2.4.5 Mar 2.4.6 Surg 2.5 Plantar Int 2.5.1 And Other Neuroge 3.1 Muscle Cr Overlap of Clir	stights
tract	Known and a pink is a summa and yet affelds a manymer public in every studied. The strengt symmetry strength of a strength studied is the system and the strength strength strength strength strength strength is a strength strength strength strength strength strength strength is common but important confident in the strength strength strength strength of a strength farmers or earlierly. The strength strengt
	tioned above, many different pathologies may coexist in the lower limb and may be a source of confusion for the clinician or alternatively may be the reason for remnimed ensurements.

McCrory et al.

McCrory et al.

McCrory et al.

Exercise-related leg pain represents one of the	derstanding of all the potential neurological causes
most common presentations in sports medicine.	of such pain. <sup>[10]</sup> To complicate matters further,
This is usually caused by musculoskeletal overuse	many of the cellinical presentations overlap, in spite
inpires, but not uncommonly, a nearogenic cause	of the fact that the underlying pathophysiology
may be suspected. Because of the complex anat-	may be related to separate vascular, compartment
omy of the leg, few clinicians have a detailed un-	or neurological dysfunction. In this review, the rel-

Deep percental nerve

Server - Congenerations

Branch to sbials anterio muscle Branch to Extensor digitorum longus muscie

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yts or parglions, sitting in a prolonged prosition (trgst): Franctional analous sits with a repetitor excisic intrologi sits with a repetitor excisic intrologi repetitor (trg, remers, yes) rand presentation (trg, remers, yes) remers, yes) remers, yes) remers, yes and with the remers, yes in the first site of the present of the CPN or a transmission with compartners typohenes, the SPN with a latteral compartners typohenes and section (trg) and the SPN with a latteral compartners typohene remers section (trg) and the SPN with a latteral compartners typohene remers section (trg) and the SPN with a latteral compartners typohene remers section (trg) and the SPN with a latteral compartners typohene remers section (trg) and the section (trg) and the section (trg) and the SPN with a latteral remers trg) remers section (trg) and the sectio

Sciatic \_\_\_\_\_

Lateral cutaneous Common peroneal -nerve

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Superficial perceal nerve

A summer of the vertices and filter similar to the strength of the vertices of of m my Main branches in leg Motor innervation in leg Sensory distribution in leg Saphanous nerve, intra-pamilar NI (chr-pamilar branch) und motor inter nerve (chr-pamilar branch) und motor al leg, ankle and actor of tool Contract periode laws Superfloat personal month of the contract periode laws Superfloat personal month of the contract and month of the superfloat period laws Superfloat period laws Superfloat Su

Lateral colateral ligament

Peroneus longus muscle

Exercise-Related Log Pain

Deep (profundus) Fig. 5. Anatomy of the perpresal (or libular) tunnel.

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and polyticat of march comparisons of a distribution of the strength of the polytication of the polyticat

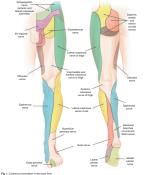
Common personal merve passing through personal (Rudar) turnel

Sports Med 2002; 32 (6)

Exercise-Related Log Pain

immediately referred for neurological assessment. These include: • Bladder or bowel dysfunction • Focal or global weakness in the lower limbs Inchypogastic nene (arterior and arterior and banched)

373



McCrory et al.

2007/1 Med 2022, 22 (8)

McCrory et al.

Exercise-Related Log Pain 375 Loss of sensation or 'pins and needles'
Loss of coordination in the lower limbs
Systemic symptoms (e.g. ferer, night sweats
and loss of bodyweight)
Night pins or rest pain
Lower limb or bottock pain that gets worse with
careria
Unitarent log pain and swelling. Feesaral Nerve Femoral lativy and ven 1.4 Examination 1.4 EXEMPLED Details of neurological examination skills are beyond the scope of this article. Readers are re-ferred to general neurological texts for further reading.<sup>(2)</sup> Notes and all a 1.5 Investigations 1.5 hvordigetienei In the meangement of most cases of leg pain where in neurological diagnosis is suspected, spe-fice continuatory tests such as area: conduction studies or electromyography should be sought.<sup>[40]</sup> The main role of relationscial imaging modalities such as isotope bore scarning, ultrassond and magnetic resonance imaging (MMI) relate to the neurological disease,<sup>[944]</sup> Saptenous Intropatellar branch of sapherous nerve Fig. 2. Anatomy of the femoral nerve and its datal branches. ASIS = anterior superior liac spine. 2. Specific Nerve Entrapment Syndromes the proximal portion of the canal and also covers the two terminal branches of the suphenous nerve, the intrapatellas branch and the descending branch<sup>10,11</sup> (price 2 and 3). The intra-patellase branch supplies he sensition to the medial portion of the joint and the overlying intercorected while. The descending branch accore-The various specific nerve entrapment syndromes re discussed separately. The list of references for ach syndrome is not meant to be exhaustive and 2.1 Saphenous Nerve 2.1 SQUARE and a more set of the second of the second set of the s

arthroscopic portal. Local injuries may similarly result in saphenous nerve symptoms either from iiritate the nerve. Some authors have speculated that stretching the nerve during kare flexion may be a biomechanical explanation of the activity of the best observed an end of the second sec Lateral Cataloga rave of trige Ferrod The state of the s intrapatellar branch of sapherous nerve 21.4 Isovaline 21.4 Isovaline Where diagnostic uncertainty exists, a local an-acuthetic block of the nerve within the addactor canal may help isolate the syndrome. Othen posi-exercise examination of the patient, with or with-out a local annexthetic block, may be the crucial diagnostic step. Land Addewa Address 2.15 Morogensel Treatment may either be conservative or in-volve surgical neurolysis.<sup>[05,20]</sup> Conservative treat-ment includes physiotherapy, 'neuromeningeal' stretching and soft tissue massage. 2.1.6 Segical Management Sangical treatment of saphenous nerve entrap-ment, in general, involves exposure of the saphe-nous nerve in the substantial acaul. The incision is approximately 10cm proximal to the patella, an-Fig. 3. Anatomy of the sacherous rerve.

McCrory et al.

tert in the untrule. The interval between quark and an addates on the interval between quark and a addates on the interval between quark sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between quark sector of the interval sector of the interval between the interval sector of the interval betwee

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ci dicharificazion of the lesion site. Depending totale and the lesion site is the lesion of the lesion of the lesion of the total approach may be considered. The most of participation approach and the lesion of the lesion of

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Common personal nerve Dranch to Castrochemias Dranch to Pinnais Tiblal nerve Branch to Gasticonemius Popileus Ranch to Tibialis posterior Branch to Filteor digitorum longus Rearch to Flexor hallucis longus Andal Janare Dava Lateral plantar nerve

The first sensory-motor branch of the lateral plattar nove may be entrapped between the mus-ies a cause of persistent heel pain, although no non-cle layer or where is passes in close relation to the plattar facial attachment to the calcaneum, lujury can no be electrophysiologically tested. Surgical

The second secon Calcaneus Lateol plantar artery and nerve

Fig.8.-Anatomy of the tensilitanesi. AH = abdactor hallucia; FEL = fiescor digitorum longur; FHL = fiescor hallucia longur; FB = percesus tenvic; FL = percesus longur; FP = tibials posterior.

decompression may be successful in the manag-ment of this condition.<sup>11,44</sup> The modul calcular branch of the this trees have been represented in the sum of the sum of the sum of the major terropycal in a TS depending on the level of thermality, a stand by an impact on the sum of the s

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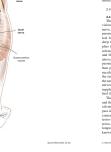
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387

3.1 Musice Cromp Systems Musice cromps represent sublers, involutiony and other painful shortening of musice, and may be attended by visible "monting" of the musice which may in turn lead to absormal postuming of the affected joint. These are perhaps the most com-mon neuronnexity disorders to affect an address undoccur universally. For the most part their origin is beinging. The common cause of musice carange is to longing a start of the s is being: The common case of muscle cramps is muscle fatgips: hower, other factors with a de-hydration, vascular insufficiency, electrolyte in-blance or nunceionid muscle activity may be associated. Rare pathological cases include moto-neuron disorders, hypothyrolidin, muscle carsyne disorder or specific movement disorders such as lace's syndheses. Traitment is usually symptos-atic and prevention by stretching, graduated exer-ice programmes and ensing adqueue hypothesis before exercise is all that is usually required.<sup>(9)</sup> 4. Overlap of Clinical Syndromes Causing Exercise-Related Leg Pain Execute - schöde Lög Pan There is somalitation field in entry hysene total are engineering somalitation somalitation program have and statistication of the somalitation of the scheme scheme some some some some sometimes sometime some some some some some sometimes sometime sometimes of the some some sometimes sometimes sometimes of the sometimes of the sometimes sometimes sometimes of the sometimes o

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McCrory et al.

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Saphenous farmer Canneen Conneent Canneen Cann	Gamoorenius musice
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sports physicians with 'recurrent' Achilles tendon-itis or 'tears'. The use of nerve conduction studies to assist in diagnosis has been reported.<sup>[10]</sup>

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clinical nerve entrapment syndromes is commonly seen in sports medicine. In general terms, surgical decompression for localised nerve compression fares better where a clear anatomic distribution of pain exists. Caution must be exercised for those netterity with neo-constonrial combinity of chain are



Exercise-Related Log Pain casional finding is compression of the nerve by a site of compression with resection of the osteo-muscle hemiation through a fascial hiatus. This phyte and neurolysis.

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have all been reperied, testing the provided of the from tight six boots and casts may similarly in this problem. The crural fascia may act as ei compression point or a fixation point for the and athletic activities which as running or sports may stretch the nerve at this level. Sim interview way the testing the same level interview way level interview.





## Acknowledgements

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