

Football Medicine & Performance Podcast

NSAID Prescribing Trends and Practices in Elite Football – Publication-Ready Transcript

Host	Dr Daire Rooney
Guest	Dr Richard Porter

Introduction

Welcome back to another Football Medicine & Performance Podcast. I'm Daire Rooney, editor of the FMPA Magazine and your host for today's episode. Today I'm delighted to be joined by Dr Richard Porter. Richard currently works as a Specialty Doctor in Rheumatology and Acute Medicine at Manchester University NHS Foundation Trust. Alongside his NHS role, he works as a sports medicine doctor for Return2Play and as an independent match-day doctor in Premiership Rugby. He also works with the England Powerchair Football and England Deaf Men's squads and serves on the examination panel for the Faculty of Sport and Exercise Medicine. Richard recently authored a thought-provoking article in the FMPA Magazine examining a topic that has remained under the radar for far too long: prescribing trends and practices within elite football. For many years there has been growing concern about the use of non-steroidal anti-inflammatory drugs, or NSAIDs, within professional football, often without consistent oversight or robust prescribing data. Richard's article provides a timely and much-needed insight into how clinicians are prescribing these medications in high-performance environments, drawing on recent survey data from practitioners working across the professional game. In today's episode we'll explore what those findings mean for footballers, medical teams and the future of medication governance in elite sport.

Unpacking the Long-standing Concerns with NSAID Prescribing

Dr Daire Rooney: Richard, thank you very much for joining us today. Dr Richard Porter: Thank you. It's great to be here. Dr Daire Rooney: To begin, and to give our listeners some context, your article appeared in the latest edition of the FMPA Magazine. Why has NSAID use—and prescribing practice more broadly—been such a long-standing concern within professional football? Dr Richard Porter: It's a really good place to start, and there are probably two main themes to consider. The first relates to prescribing practice in general. The regulatory framework surrounding football clubs as healthcare providers is not especially well defined. Because of that lack of structure, prescribing habits, trends and clinical practice are rarely subjected to wider governance or meaningful external review. Many practitioners regularly audit and reflect on their own prescribing, but there isn't a coordinated national system for doing that across football. The second theme is specific to NSAIDs themselves. Historically, both clinicians and players tended to assume that most sports-related pain or soreness was primarily inflammatory in nature. As a result, NSAIDs became almost routine in many sporting environments. That perception is gradually changing. There are certainly situations where NSAIDs remain clinically appropriate—for example, in selected cases of acute reactive tendinopathy—but our understanding of the balance between potential benefit and potential harm continues to evolve. Another important factor is accessibility. Ibuprofen, in particular, is available over the counter, meaning many players begin using these medications long before they enter elite sport or come under the care of a sports physician. Players often arrive with long-established habits of self-medicating, so clinicians aren't simply deciding whether or not to prescribe; they're also trying to change behaviours that may have developed over many years.

Do NSAIDs Really Enhance Recovery

Dr Daire Rooney: There seems to be pressure from both staff and players on the clinician to prescribe NSAIDs. Based on the current evidence, how effective are NSAIDs at relieving pain and enhancing recovery following football injuries such as muscle strains or contusions? Dr Richard Porter: That's a really important distinction because pain relief and enhancing recovery aren't necessarily the same thing. There is certainly pressure from players, coaches and support staff to find interventions that appear to speed up recovery. Everyone wants a player back on the pitch as quickly as possible. However, the idea that NSAIDs generally "enhance recovery" is becoming increasingly outdated. In fact, particularly in muscle injuries, the opposite may sometimes be true. There is little convincing evidence that NSAIDs improve recovery following acute muscle injury. They certainly have a role in managing acute pain, and they can form part of an appropriate analgesic strategy, but we need to distinguish pain management from tissue healing. Inflammation following injury is not simply something to suppress; it is an essential part of normal tissue healing. After muscle injury, prostaglandin production promotes vasodilation, inflammatory cell recruitment and the wider cascade involved in tissue repair. One concept that has really influenced my thinking comes from the work of Dr Carlos Pedret, whose approach places great emphasis on respecting tissue loading and allowing sufficient biological healing time following muscle injury. From that perspective, we need to be cautious about prescribing NSAIDs because they may interfere with normal healing. This isn't to suggest that we shouldn't treat acute pain. Rather, there appears to be a spectrum. Initially, symptom relief may outweigh any potential disadvantages. However, as time passes, the balance may shift, and continued NSAID use could potentially delay tissue healing.

Understanding the Short- and Long-term Risks of NSAIDs

Dr Daire Rooney: For the non-medics listening, what are some of the known short- and long-term risks associated with regular NSAID use in elite athletes, particularly when they're taken during ongoing training or competition? Dr Richard Porter: The side effect most people immediately think of is gastrointestinal irritation. By reducing prostaglandin production, NSAIDs increase the risk of gastritis, gastro-oesophageal reflux and gastric ulceration. Another major consideration is renal function. During intense exercise, blood flow to the kidneys naturally decreases. NSAIDs further reduce renal blood flow, and when that effect is combined with prolonged or intense exercise—particularly in hot environments—the risk of acute kidney injury increases significantly. Long-term use presents additional concerns. Prolonged NSAID exposure is associated with chronic kidney disease and interstitial nephritis. Perhaps less widely appreciated is the increased cardiovascular risk associated with NSAIDs, especially with diclofenac and COX-2 selective inhibitors, both of which are associated with an increased risk of thromboembolic disease. As clinicians, we therefore need to consider an athlete's overall cardiovascular risk profile, particularly in older athletes and those competing at amateur or semi-professional level.

The Personal Journey Behind the Research

Dr Daire Rooney: Was it these issues that prompted you to investigate prescribing practice, or was there another moment in your career that led you towards this research? Dr Richard Porter: It was really a combination of factors. Around the time I began developing the project, I was becoming increasingly involved in football medicine. Not long beforehand I'd heard Dr Andy Massey speak at the BASEM Conference about some of the ethical challenges surrounding prescribing in elite sport. He discussed issues such as player requests for injections, off-label treatments and interventions that have little or no evidence base. Listening to that presentation made me realise that I needed a much stronger understanding of the available evidence because, ultimately, I'd soon be making those decisions myself. When I started looking into it, though, I discovered there was very little evidence to guide clinicians. As most people working in elite sport appreciate, every player and every clinical situation is different. That degree of heterogeneity makes it extremely difficult to generate high-quality evidence or produce straightforward clinical guidelines. Initially, the project was driven by my own learning, but I also suspected I wasn't the only clinician facing these uncertainties. The aim wasn't necessarily to provide all the answers, but to begin understanding how clinicians are prescribing, both within the UK and internationally, so that over time we can develop better governance, stronger prescribing frameworks and ultimately better care for players.

Unveiling Prescribing Trends Across Elite Football

Dr Daire Rooney: Could you explain how the study was designed and share some of the key findings so far? Dr Richard Porter: The study surveyed healthcare professionals working across football, primarily within the UK but also internationally, asking about their prescribing practices across a wide range of clinical scenarios. We received responses from 126 clinicians, with 78% practising in the UK. Importantly, 78.6% worked within international, Premier League or Championship-level football—or equivalent professional competitions—which gives us confidence that the findings genuinely reflect practice within elite football. Perhaps unsurprisingly, paracetamol emerged as the most commonly prescribed medication. Regular paracetamol use was reported by 57% of respondents during training, while 96% reported regular use around matches. Although occasional paracetamol use is generally safe, these findings may also act as a marker of broader prescribing behaviour. One particularly interesting finding was that clinicians who regularly prescribed paracetamol around training and matches were also significantly more likely to prescribe both NSAIDs and opioid analgesics. We also observed national differences. Compared with clinicians practising elsewhere in the world, UK clinicians were significantly more likely to prescribe both paracetamol and opioid medications. That is an observation that deserves further exploration.

Red Flags in Prescribing Practice

Dr Daire Rooney: Do the results still raise concerns? Dr Richard Porter: I think there are certainly reasons to be optimistic, but there are still some clear warning signs. One finding that particularly stood out was prescribing pressure. Across all respondents, the average proportion of prescriptions that clinicians felt were made primarily because of pressure—from players, coaches or the wider performance environment—was 26%. In other words, around one in four prescriptions were perceived as being influenced more by external pressure than by purely clinical judgement. Anyone who has worked in elite sport will recognise that feeling. There is often an expectation that the medical team should "do something", particularly when a player is approaching an important fixture. Ultimately, improving prescribing practice isn't about criticising colleagues; it's about supporting better clinical decision-making across the profession.

Educating Players

Dr Daire Rooney: How much understanding do you think players generally have about the medications they're taking? Do you think better player education could change how treatments are requested and used? Dr Richard Porter: Absolutely. Player education is probably one of the biggest opportunities we have to improve prescribing practice. Every clinician working in football has probably experienced the situation where a player says, "Can I have what I usually take before a match?" Simply refusing those requests isn't enough. Ibuprofen and other NSAIDs remain readily available over the counter. If we don't accompany changes in prescribing with consistent education, players can simply continue self-medicating outside the club environment. Education has to become part of everyday clinical practice. Players need to understand why a medication may—or may not—be appropriate, rather than simply being told "yes" or "no." Over time, that education becomes far more valuable than any individual prescribing decision.

The Future of Medication Governance in Elite Sport

Dr Daire Rooney: Looking ahead, what would you most like to see happen next? Dr Richard Porter: Sport is incredibly heterogeneous. Every athlete is different, every injury is different, and every club operates slightly differently. That makes guideline development challenging. Paracetamol, NSAIDs and weak opioid analgesics are all prescribed for a variety of legitimate reasons—not simply acute injury. That makes it difficult to collect meaningful data on whether individual prescriptions were necessary or avoidable. Going forward, we need better ways of capturing those data. Encouragingly, organisations such as FIFA already collect information on medication use during major tournaments like the FIFA World Cup. Hopefully studies such as ours will add another layer to that work by broadening the conversation around prescribing behaviour and medication governance throughout football. On an individual level, I think we all have a responsibility. As clinicians, we need to make player education part of everyday practice and embed that within the culture of our clubs.

Closing Remarks

Dr Daire Rooney: Richard, thank you very much for joining us today and for shedding light on what is undoubtedly an overlooked—but incredibly important—aspect of elite football medicine. It's encouraging to see this work beginning to fill an important gap in the evidence base, and hopefully it will pave the way for further research and improvements in clinical practice over the coming years. Dr Richard Porter: Thank you very much. It's been a pleasure. Dr Daire Rooney: And thank you to everyone listening. If you enjoyed today's episode, you can read Richard's article in the latest edition of the FMPA Magazine. You can also subscribe to the Football Medicine & Performance Podcast on Spotify or SoundCloud, where you'll find our full catalogue of previous episodes. Alternatively, all of our podcasts are available free of charge via the podcast section of the FMPA website. Thank you for listening to the Football Medicine & Performance Podcast. We'll see you next time.

Editorial Note

This edited transcript has been prepared for publication by removing timestamps and transcription artefacts, correcting speech-recognition errors, standardising spelling to British English, correcting medical terminology and drug nomenclature, improving grammar, punctuation and readability, removing false starts and repeated phrases while preserving the speakers' intended meaning and conversational style, and retaining all substantive content without altering the scientific or clinical discussion. The result is suitable for publication in the FMPA Magazine, on the FMPA website, or as an official podcast transcript.