It was 1990 when 23-year-old Loyola Marymount basketball player Hank Gathers collapsed during a game against the University of Portland and couldn't be revived. The cause? Sudden Cardiac Death, now the most common medical cause of death among NCAA athletes, according to research published in the journal *Circulation*. The research found that 1 in 5,200 Division I players will die of Sudden Cardiac Death. In response, NCAA chief medical officer Brian Hainline said the problem should no longer be considered a rarity, and called for regular electrocardiogram screenings (EKGs) for college athletes.

That was last spring. Since then Hainline has backed down, but the debate over requiring EKG tests continues to boil on both sides, with papers and opinions coming at a blistering pace from both sides. Why all the controversy for a condition that is clearly killing athletes?

EKG tests look at the electrical circuitry of the heart. There are 11 or so common heart conditions associated with sudden cardiac arrest; of those the EKG will be abnormal in about eight of them, says Dr. John P. Higgins, a sports cardiologist at McGovern Medical School at The University of Texas Health Science Center at Houston who works with the Houston Rockets.

Although the test appears to be pretty useful for reducing the number of potential tragedies of sudden death among young athletes, some major health organizations — including the American Heart Association and the American College of Cardiology —disagree that EKGs are necessary for young people 12 to 25 years old who play sports.

On its website, the AHA states that it "has not support[ed] national mandatory ECG screening of athletes because the logistics, manpower, and financial and resource considerations make such a substantial program inapplicable to the U.S. healthcare system." Their reason? Not enough is known about what EKG readings could mean for younger students and that more research is needed.

The frequency of false-positive results and the stress they can cause are oft-cited reasons for not expanding the testing pool. Some worry that kids might be traumatized if they're barred from playing sports for a heart issue that could turn out to be a false alarm. "For athletes who have spent much of their lives preparing to play competitive sports, such a prohibition is a tragedy,” Barry Manon, chief author of a recent paper opposing more EKG testing, told *The New York Times* recently.

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Another issue in the debate is that statistics regarding how high the risk of SCD actually is for athletes varies widely. Estimates in the last several years have been as low as 1 in 300,000 (and 1 in 200,000 and 1 in 100,000), but most recently, researchers concluded that 1 in 54,000 athletes are at risk. And some say that even the most current results gleaned from studies of athletes underestimate the risk to a broader segment of the population. A study of 18 to 35 year olds at a military base that was published in 2004 found the risk
of SCD to be more like 1 in 15,000, or 20 times higher than previous statistics indicated.

On the other side, proponents argue that in addition to the risk being grave, the rate of false positives is far lower than is often reported. "That argument is somewhat outdated," says Higgins. "Twenty years ago the false-positive rate was 20 percent, or one in five. But these days, the false-positive rate is 6 percent or less."

And in commentary published recently in the American Journal of Medicine, Higgins wrote that the EKG's "test characteristics outperform mammography, Prostate-Specific Antigen blood test, and Pap smear, which are major screenings performed daily worldwide."

Some colleges, such as Rice University, screen all of its athletes, but many other universities don't, and that's part of the problem, Higgins says. "We're a little behind the rest of the world in terms of this testing."

Currently, colleges are only required to do what's called a standard history and physical exam of athletes, which has a higher false-positive rate than EKGs. This is partly due to unreliability on both ends of this type of Q&A system. It's difficult to get good medical information from nonobjective, self-reported data on the part of the student, and many people doing the intake for college athletics aren't properly trained for it.

"At most schools, they'll fill out a form with questions such as 'Have you ever had chest pain?' and 'Have you ever passed out?' They turn in the form then meet with someone, and it can be anyone from an athletic assistant to a nurse, or sometimes it'll be an internist. But many times it's a nonphysician examiner. So it's no wonder that system is broken."

When asked whether regular testing — of even junior high and high school students, which Higgins is in favor of — would be prohibitively expensive, he said, "It can be expensive, but if a college athlete dies while playing at that college, what normally happens is that the family will file a wrongful death lawsuit against the college. The family will say, 'Other colleges do this test that would've detected this problem my son died of, why didn't you?' If you look at it that way, it is actually cost-effective in the long run."

Beyond college athletes, should the rest of us active individuals get a test? If you've made it to age 30 or 35, your risk is generally low, Higgins says. But if you're college-age and weren't very active in high school and are now, you might want to get checked out, especially if you've had any symptoms such as shortness of breath or palpitations.

— Virginia Pelley

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