

Care and Feeding of Racewalking Injuries

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A recent, extended bout with a ridiculously misdiagnosed case of sartorial tendonitis in my right knee has prompted me to say a few words on the subject, in the hopes that it may save an anonymous racewalker or two from a similar unnecessary layoff. In the last few days I've finally returned to normal (knock on wood) training again after nearly ten weeks off due to an unpleasant sensation in my knee that at times was remarkably similar to the feeling one gets when an ice pick is accidentally hammered into the area. In the week following the 1994 New York City Marathon I began to experience pain on the medial side below my right knee. I felt fine during the race and didn't feel too bad afterwards, but I did notice a little tightness in my hips and lower abdominal region in the later stages of the race.

In the days following the race I was only able to walk for twenty minutes or so before my hips tightened up, and then the knee became very painful. My therapists came up with all kinds of crazy diagnoses: A sprain. A torn meniscus. A torn ligament. An inflamed plica. Chondromalacia. All along I thought it was a simple case of tendonitis, but that was too easy. Two months and several hundred dollars later I decided to take matters into my own hands and began treatment as if I had a simple case of tendonitis. Less than a week into treatment I was able to return to normal training. Occasionally I push too hard and I feel a little pain, but a little extra stretching seems to hold it at bay. The moral of the story? Listen to your own body. Over the last few months I've worked with several highly qualified doctors and therapists, but ultimately the patient has a better feel for what's wrong with him than anybody poking and prodding from the outside. Doctors work in generalities: If the doctor works with a lot of basketball players, a torn meniscus is probably a reasonable guess as the source of medial knee pain. Likewise, a sprain may be a likely diagnosis for a soccer player. Chondromalacia is fairly common among runners. Unfortunately most doctors have never seen a racewalker and aren't sure what kinds of assumptions they should make.

In my experience racewalkers suffer relatively few injuries, but nearly all are overuse injuries rather than traumatic ones (i.e. sprains and tears). Tendonitis of the knee (iliotibial or sartorial), feet (plantar fasciitis or cuboid peroneal syndrome), shins ("shin splints" or posterior tibial myositis/tendonitis) or of the achilles tendon are all common overuse injuries. Bursitis of the hip or knee is also fairly common. The trick with tendonitis is to remember just what tendons are: They're tough fibrous sheaths that connect muscles to bones. Fortunately, 99% of the time there's nothing wrong with the tendon itself--it's simply being abused by a tight muscle. Racewalking, like running, does nothing to enhance flexibility. The racewalker is propelled forward by contracting muscles. Over time, the muscles incrementally lose flexibility if they are not stretched gently after exercise. As the tight muscle shortens, it pulls at its origin and insertion points (at the tendons, and fascial sheaths). The only way to release the strain on the tendon is to stretch the muscle. Similarly, bursitis is the inflammation of a bursa (a fluid-filled sac) found or formed in areas of friction. As the muscles tighten, friction around the joints increases and bursae are irritated. Releasing tight muscles will reduce friction and allow the bursa to return to normal.

We are often ingrained with a quick-fix, bandaid approach to sports medicine: Rest, ice and aspirin will make the pain go away. All true, but these approaches attack the symptom and not the cause. The pain is in tendon or bursa, but the root cause is the tight, neglected muscle. Treatment for these injuries must begin with isolation of the muscle or muscles involved. In most cases the athlete will notice discomfort and tightness in certain muscles that may lie far from the injured area. Don't ignore these sensations! My last serious bout with tendonitis involved the insertion of my iliotibial band into the outside of my right knee. I felt a little tight on the outside of my right hip as well, but thought nothing of it, since it was never very painful. Meanwhile two months of rest did nothing to cure the knee once I tried to return to training. I was in exactly the same stage of

pain after two months of rest because I failed to attack the tight iliotibial band and hip muscles. The treatment that finally cured me involved digging at scar tissue in my hip and thigh with the back end of a screwdriver to release the muscle and tendon, and then learning how to ward off further flare-ups with a sensible stretching routine.

An ounce of prevention is worth two in the bush (or something like that...) If the weather is just too lousy to get out the door to train, stay inside and stretch! Attack those tight muscles before they turn into debilitating injuries. There are dozens of excellent books out there on stretching--perhaps Bob Anderson's *Stretching* is the best known--but each individual must find the particular stretches that work for him or her. Experiment to see which positions get it right where it hurts. Certainly stretching is an important first step in recovery, but gains in flexibility will be short-lived if the involved muscles are weak and atrophied. Strength training is equally critical in injury rehabilitation or preventative care. Whether using free weights, weight machines, elastic devices or isometric exercises, the involved muscles should be isolated in such a way as to ensure that they are being worked through a range of motion that mimics their racewalking action as closely as possible. This may involve a good deal of improvisation with weight machines, or experimentation with postural changes until the perfect position is found. During rehabilitation, resistance should be just enough to cause minor fatigue without hurting the injured area. As strength improves, work up to three sets of 10-12 RM. (RM = repetitions maximum. 1 RM is the amount of weight that you are able to lift one time, but not two. 10 RM is the amount of weight that you're able to lift ten times before failure.) Always allow 48 hours for recovery between sessions--three days of weight training per week is optimum.

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