three day period. If it can be avoided, boxers should not compete more than once on the same day.
Section SEVEN – Tournament Officials:

1. The Official-in-Charge, referees, judges, timekeepers, clerk of scales and Medical Officer’s Assistants shall be appointed by the appropriate Association for all tournaments in accordance with Section 2. The club promoting the tournament is responsible for the attendance of a qualified Medical Officer and Master of Ceremonies and Recorder.

(2-4)

5. Each Association shall compile an official list of registered OICs, referees, judges, timekeepers and MCs who must be qualified by examination by a Member of the ABAE Referees and Judges Commission.

(6-9)

10. The Referees & Judges Commission, or the appropriate Association concerned, shall have power to remove any referee or judge from the official list. Upon this act being taken, both the official concerned and, if nominated for the panel by an Association, his parent Association shall be notified of the reason or reasons for the action taken. He shall have the right of appeal for a reconsideration of his case, either directly or through his parent Association.

Section EIGHT – The Official-In-Charge:

1. The duties of an Official-in-Charge [OIC] are to:

   [a] regulate the programme, after consultation with the club Secretary, to see that the Rules of the Association are complied with;
   [b] ascertain that the tournament ring and equipment comply with the Rules;
   [c] see that the boxers and coaches comply with the Rules as to attire;
   [d] nominate, where appropriate, one of the referees or judges to be responsible for a duty rota for the officiating referees and judges;
   [e] ensure that a competent MC has been appointed;
   [f] ensure that no person who officiates [including coaches] at any tournament shall partake of alcoholic beverages until their period of duty is completed.
   [g] report to the appropriate Association any serious breach of the Rules and any injury to a boxer considered serious; unsatisfactory conduct occurring at a tournament or any incorrectness to the programme.

In the event of any matter arising in connection with the tournament not provided for, the Official-in-Charge shall have authority to deal with it.

2. General Responsibilities.

   [a] The OIC at a tournament has overall responsibility for its administration and safe progress. The Medical Scheme has greatly increased the work of the OIC, but without his co-operation and support it can only be partially successful. Most of his duties have some impact on the safety of the sport. This includes his responsibility for ensuring that the correct equipment is available and in a satisfactory condition, that boxers wear the necessary protective items of dress, and that all tournament officials carry out their duties to the highest possible standard. The latter is particularly important with respect to the standard of refereeing, in which the OIC has the authority (and the responsibility) to advise or report to the Division/Association Secretary any referee who is not adequately protecting the boxer.
   [b] He must ensure that regulations regarding the matching of boxers are rigidly adhered to.
   [c] He must be totally familiar with the rules and regulations of the sport and apply them impartially. In cases where he must use his discretion and
judgment, he must always decide on the course of action that will be safest for the boxers. A good OIC will carry the respect of all concerned and the public will see the sport to be competently and safely administered.

[d] During a Tournament, should the OIC observe any infringement of the rules, he is empowered to caution the offender, and in the event of any further offence committed by that person, to remove him/her from the ringside. The matter will be entered on the OICs Report Form.

[e] The OIC is empowered to use his discretion on any matter not covered by the rule book.

3 Specific Duties within the Medical Scheme.

[a] The OIC has overall responsibility to see that the Medical Scheme is administered at the tournament. In this, his main duties are delegated to the Medical Officer’s Assistant. He must ensure that the duties of the Medical Officer’s Assistant are properly carried out as defined in the section above.

[b] If, in his opinion, the OIC believes that a boxer has sustained an injury, he must bring this to the attention of the Medical Officer either directly or through the Medical Officer’s Assistant.

[c] If a boxer receives an injury, or a large number of blows to the head, the OIC may retain his ME3, if necessary, pending medical advice. This must be sent, together with the Tournament Record Sheet and the ME4, to the Local Records Officer [LRO]. If a boxer receives a 28 day suspension due to a knock out or RSCH the official in charge will retain his ME3 and return it to the boxer’s Association Medical Registrar for holding until the boxer is eligible to box again.

[d] If the OIC observes or is informed of anything that has a bearing on the medical fitness of a boxer, it is his duty to inform the Medical Officer and the LRO of this. The LRO will then take the necessary action.

[e] It is the Medical Officer’s duty to make decisions regarding injury or illness of a boxer. If the situation appears to be at all serious, the contestant should be conveyed to hospital, by ambulance if necessary, accompanied by a responsible person. The OIC should send with them a brief note (or the approved Form C) addressed to the Casualty Officer on duty, giving the boxer’s name, home address (and telephone number if known), the venue, the nature of the illness or injury and any other relevant information. In cases of knock-out or RSC(H), an indication of the number and severity of blows, and the length of period of unconsciousness or amnesia (loss of memory), is important. In other cases of KO(H) or RSC(H), Form B must be completed and handed to the boxer with the instructions to consult his General Practitioner within 24 hours.

[f] It is advisable to send every boxer who suffers from concussion or amnesia, after a boxing contest, to hospital for examination. If the OIC is in any doubt he should take this action immediately. No hospital will mind referrals if there is cause for concern. It is, however, negligent not to refer a boxer who has a serious or potentially serious condition.

[g] The OIC must follow the advice of the Medical Officer. It is the responsibility of the promoting club to provide transport where necessary and to ensure that an injured boxer is accompanied to his home if this is advised by the Medical Officer. In such cases, the boxer’s coach, a club official or member of his family should be informed that if symptoms persist he should seek urgent medical attention or be taken to hospital. If he has suffered a knockout or RSC(H) and appears well, he should nevertheless be given Form D, which advises on the care of a patient with minor head injury.
RULE 1: THE RING

At all tournaments the ring must conform to the following requirements:

a. The minimum size shall be 3.66 metres square (12 ft sq) and the maximum size 6.10 metres square (20 ft sq), measured inside the line of the ropes. In Championships the minimum size of ring must be 4.88 metres square (16 ft sq).

b. The platform shall be safely constructed, level and free from any obstructing projections and extend for at least 50 cm (18 ins) outside the line of the ropes. It shall be fitted with four corner posts, well padded or otherwise constructed as to prevent injury to the boxers.

c. The floor shall be covered with felt, rubber or suitable ABA approved material having the same quality of elasticity, not less than 1.5cm (½ in) and not more than 1.9cm (3/4 in) thick, over which the canvas shall be stretched and secured in place. The felt, rubber or other approved material and canvas shall cover the entire platform.

d. There shall be four ropes of a thickness of 3 cm (1.18 ins) minimum to 5 cm (1.96 ins) maximum tightly drawn from the corner posts at equal intervals from 40 cm (1 ft 3.7 ins) to 1.30 metres (4 ft 3 ins) high. The ropes shall be covered with a soft or smooth material. The ropes shall be joined on each side, at equal intervals, by two pieces of close textured canvas 3-4 cm (1½ ins) wide that must not slide along the rope.

e. The ring shall have suitable steps at opposite corners for the use of contestants, officials and seconds. A third set must be provided for the MC and Medical Officer.

f. At all boxing tournaments a minimum distance of 2 metres (6 ft 6 ins) shall be clear of all tables, excluding those required for the use of officials.

g. The only persons authorised to enter the ring shall be a boxer, coach, referee, MC and Medical Officer on instruction of the Referee.

h. A used swab container must be fixed to the outside of one or both neutral corner posts.

i. Mobile phones and audible pagers are not permitted in corners or at ringside during all competitions so as to prevent boxers and officials being distracted during contests. The only exception to this rule being Doctors.

RULE 2: GLOVES

All boxers will wear 10 oz gloves made by manufacturers approved and stamped by AIBA

RULE 3: BANDAGES

A crepe type bandage or an AIBA approved wrap, which must be 2.5 metres long and 5cms wide, must be used on each hand. NO OTHER KIND OF BANDAGE MAY BE USED. The use of any kind of tapes, rubber or adhesive plaster, as bandages, is forbidden. A single strap of adhesive not to exceed 7.6 cms long and 2.5 cms in wide, may be used at the upper wrist to secure the bandages. All boxers must wear bandages as described above

RULE 4: THREE DAY RULE
From the day of the contest three clear days must have elapsed before boxing again. (eg If a boxer boxes on Monday he cannot box again until Friday)

During specific championships and internationals the three day rule will not apply.

**RULE 5: DRESS**

Competitors shall be dressed in accordance with the following:

a. Competitors shall box in light boots or shoes (without spikes and without heels), socks, standard shorts reaching at least half-way down the thigh and not below the knee, and a vest covering the chest and back. Where shorts and vest are the same colour, the belt line must be clearly indicated by marking of a distinctive colour. *(Note: the belt is an imaginary line from the navel to the top of the hips.)*

b. At all tournaments properly fitting headguards, must be worn. In cases of the headguard becoming displaced, the following shall apply:
   
   1st occasion:
   The referee shall instruct the second to re-fit the headguard.
   
   2nd occasion:
   The referee shall take similar action, except that he shall warn the second that if the headguard becomes displaced a third time, the bout shall be stopped RSC in the opponent’s favour. The referee shall use his discretion as to the time allowed to replace of the headguard on occasions 1 and 2.

   If, in the referee’s opinion, the headguard has become displaced due to the activities of the other boxer, he will not count it as a first or second occasion but will caution or warn the other boxer for a foul.

   Only headguards approved and stamped by AIBA will be used at any tournament within the area controlled by The ABAE.

   The headguard will be fitted in the ring after the referees inspection. It will be removed, along with the gloves, after the bout is over and before the decision is announced.

c. Gumshields must be worn. If the gumshield comes out accidentally it shall be washed and replaced. If it is deliberately ejected or removed one or two times the boxer shall be cautioned. A third offence will warrant a warning. Red (pink & orange) gumshields are forbidden.

d. The referee shall exclude from competing any boxer who is not wearing a cup or abdominal protector or any boxer who is not clean and properly dressed.

e. In the event of a boxer’s dress or gloves becoming undone during the bout the referee shall stop the contest and have it attended to.

f. No other objects may be worn during the contest.

g. The use of grease, Vaseline or products likely to be harmful or objectionable to an opponent, on the face, arms or any other part of the body is forbidden.

h. Boxers should be clean shaven with moustaches permissible not extending beyond the upper lip. Long hair is not permissible unless completely covered by the head-gaurd. A fringe in front must not extend below the level of the eyebrows. A boxer practising the Sikh religion will be allowed to compete provided that his facial hair is contained within a thin black net. *[NOTE: AIBA rule is clean shaven]*
i. It is recommended that competitors wear distinguishing colours. A suitably coloured sash will be worn, if required, to define the belt line (See above a.)

j. It is recommended that female contestants wear a sports bra together with a singlet or top that covers the back and is designed to preserve modesty. Breast protectors are recommended. Low blow protectors must also be worn. [NOTE: AIBA rules]

k. Every Regional Association will arrange for boxers to have an ME3 which must contain a record of the boxer's bouts, names of opponents and showing the result, how won or lost.

RULE 6: WEIGH-IN:

At all tournaments a weigh-in will take place and must be overseen by the Official-in-Charge or an official from the Referees & Judges list appointed as Clerk of Scales.

All boxers must weigh-in on the day of the competition. Junior boxers must wear shorts/underpants when weighing in. Seniors can weigh in stripped, but may, if they wish wear shorts or underpants.

No boxer will be allowed to take part in a contest where the weight differential is greater than that allowed in championship categories.

Scales for Championships and Internationals must have a valid certificate of calibration issued within 48 hours prior to the weigh in.

ME3s must be produced at the weigh-in and the medical examination.

Female contestants must weigh-in dressed in shorts and singlet or top.

RULE 7: THE SECOND

Each competitor is entitled to one second and an assistant second who shall be governed by the following rules:

a. The chief second must be qualified to at least ABA of England assistant coach and the assistant second must be 18 years of age or over.

b. No advice, assistance or encouragement shall be given to the competitor by his second or assistant during the progress of the rounds.

c. A second may retire his boxer and may, when he considers his boxer to be in difficulty, throw the towel into the ring, except when the referee is in the course of counting.

d. No stimulant of any kind, other than water, may be administered to a boxer prior to or during a bout.

e. Inhalers are not allowed in the corner.

RULE 9: CONTROL OF BOUTS

A referee, three/five judges and a timekeeper shall control all contests. The referee shall officiate in the ring. When only two judges are available, the referee shall complete a scoring paper.
The referee shall be solely responsible for the control of the bout in accordance with the rules and the three judges shall independently award points.

When computer scoring is used there will be five judges.

**RULE 11: THE REFEREE**

1. The referee shall officiate in the ring.

2. He shall:
   a. Check the gloves and dress prior to the fitting of the boxer’s headguard
   
   b. Prevent a boxer from receiving undue punishment

(3-4)

5. The referee is empowered:
   a. To terminate a contest at any stage if he considers it too one-sided
   b. To terminate a contest at any stage if one of the boxers has received an injury on account of which the referee decides he should not continue

(c-h)

i To interpret the rules in so far as they are applicable to the actual contest and take action on any circumstances of the contest which are not covered by a rule.

6. Should a boxer receive 3 counts in any one round or 4 during a contest, the referee must terminate the contest. For junior and female contests the bout will be terminated if the boxer receives 2 counts in any round and 3 during the contest.

7. a. If a boxer infringes the rules but does not merit disqualification for such infringement, the referee shall stop the contest and shall issue a warning to the offender. (..etc..) Only three warnings may be given to the same boxer in one contest. A third warning will result in automatic disqualification.

(b)

8. Medical Examination of Referees for Tournaments:

A referee, before officiating in any Championship or International tournament conducted under these rules, shall undergo a medical examination as to his physical fitness for carrying out his duties in the ring. His vision should be at least 6/12 (Snellen test) in each eye. The wearing of spectacles by a referee during the progress of a bout is not permitted, but contact lenses are allowed.

**RULE 12: THE JUDGES**

(a-c)

d. He shall not speak to the contestants, nor to another judge, nor anyone else except for the referee, during the contest but may, if necessary, at the end of a round, bring to the notice of the referee any incident which he (the referee) may not appear to have noticed, such as misconduct of a second, loose ropes, etc.

**RULE 14: DECISIONS**

(a)

b. Win by Retirement:

If a boxer retires voluntarily owing to injury or other cause, or if he fails to resume boxing immediately after the rest between rounds, his opponent shall be declared the winner.
c. Win by Referee Stopping Contest:
   i. OUTCLASSED: If a boxer, in the opinion of the referee, is being outclassed, or is receiving excessive punishment, the bout shall be stopped and his opponent declared the winner.
   ii. INJURY: If a boxer, in the opinion of the referee, is unfit to continue because of injury or other physical reasons, the bout shall be stopped and his opponent declared the winner. The right to make this decision rests with the referee, who may consult the Doctor. Having consulted the Doctor, the referee must follow his advice. When a referee calls a Doctor into the ring to examine a boxer, only these two officials should be present. No seconds should be allowed into the ring or on the apron.
   iii. If both boxers are injured or are unable to continue, the judges shall record the points gained by each boxer up to its termination, and the boxer who was leading on points up to the actual end of the contest shall be declared the winner.

d. Win by Knock-Out:

   If a boxer is “down” and fails to resume boxing within ten seconds, his opponent shall be declared the winner by a knock-out.

RULE 17: DOWN

1. A boxer is considered “down”:
   i. If he touches the floor with any part of his body other than his feet; or
   ii. If he hangs helplessly on the ropes; or
   iii. If he is outside or partly outside the ropes; or
   iv. If, following a hard punch he is still standing, but is in a distressed state and cannot, in the opinion of the referee, continue the bout.

2. In the case of knockdown, the referee shall immediately begin to count. When a boxer is down his opponent must at once go to the neutral corner indicated by the referee and will stay there until the referee commands “Box”. (etc.)

3-4 When a boxer is “down” as a result of a blow, the bout will not continue until the referee has reached the count of eight, even if the boxer is ready to continue. After the referee has counted “ten” the bout ends and the decision is a “Knock-out”.

5. In the event of boxer being down at the end of a round, the referee will continue to count. Should the referee count up to ten, the boxer shall be deemed to have lost the bout by knock-out. If the boxer is fit to resume boxing before the count of ten is reached, the referee will use the command “box”.

6. If a boxer is “down” as the result of a blow and the bout is continued after the count of 8, but the boxer falls again without having received a fresh blow, the referee shall continue from the count of 8.

7. A boxer who fails to resume boxing immediately after the termination of the rest interval, or who, when knocked down by a blow fails to resume within 10 seconds, shall lose the contest.

8. When a Senior boxer has three compulsory counts in the same round, or four times in
the bout the referee shall stop the contest (RSC or RSC(H)) This does not apply if the count is a result of any foul.

11. A bout between junior or female boxers shall be stopped after two counts in one round or three during the bout.

**RULE 18: PROCEDURE AFTER KNOCK-OUTS AND RSC(H)**

1. If a boxer is rendered unconscious then only the referee and the Doctor summoned should remain in the ring, unless the Doctor needs extra help.

2. A boxer who has been knocked out during a contest or wherein the referee stopped the contest due to a boxer having received hard blows to the head making him defenceless or incapable of continuing shall be examined by the Doctor immediately afterwards and accompanied to his home or suitable accommodation by a responsible person.

3. A Boxer who has been knocked out during a contest or wherein the referee has stopped the contest due to a boxer having received hard blows to the head making him defenceless or incapable of continuing shall not be permitted to take part in competitive boxing or sparring for a period of at least 28 clear days after he has been knocked out. (or RSC(H))

4. A boxer who has been knocked out during a contest, or wherein the referee has stopped the contest due to a boxer having received hard blows to the head making him defenceless or incapable of continuing, twice in a period of 84 days shall not be permitted to take part in competitive boxing or sparring during a period 84 days from the second knock-out or RSC(H).

5. A boxer who has been knocked out during a contest, or wherein the referee has stopped the contest due to a boxer having received hard blows to the head making him defenceless or incapable of continuing, three times in a period of 12 months shall not be allowed to take part in competitive boxing or sparring for a period of one year from the third knock-out or RSC(H).

5. The referee will indicate to the OIC and judges to annotate the score card “RSC(H)” when he has stopped the contest as a result of a boxer being unable to continue as a result of blows to the head.
XII. Rules for Female Boxing

Female Boxing is conducted according to AIBA and EABA Rules as recorded in Appendix VII of the AIBA Medical Handbook of Amateur Boxing (Sixth Edition 2004) “Competition Rules for Female Boxers”.

The following is an extract from the AIBA Regulations:

1. Principle:
   The Articles & Rules of AIBA shall apply to the training and competition of female boxers in lieu of or in addition to the special provisions contained in this document.

2. Special Provisions:
   **Addition to Rule IV – Dress**
   Female boxers must wear a short sleeved T-shirt beneath their vest.
   Female boxers may wear a well-fitting breast protector not interfering with the boxer’s ability to compete. Such a breast protector must not be manufactured in any material that might be harmful to the opponent.

   (NOTE: “breast protectors” may be worn so that the risk of fat necrosis of the breasts may be minimised. As of May 2006 NO specific breast protectors have been approved by AIBA or EABA and no breast protectors have been submitted to the ABA of England Medical Commission for assessment.)

   Hairnets, barrets, head cloths, rubber bands or other banding devices may be used to secure hair beneath the headguard. Hair pins or clips or any device made of metal, plastic or other hard material are not permitted.

   **Addition to Rule VI – Medical, Examination and Weigh-In for Competition.**
   A special International Record Book shall (Note) be devised for female boxers where all relevant findings of the special physical exam they are required to undergo, shall be recorded.
   In addition, female boxers shall furnish, prior to any competition, all information required as to their physical condition, and confirm with their signature the correctness of these statements. In the event of incorrect statements being made, the female boxer shall be held responsible for any consequences resulting therefrom.

   (NOTE: It is universally accepted that no Female should be allowed to box if she is, or may be, pregnant. Every Female wishing to box must sign, at the time of weigh-in, that she is not, nor may be, pregnant. It is this “condition” that is referred to above.)

   Female boxing contests shall be controlled by female or male referees.
   As for the panel of judges, it may consist of females and males. However the judge in place No.1 shall always be a female.

   The jury at female boxing competitions shall be composed of female and/or male officials.

   A bout between female boxers shall be stopped after two counts in one round or three during the bout.
Special Rules for Medical Examinations of Female Boxers

The initial medical examination (ME1)

- The boxer should be specifically questioned for:
  1. Any history of breast disease or surgery, or significant symptoms such as breast lumps or history of breast injury resulting in lumpiness.
  2. Any history of gynaecological disorders or surgery or symptoms such as chronic pelvic pain, abnormal vaginal bleeding or significant menstrual abnormalities.
  3. Pregnancy & breast feeding.
  4. Breast Augmentation with implants or tissue transfer.

A finding of any of the above renders the boxer unfit

- The examination should be generally as that for a male boxer. Attention is however drawn to the following points:
  1. As with all boxers undergoing any examination, medical ethics should be strictly maintained.
  2. It is strongly advised that chaperones be present.
  3. Breast and pelvic (internal) examinations should not be performed. If indicated by anything in the history above, the boxer is to be referred back to her GP for further information.
  4. A routine urine sample should be obtained at a time when the boxer is not menstruating.

The pre-bout medical examination (ME2)

- The boxer should be questioned for:
  1. Any possibility that she may be pregnant and she must sign that she is not.
  2. Any recent history of breast injury/disease/surgery: any will render the boxer unfit to box.
  3. Any recent history of lower abdominal/pelvic pain or a recent significant change in menstrual pattern (dysmenorrhoea/menorrhagia/amenorrhoea): any will render the boxer unfit to box.
  4. The boxer’s attention should be drawn to the information outlined in the back cover of the ME3 regarding pregnancy and breast disease.
  5. The boxer is to confirm that she understands that information and is aware of the risks of boxing and sign to that effect.

- The examination should be as that for a male boxer, noting the points made for the ME1

C. The bout itself

- As for male boxers, a fitting pelvic protector should be worn.
• Breast protectors are optional (with fat necrosis education).
  (If used, the acceptability of design must comply with AIBA current regulations.)

• As for male boxers, long hair should be tied back so as not to pose a disturbance to vision. Metal hair clips etc. are not to be worn. All the hair must be hidden under the headguard

Appendix to the ME3 (to be sealed inside the back cover) for all female boxers

<table>
<thead>
<tr>
<th>PREGNANCY AND BOXING</th>
</tr>
</thead>
<tbody>
<tr>
<td>In normal circumstances the female genital organs lie within the confines of the bony pelvis and are not at specific risk of injury during boxing.</td>
</tr>
<tr>
<td>However, with advancing pregnancy (especially after 10 weeks), the pregnant uterus (womb) expands to accommodate the growing foetus and rises out of this protected area into the abdomen.</td>
</tr>
<tr>
<td>Blunt trauma to the lower abdomen may damage a developing baby as well as placing you at a significant risk of internal bleeding and permanent damage to your reproductive organs.</td>
</tr>
<tr>
<td>It is YOUR responsibility to ensure that you are not pregnant whilst participating in boxing.</td>
</tr>
<tr>
<td>You will be reminded of this responsibility at every pre-bout medical inspection by the Medical Officer and you will be asked to confirm that to the best of your knowledge you are not pregnant and you must sign to that effect.</td>
</tr>
<tr>
<td>Pregnancy tests will NOT be carried out by the boxing doctor.</td>
</tr>
<tr>
<td>If you even think you might be pregnant, you should NOT box!</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BREAST DISEASE AND BOXING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blunt trauma (e.g. Punches) to the breast can result in damage to breast tissue known as fat necrosis.</td>
</tr>
<tr>
<td>Fat necrosis may mimic or mask serious breast diseases such as cancer and can therefore lead to surgery (sometimes major surgery, including removal of a breast) to exclude malignant disease.</td>
</tr>
<tr>
<td>It is YOUR responsibility should you wish to take this risk.</td>
</tr>
</tbody>
</table>
XIII. Medicals for Referees

The medical examination of referees is mandatory at International level with strict health criteria laid down. The object is to ensure that the referee is fit to move quickly around the ring with the boxers and that he can see what is happening. As referees tend to be significantly older than boxers, the medical is aimed at ensuring that they are fit and without evidence of degenerative disease.

Within the Rules of The ABA of England Ltd. medical standards for referees have not been legislated as yet. The following are therefore guidelines for referees to assess their fitness and as preparation for AIBA Medical standards.

General Medical standards:

a) History:
No history of heart disease or angina or circulatory problems such as claudication or thrombosis.
No chest disease resulting in shortness of breath.
No arthritic, neuromuscular or orthopaedic conditions that restrict mobility
No evidence of Diabetes Mellitus requiring medication.
Normal mental status and memory
No psychoneurotic disease

b) Examination:
Height & weight within normal proportions.
Body Mass Index (BMI) must be no greater than 30.
\[ \text{BMI} = \frac{\text{Weight} \, (\text{Kgs})}{\text{Height} \, (\text{Metres})^2} \]
Blood pressure, at rest, not to exceed 140/90
Pulse rate, at rest, not to exceed 100/minute and no arrhythmias
Normal auscultation of heart and lungs
Pulmonary peak flow rate not less than 300ml
Eye sight not less than 6/12 (may be corrected with contact lenses) or no more than +/- 6 dioptres correction whichever is less.
Normal reflexes and agility.

c) AIBA Fitness Test
A fitness test is done at major tournaments according to the following protocol:
The resting pulse is taken (P1) then 30 steps up and down or deep knee squats are performed in 45 seconds.
Immediately after the exercise the pulse is taken again (P2)
After a further 1 minute the pulse is taken again (P3)

\[ \text{Result} = \frac{(P1 + P2 + P3) \, \text{minus} \, 200}{10} = \text{Score} \]

Score: 0-2 Athletic; 3-5 Fit; 6-10 Average;
>10 Unfit to officiate as referee (may still officiate outside ring)

[Note: The full AIBA requirements are detailed in the AIBA Medical Handbook and also include an annual medical to be carried out by the Referee’s home federation prior to going to officiate at International Championships (such as World Championships, Olympic Games, World Cup) and additional laboratory tests and exercise ECG are included]
Orthodontic Surgeon Letter Proforma
(for boxers wishing to box with dental brace in situ).

The following style of letter is to be completed by the Consultant or Specialist Orthodontic Surgeon who has fitted the brace AND provided a custom made mouth guard for the boxer. Such a letter is to be completed on the Consultant/Specialist’s personal professional headed notepaper and to be dated and signed by that Orthodontic Surgeon.

" I……………………(full name and qualifications) ………………… confirm that I have fitted a …………………(details of dental brace)………………… to ………….(full name of boxer)……………………………. on………………(date)……………… and expect him/her to need to keep it in place until …………..(date)……………………..

I also confirm that I have personally fitted …………. (full name of boxer) ………… with a custom made protective mouth guard that I am confident will provide him/her with normal protection to the mouth, gums and teeth and the dental braces should he/she wish to participate in any contact sports.

I consider that …..(full name of boxer)……..will therefore be at no more risk than any other person taking part in Amateur Boxing.

In this belief, I am happy for him/her to participate in Amateur boxing contests in accordance with the rules of the ABA of England Limited.

Signed …………………………………………..    Date ……………………………….

Any boxer wishing to box with a dental brace in situ MUST present such a letter whenever they attend for a weigh-in or pre-bout medical as well as have the custom-made mouthguard fitted in place and visible for full inspection.

It is ONLY with such a fully completed letter that any boxer with a dental brace in situ may take part in sparring or boxing contests. It is to be ensured by the Doctor, Official in Charge and the Referees that the mouthguard is custom made and does apparently give full protection.

The mouthguard MUST be worn at the initial medical inspection and at the weigh-in. If there is any doubt regarding the efficacy of the mouth guard, then the officials shall jointly decide whether the boxer may be allowed to compete but should err on the side of caution and according to ABA rules.
Appendix 2  ME1 proforma for Boxer

Page 1

ABA OF ENGLAND: INITIAL MEDICAL EXAM: ME1

IMPORTANT NOTE FOR ALL POTENTIAL BOXERS: The following are the most common disorders that will automatically result in failure to pass the initial medical examination:

- Epilepsy
- Eye surgery, including Laser, except squint correction (also very poor eyesight)
- Head injury requiring surgery
- Hepatitis B / C or HIV infection
- Insulin dependent diabetes
- Severe asthma
- Sickle cell disease (not Sickle Cell Trait)
- (Females: Breast Implants)

If you have any of these, you should NOT proceed with the expense of a medical examination.

Please answer the following questions regarding your general health. If you are under 18 years of age, this section should be filled in by a parent or guardian. If you are unsure of any question, please ask the Doctor performing your examination to explain.

PERSONAL HISTORY QUESTIONNAIRE
(Boxer / Parent to complete before medical examination)

Have you ever been diagnosed with:  (Y=Yes/ N=No)
Heart disease including high blood pressure  Y / N
Lung disease including asthma or TB  Y / N
Liver disease including hepatitis  Y / N
Kidney disease  Y / N
Diabetes mellitus  Y / N
Any blood disorder including haemophilia, sickle cell / anaemia  Y / N
Head injury requiring hospital treatment  Y / N
Other neurological disease including epilepsy, fits, faints or dizzy spells  Y / N
Back or joint problems  Y / N
Eye problems requiring specialist treatment  Y / N
Infectious diseases including sexually-transmitted diseases  Y / N
Breast disease requiring surgery including implants (female boxers only)  Y / N
Significant gynaecological disorders (female boxers only)  Y / N

Have you had any injuries including broken bones? (please list)

................................................................................................................

Have you had any operations? (please list)

................................................................................................................
Have you been admitted to hospital for any illness or injury not mentioned above? (please list)

Are you seeing a doctor or having any treatment now? (please list)

**MEDICATION HISTORY**

Are you currently taking any medications from your Doctor? Y / N
Do you take any other non-prescribed medications or supplements? Y / N
Are you currently taking, or have you ever taken illegal drugs? Y / N

**FAMILY HISTORY**

Does anyone in your family suffer from the following?

Sudden death under age of 40 years (males) or 50 years (females) Y / N
Sickle cell disease Y / N
Kidney disease (especially polycystic kidney disease) Y / N
TB Y / N

Any other family disease? (please list and give information of any of the above)

Applicant

Name…………………………………………………..…  Date of Birth…………………
Address………………………………………………….

Boxing Club
Region / Division

Signed. Boxer / Parent (Delete as appropriate)  Date
Appendix 3 ME1 proforma for Doctor

ABA OF ENGLAND: INITIAL MEDICAL EXAM: ME1

MEDICAL EXAMINATION (to be completed by Doctor)

(Please see attached guidance notes.)

Name of Boxer…………………………………… Male / Female

<table>
<thead>
<tr>
<th>General appearance / skin &amp; subcutaneous tissues</th>
<th>Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height (cm)</td>
<td></td>
</tr>
<tr>
<td>Weight (kg)</td>
<td></td>
</tr>
<tr>
<td>Anaemia / Jaundice</td>
<td>Y / N</td>
</tr>
<tr>
<td>Lymphadenopathy / Clubbing</td>
<td>Y / N</td>
</tr>
<tr>
<td>Facial deformity (mandibular / nasal)</td>
<td>Y / N</td>
</tr>
<tr>
<td>Mouth and dental abnormality</td>
<td>Y / N</td>
</tr>
<tr>
<td>Thyroid enlargement</td>
<td>Y / N</td>
</tr>
<tr>
<td>Melanotic or other skin lesions</td>
<td>Y / N</td>
</tr>
<tr>
<td>Severe acne</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

Chest (respiratory) examination

| Deformity / scars                               | Y / N   |
| Expansion normal                                | Y / N   |
| Breath sounds normal                            | Y / N   |

Cardiovascular examination

| Pulse (regular and within limits if recent exercise) |         |
| Blood pressure (sitting without rest period)       |         |
| Heart sounds normal                               | Y / N   |

Abdominal examination

| Scars (Note reason for scars)                    | Y / N   |
| Organomegaly or masses (Females ?uterus)         | Y / N   |
| Herniae                                         | Y / N   |

Genitourinary examination

| 2 testes present and normal (Males)              | Y / N   |
| Scrotal mass (Males)                             | Y / N   |
| Urine dipstix (no blood or glucose; protein < +) | Y / N   |
Neurological examination

Pupils: equal & reactive Y / N ………………………..
Gross co-ordination Y / N …………………………
Modified Rhomberg’s (30sec) > 6 Y / N …………………………

Musculoskeletal

Deformity or other hand abnormality Y / N …………………………
Deformity / wasting / scars on any limb Y / N …………………………
Brief spinal examination for deformity / scars Y / N …………………………

Eyes

Acuity: Best eye worse than 6 / 12 Y / N Actual …………………
Worst eye worse than 6 / 24 Y / N Actual …………………
Movements Equal & full Y / N …………………………
Nystagmus Y / N …………………………

Ears

Tympanic membranes intact Y / N …………………………
Gross hearing adequate Y / N …………………………

Any other unusual finding
Specify ………………………………………………………………………….
……………………………………………………………………….
……………………………………………………………………….
……………………………………………………………………….

Doctor …………………………… Qualifications…………………………
(Print Name)

Address …………………………………………………………………………
(Print Address)

Signature …………………………… Date …………………
GUIDANCE NOTES FOR DOCTORS COMPLETING ME1

The following guidelines are issued to assist Doctors performing the initial medical examination. They are not exhaustive but aim rather to cover the more common areas of decision-making in respect of whether a potential amateur boxer is fit to engage in competition.

If further clarification is required, fuller information is available in 5th Edition of Medical Aspects of Boxing (2006) and the Medical Commission of the ABA of England are happy to assist. Contact via the ABA of England Office as follows:

Telephone: 0114 223 5654

In some circumstances, a letter of clarification may be required from the appropriate specialist involved in the Boxer’s management. This would need to be sent with the completed ME1.

PERSONAL HISTORY

- Heart disease: Congenital heart disease / rheumatic heart disease will almost always preclude. Innocent murmurs and treated hypertension require specialist investigation and clarification as does previous cardiac surgery.

- Lung disease: Severe asthma precludes. That not exacerbated by exercise may be permissible.

- Liver disease: Jaundice, significant enlargement and / or hepatitis B / C preclude. Others may require clarification.

- Kidney disease: 1 kidney precludes, Polycystic kidney disease precludes.

- Unilateral or undescended testis precludes (Males only)

- Diabetes: Insulin dependent diabetes mellitus precludes.

- Sickle cell disease (not trait), and any bleeding disorder preclude.

- Neurological disease: Diagnosed epilepsy precludes (infantile febrile convulsions in isolation are permissible). Nearly all other significant neurological disorders requiring medical therapy and all requiring neurosurgery will preclude. Viral meningitis with no residual deficit and mild migraines are however permissible.

- Back / joints: severe problems will require clarification.

- Eyes: A history of retinal detachment, cataract or glaucoma and any previous intra-ocular or laser surgery preclude. Corrective surgery for squint is acceptable.
Infective disease: proven infection with hepatitis B/C or HIV precludes. Tropical infections and sexually-transmitted diseases require clarification (as well as eradication).

**Page 2**

Additional for females:
- Breast: Any history of breast disease / surgery / or significant symptoms such as breast lumps will require clarification. Breast implants or reconstruction preclude.
- Gynaecological disorders / surgery or symptoms such as chronic pelvic pain or significant menstrual abnormalities may preclude and require clarification. Pregnancy & breast feeding preclude.

**MEDICATION HISTORY**

- Anti-coagulation therapy precludes.
- Performance enhancing drugs preclude.
- Where doubt exists regarding specific prescribed regular medical treatments, clarification can be sought on the WADA website at www.wada-ama.org
- Some drugs e.g. salbutamol will require the issue of a therapeutic use exemption (TUE) certificate.
- Substances subject to misuse laws preclude

**FAMILY HISTORY**


**MEDICAL EXAMINATION**

**General appearance**

- Height & weight: gross deviations may require investigation for endocrine / collagen disorder.
- Anaemia / Jaundice: require specialist investigation
- Lymphadenopathy / Clubbing: require specialist investigation
- Facial deformity (mandibular / nasal): gross abnormalities may require clarification. Any leading to severe nasal obstruction precludes.
- Mouth and dentition: see guidelines in Medical Aspects of Boxing
- Thyroid enlargement: requires specialist investigation
- Melanotic or other skin lesions: may require specialist investigation
- Severe active acne / other active infective skin problems preclude until treated.

**Chest (respiratory) examination**

If abnormalities found See points h), ii & iii. Medical Aspects of Boxing (Page 57)

**Cardiovascular examination**

If abnormalities found See points h), ii & iii. Medical Aspects of Boxing (Page 57)
Abdominal examination

- Significant organomegaly precludes. Abdominal mass requires specialist investigation. Healed scars do not preclude but may indicate previous relevant pathology. Herniae (other than very small) preclude until treated.

Neurological examination

- Pupils: unequal or non-reactive pupils do not automatically debar, however the cause might indicate an underlying neurological problem or unacceptable acuity which would then debar the boxer. The findings should however be clearly recorded to prevent subsequent confusion were head injury to occur.

- Gross co-ordination should be apparent on walking / posture but can be more formally tested using a heel to toe test.

- The modified Rhomberg test requires the boxer to stand on one leg with both arms outstretched and the eyes closed. Failure is indicated by putting foot to floor or opening eyes more than 6 times during a 30 second period and would debar a boxer pending specialist opinion and / or MRI scanning.

Genitourinary examination

- Absent or enlarged testes should be referred for specialist investigation (as should very delayed puberty) unless cause already known. Single/Absent testis debars.

- Urine dipstix: Traces / 1 plus of protein can be ignored. Other positive findings require specialist investigation.

Musculoskeletal

- Any deformity of the limbs should be recorded and might debar a boxer if joint movement is restricted. The hands in particular should not have evidence of significant metacarpal malunion or any fixation plates which will debar until the bones are soundly united.

- Significant spinal deformity leading to immobility requires specialist investigation.

Eyes

- Acuity performed without aids (NO contact lenses, spectacles etc.):
  - Best eye: worse than 6 / 12 debars
  - Worse eye worse than 6 / 24 debars

Ears

- Significant bilateral deafness debars
- Suppurative otitis (externa or media) requires treatment
- Dry tympanic perforation is permissible.