ILLNESS IN A COLLEGIATE FOOTBALL PLAYER
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**Background:** A 20 year old male collegiate football defensive end complained of headache, nausea, dizziness, sinus pressure, and upset stomach that increased with exertion in early September of the 2005 season. He took himself out of practice stating he felt he had the flu. No specific mechanism of injury or change in diet could be recalled. Symptoms were mild and mostly only apparent during practice for approximately a week, but they did not warrant the athlete’s concern until he began to feel such symptoms outside of football. The athlete had no significant history. Cognitive testing took place, but showed no obvious concern for concussion. The athlete was out until the following Tuesday when he reported his symptoms had decreased. During his first practice back, the athlete complained of headache, severe dizziness, and nausea. The athlete was referred to the MD. A blood test showed a decrease in white blood cells and a positive previously acquired mononucleosis screen with no other significant findings. It was determined that the athlete had a viral infection and previous unknown history of mononucleosis. The athlete was ordered to rest and drink plenty of fluids for the next week. Upon return, the athlete vomited at practice, exhibited mild jaundice, and complained of the same symptoms along with weight loss. A second MD referral was made. **Differential Diagnoses:** The differential diagnoses at this time were concussion, sinus infection, flu, dehydration, mononucleosis relapse, parasitic infection, hepatitis A, hepatitis B, hepatitis C. **Treatment:** The athlete was admitted to the hospital where further testing showed abnormal liver function. Subsequent blood tests and ultrasounds led to a diagnosis of acute hepatitis A. The athlete was hospitalized for one week in contact isolation, placed on IV fluids containing a hypertonic sodium chloride glucose solution with potassium chloride, prescribed compazine and ibuprofen, and put on a carbohydrate diet. Anyone known to come in contact with the athlete, including all teammates, coaching staff and medical staff, was vaccinated as part of the emergency exposure control plan at the university. A thorough history discovered the athlete had eaten raw oysters prior to arriving at preseason football which caused him to contract the virus. Upon the athlete’s discharge from the hospital he was advised to avoid alcohol and exertion until further scans showed no inflammation of the liver and prescribed ibuprofen and atarax. The athlete returned to play approximately nine weeks from when he first exhibited symptoms and five weeks from diagnosis. The athlete currently exhibits no symptoms of hepatitis A and remains and active member of the football team. **Uniqueness:** This injury is unique because most hepatitis education remains focused on types B and C. Hepatitis A signs and symptoms can also be easily confused with other conditions that are more typically seen among college athletes such as concussion or other viral infections. Most personal illnesses or injuries also do not warrant the treatment of such a vast majority of people in a typical sports environment. **Conclusion:** The athlete will always test positive for hepatitis A, but shall remain symptom free and able to fully participate in college athletics. This case stresses the importance of hand washing and not sharing water bottles as preventive measures in decreasing the likelihood of spreading disease, including ones rarely considered. The dangers of consuming raw food are also addressed. Most significantly it stresses the importance of maintaining an effective and efficient emergency exposure plan at all times. Due to Yale University’s timely action no other person was reported to have contracted the hepatitis A virus.

**Key Words:** Virus, Exposure control, Liver

**Word Count:** 593