BACKGROUND: A 17 year old male high school football player presented to the ATC during a junior varsity game with the inability to move his right hand or wrist after being stepped on by an opponent. The athlete complained of mild forearm soreness, but felt as though he could continue playing, if allowed. Inspection revealed the wrist slightly flexed and fingers also in a flexed position and abrasions on the forearm from the cleats. There were no obvious signs of swelling. The athlete was unable to actively move the wrist and fingers. Passive range was extremely limited and resulted in pain in the forearm. There was no pain in the elbow region and there was full active range of motion at the elbow joint. There was pain along the radius and ulna in the forearm, but no obvious deformity was seen or palpated. The fingers were warm and the radial pulse was present bilaterally. DIFFERENTIAL DIAGNOSIS: Radius, ulna, or humerus fracture, or elbow dislocation. TREATMENT: Ice was applied to the area and athlete was immediately referred to the emergency room for x-rays. Pulse and sensation in the hand were monitored until the athlete’s mom arrived to transport. Initial x-rays were negative. He was treated for his abrasions, splinted him in the deformity and given a prescription for pain relievers. He was referred to his primary care physician for follow up care and released. Approximately 24-30 hours after the initial contact, the athlete slowly regained movement of his fingers. Approximately 36 hours after the incident full range of motion in the fingers and wrist return. 4 days later, his PCP cleared him to return to activity. In a follow up evaluation by the ATC, there was still pain in a 2-3cm area over the distal radius and in the interosseous space. Pain was also elicited there during forced wrist extension and flexion as well as resisted wrist flexion and extension. Resisted pronation and supination also resulted in pain. The athlete was ordered to rest for another week from the team physician. Following the week of rest, the pain was still present and had not lessened. The athlete was referred to a hand specialist for follow up care. A second set of x-rays then revealed a small buckle fracture on the distal radius. He was withheld from play for 2 more weeks, but no cast or splint was prescribed. He is still currently under the specialist’s care. UNIQUENESS: Volkmann’s contracture is rare in athletics. It is usually the result of a fracture within the forearm or elbow. The trauma results in forearm compartment syndrome and when the blood supply is compromised, the contracture results. Although the athlete did have a small fracture, it was missed on the initial set of x-rays and the trauma of getting stepped on was mostly likely the cause of the forearm compartment syndrome. It is also unique because most cases must be surgically corrected or permanent neurological damage ensues. This athlete’s resolved on its own and did not result in any permanent damage. The athlete also never had a loss of sensation or pulse. CONCLUSION: Although forearm compartment syndrome and Volkmann’s contractures are rare in athletics, immediate care is necessary and should include monitoring neurological and circulatory symptoms. Also, because of the seriousness of compartment syndrome, extreme caution should be used when returning an athlete to play, especially if the symptoms are not completely gone. Athletic trainers should trust their clinical judgment regarding return to play and continued referral is important if the signs and symptoms don’t match the initial diagnosis.