Runner’s stitch and the thoracic spine

The cause of the abdominal pain commonly referred to as ‘stitch’, but more accurately known as exercise related transient abdominal pain (ETAP), had until recently attracted more speculation than research. Explanations for the pain have included diaphragmatic ischaemia,1 stress on peritoneal ligaments,2 and irritation of the parietal peritoneum.3 Although the exact cause of the pain remains to be elucidated, a neurogenic explanation has not appeared in the literature.

We present the case of an elite runner who, after a thoracic spine trauma, developed severe and recurrent episodes of ETAP which were relieved by localised treatment. As a follow up study, we made observations on 17 other runners who often experience episodes of ETAP and found that palpation of specific facet joints could reproduce symptoms of ETAP shortly after an episode of the pain had been relieved.

Case study

The patient was a 25 year old man who had been actively involved in competitive running for about 16 years. During this time, he claimed that he occasionally experienced mild symptoms of ETAP during training and competition, although they were not disrup- tive to performance. After trauma to the thoracic spine in a trampoline accident, he began to experience ETAP with greater frequency and severity. Subsequently he would develop ETAP often when walking and consistently when running. The presenta- tion of the pain essentially forced him from competition. He had received advice from several medical practitioners before being referred to our clinic about two years after the symptoms had been present and persistent when running was attempted for this time period.

On questioning, it became apparent that several conditions that stress the spine exacerbated the experience of ETAP. For example, torso hyperextension coupled with the jolting movement of downhill running provoked the pain. In addition, tight erector spinae after a surfing session seemed to induce the likelihood of experiencing ETAP.

On assessment, vertebral hypomobility was observed at the T7–T8 level, presumably as a result of the trampoline accident. Accompanying this was hypermobility of the T8–T9 joint. Palpation of the left T8–T9 facet joint resulted in reproduction of substernal pain consistent with the patient’s exercise induced experience of ETAP. Further, the site of the pain reproduction was consistent with the dermatome distribution arising from the T8–T9 level. Palpation of the joints above and below the joint caused no pain referral.

Localised treatment aimed at mobilising the T7–T8 joint was administered in the clinic, and the patient was given mobilising exercises to perform. After about four weeks of treatment, he reported a reduction in the symptoms of ETAP. He has since resumed competitive running.

Further observations

In response to the presentation of this case, we recruited 17 other runners who spasmo- dically experienced ETAP during training and competition. Ethical clearance was obtained from the Avondale College human research ethics committee. The subjects exercised on a treadmill after a meal until ETAP developed, at which time the exercise session was terminated. After the pain had completely disappeared, the subjects lay in a prone position and were submitted to a spinal assessment, in which facet palpation was performed along the length of the thoracic region. The subjects were not informed of the intent of the study but were asked to volunteer any symptoms of pain or discom- fort that arose.

In eight cases (47%), the exact previous experience of ETAP was reproduced through palpation of the thoracic spine at various levels from T8 to T12. In another six cases (35%), the subjects reported lateral and anterior pain referral towards the site of ETAP as a result of the palpation. The longitudinal site of ETAP along the abdomen correlated significantly with the level of the thoracic spine producing symptoms on palpa- tion. This result was observed when only the subjects reporting exact reproduction were analysed (r = 0.78, p<0.05) and also when all subjects reporting any form of pain referral were included in the analysis (r = 0.63, p<0.05). Further, the level of the spine producing symptoms on palpation and the site of ETAP were consistent with dermatome distribution.

Discussion

There has been little or no mention in the literature of the possible role of the spine in the cause of ETAP, although there are several observations that indicate that its contribu- tion may be noteworthy. Firstly, in 1941 Capps’ anecdotal observations that people with an increased kypholordotic postural align- ment seemed most susceptible to the pain. To investigate this further, we recently con- firmed in a study involving a comprehensive postural assessment of over 150 subjects that increased kyphosis is provocative of ETAP.4 This observation is interesting given that intercostal nerves arising from the thoracic region supply the anterior abdomen. In addition, it has been suggested that “jolting” of the torso is primarily responsible for evoking the pain, and this action is known to result in intervertebral compression.5 As a side issue, we documented that horse riding is one of the sporting activities most likely to induce ETAP.6 It has also been asserted that an episode of ETAP can be relieved through body inversion.7 Finally, we have argued that the characteristics of the pain, being well localised, lateral, and mostly sharp, are consistent with somatic rather than visceral abdominal pain.8 An explanation for the pain involving the intercostal nerve would account for these pain characteristics.

The extent to which the thoracic intercostal nerves may contribute to the experience of ETAP is worthy of further investigation. It seems plausible that, in some cases mechanical compression of the nerve root may refer pain distally, resulting in abdominal pain. Alternatively, irritation of the nerve may sensitise it to stimuli such that the threshold required for activation is lessened. Hence, in this study, palpation after the pain had been relieved may have allowed tissues innervated by the intercostal nerves, such as the abdom- inal musculature or parietal peritoneum, to recreate sensations of pain.

Although the significance of the observa- tions documented in this report remains to be fully elucidated, they do indicate that the spine may play a role in the genesis of ETAP. Further studies are required to determine the extent to which the spinal nerves are involved and the potential benefits of improving spinal integrity in ETAP sufferers. Certainly, the spine should be considered when treating patients with recurrent symptoms of ETAP.

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doi: 10.1136/bjsm.2003.009308

References


Science versus opinion

Dr Berger recently responded1 to my article in the British Journal of Sports Medicine entitled: Berger in retrospect: effect of varied weight training programmes on strength.2 Dr Berger presented no scientific evidence to support his opinion on single versus multiple sets, cited references that were irrelevant to the topic, and challenged the reported statistical analyses.

Dr Berger claimed that most athletic and therapeutic professionals have added cre- dence and support to the belief that multiple sets are required for optimal gains in strength because they use multiple sets in their practice and research (p 372).1 However, just
using multiple sets in practice is not evidence that multiple sets are superior to a single set; it merely perpetuates an unsubstantiated belief (p 372). In my retrospective lists 57 studies that reported no significant difference in strength gains as a result of performing a greater number of sets. Dr Berger failed to cite a single study to support his opinion of the benefits of multiple sets. In fact, Dr Berger’s own follow up studies, which are described in my retrospect, failed to support his opinion—that is, a greater number of sets did not result in a significantly greater strength gain in either of his follow up studies. Dr Berger claimed that some early studies compared different weight training programs (p 372) and cited five studies. However, these studies (described below) are irrelevant to the issue of single versus multiple set resistance training.

Delorme et al treated eight men and 11 women with poliomyelitis-weakened and atrophied knee extensor muscles. Their goal was to increase muscular strength and hypertrophy. The patients performed three sets of 10 repetitions (intensity not reported) of knee extension and leg press exercises four times per week for one to four months. Isometric force increased 1–200%. No statistical pre to post training analysis was reported. All the patients performed three sets of each exercise; consequently, there was no comparison of single versus multiple sets. Krusen randomly assigned military aged men (n = 23) and female (n = 1) patients with poliomyelitis to one of two knee extensor strength training programs (sessions per week not reported). One group performed five repetitions with 25%, 50%, and 75% 10RM, and five repetitions with 150% 5RM, with limited range of motion on the last two sets twice a day for 3–19 weeks. Krusen claimed that, to rule out the difference in initial conditions, subjects in each group were matched for strength and compared after five weeks of training. Knee extension 1RM increased in both respective groups (74.5% and 60.0%), with no significant differences in groups in strength gains. A comparison of single versus multiple sets was not possible because both groups performed three sets of each exercise. The actual comparison was between a low intensity protocol (five repetitions with 75% 5RM) and high intensity protocol (five repetitions with 100% 5RM), which resulted in similar strength gains.

McMorris and Elkins trained the right thigh muscles in healthy men and three women (20–29 years of age) with four sets of exercise five times a week for 12 weeks. One group performed four sets of 10 repetitions with 25%, 50%, 75%, and 100% 10RM in ascending order, while the other group performed four sets of 10 repetitions with 100%, 75%, and 25% 10RM in descending order. McMorris and Elkins reported a 5.5% greater gain in strength for the group that performed the ascending protocol. There was no statistical analysis reported. Because all the patients performed four sets of each exercise, no comparison of single versus multiple sets was possible.

Burich and Houtz reported their observations of what they described as 620 experiments in 17 male and female competitive athletes. Wrist flexion and extension exercise varied from 3 to 40 sets of 25 repetitions with 25–100% 25RM three to five times a week for one to four months. There was no statistical analysis reported, and more importantly, no comparison of single versus multiple sets.

McGovern and Luscombe reported on a two part investigation. In part 1, 10 healthy men (20–30 years of age) were divided into two groups (A and B). Group A performed one warm up set of unilateral quadriceps exercise for five repetitions using 50% 10RM, followed by one set of 10 repetitions with the 10RM. Group B performed one range of motion warm up set (no resistance), followed by three sets of 10 repetitions with 100%, 75%, and 50% 10RM, respectively, and one minute rest between sets. A third group (C) of five male orthopaedic patients (20–30 years of age) performed three sets of 10 repetitions with 50%, 75%, and 100% 10RM respectively. The groups trained five times a week for three weeks. No pre to post training or between group statistical analysis was reported. However, the authors stated that the increase in 10RM was similar for groups A, B, and C (7.7, 8.7, and 7.7 kg respectively) in part 1. In part 2, a male and female orthopaedic patients (20–30 years of age) trained five times a week for four weeks. Half the patients performed one set of 10RM and the other half performed three sets of 10 repetitions with 50% 75% and 100% 10RM. The two groups of patients showed similar gains in 10RM (5.8 and 6.0 kg). McGovern and Luscombe concluded that the two training protocols produced similar strength gains, with a time saving advantage to the single set group.

The study by McGovern and Luscombe was the only one of the five studies cited by Dr Berger that compared single versus multiple sets, and they reported similar strength gains as a result of one set or three sets of exercise.

Dr Berger claimed that the medical applications of strength training for physical therapy have substantiated multiple sets, and that one set was the exception (p 372). In 1991, Delorme and Watkins specifically stated that increasing the resistance after each of three sets provided an advantage for warming up the muscles in patients suffering from poliomyelitis, but probably did not contribute to the increase in muscular strength. They concluded that performing one set or three sets of 10RM would produce a similar increase in strength (pp 27–8). Contrary to Dr Berger’s claim that one set was an exception, and contrary to Dr Berger’s study where his nine groups performed four sets of each exercise, the data in Table 3 of my retrospective shows that for the groups who performed the same number of repetitions (two, six, or 10), seven out of nine of Dr Berger’s comparisons showed no significant difference in the magnitude of strength gain. For example, the strength gain in the 3×6 group was significantly greater than the 2×6 group, but not significantly greater than the 4×6 group. 3×2 was significantly greater than 2×2, but not significantly greater than 1×2. The data are all from Dr Berger’s table 4 (p 176). Dr Berger about the three typographical errors in his table 4, said that he was not aware of these errors and claimed that no one else had ever questioned them before our telephone conversation in 1998. The correct data are shown in Table 2 of my retrospective (p 320).

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Dr Berger claimed that when he compared the main effects among one, two, or three sets, and among two, six, or 10 repetitions, those in six repetitions resulted in the greatest improvement in strength (p 373).¹ In his Results section¹ Dr Berger stated that analysis of covariance was used to test for a significant interaction between sets and repetitions—that is, whether one, two, or three sets might be better in combination with two, six, or 10 repetitions. The F ratio was not significant at any period of training (p 178).¹ Dr Berger also reported in Conclusion 6 that training with one, two, or three sets could be more effective in combination with two, six, or 10 repetitions per set (interaction) was not more effective for improving strength than other combinations of sets and repetitions (p 181).¹ However, in Conclusion 7 Dr Berger claimed that a combination of sixRM performed with three sets was more effective in improving strength than any other combination of sets and repetitions (p 181).¹ These antithetical statements were reported in my retrospective.¹ Dr Berger failed to address them in his response or in our personal correspondence (1998).¹ 

Dr Berger noted that he spoke with me about my misuse of statistics and that he suggested that I consult a statistician (p 373).¹ I followed his advice and consulted two statisticians before submitting my retrospective.¹ Their opinion was that Dr Berger should not have made the 36 individual comparisons that he reported because the multiple comparisons increased the chance of a type I error, which could have led to rejection of the null hypothesis when the null hypothesis was actually true.¹ 

Dr Berger stated that he still unequivocally supports multiple sets over a single set for optimising strength (p 373).¹ Dr Berger is perfectly entitled to his opinion, but it has nothing to do with supporting his belief with scientific evidence. As noted in my retrospective,¹ Dr Berger expressed his opinion about the superiority of multiple sets in our personal correspondence (1998), and at least five publications.¹,⁶,¹⁰ The only study he cited to substantiate his opinion was his 1962 study.¹ Dr Berger neglected to cite his own follow up studies¹ that failed to support his opinion.¹ 

Dr Berger suggested that I conduct research in the hope of gaining support for my position, although he does not define his position (p 373).¹ In fact, my position is simply that if someone in the scientific community makes a claim about anything, they should be held accountable to support that claim with peer reviewed scientific evidence. As noted in the flow chart (p 320) of my retrospective,¹ most of the physiologists who recommend multiple sets of each exercise cite each other’s opinion, reviews and books, cite nothing at all, or they cite Dr Berger’s study.¹ Because I am not making a claim about the superiority of one strength training protocol over another, I am under no obligation to conduct research. I am simply challenging the widely held belief that multiple sets are superior to a single set, and in turn, challenging the apparent genesis of that belief—Dr Berger’s study.¹

References

Medical India
6–8 April 2004, New Delhi, India
This exhibition and conference will be held for the first time, following India’s ambitious “health for all” programme launched in 2002.
Further details: Rob Grant, Kinex Log, 5 New Quebec Street, London W1H 7DD, UK; tel: +44 (0)207 723 8020; fax: +44 (0)207 723 8060; email: rob.grant@kinexlog.com; websites: www.medicare-expo.com and www.kinexlog.com

12th International Congress on Physical Education and Sport
21–23 May 2004, Kornatini, Greece
Round tables, seminars, oral communications, and posters will take place within the frame of the congress. The congress will include an international audience of doctors, physicans, therapists, scientists and coaches.
Further details: Secretariat of the congress, email: icpes@phyed.duth.gr; website: www.phyed.duth.gr/icpes2004

The 6th STMS World Congress on Medicine and Science in Tennis in conjunction with the LTA 2004 Sports Science, Sports Medicine and Performance Coaching Conference
Keynote speakers include Professor Per R. Renstrom (SWE), Professor Peter Jokl (USA), Professor Savio Woo (USA), Dr Carol Ottis (USA), Dr Mark Safran (USA), Dr Ben Kibler (USA), Prof Bruce Elliott (AUS), and Professor Ron Maughan (UK).
Further details: Dr Michael Turner, The Lawn Tennis Association, The Queen’s Club, London W14 9EG, UK; email: michael.turner@lta.org.uk

9th European College of Sports Science Conference
3–6 July 2004, Clermont-Ferrand, France
More than 1500 participants from 70 countries are due to attend.

The Leeds Sports Imaging Course
6–7 September 2004, Leeds, UK
This two day course is aimed at both radiologists and clinicians who are involved in sports imaging. The course will comprise an imaging and clinical overview of all relevant joint, bone and soft tissue sporting injuries.

The faculty will comprise internationally recognised skeletal imaging and clinical experts from the UK, Europe and North America who will deliver state of the art lectures and lead small group discussions. Each session will cover the spectrum of injury for a specific anatomical area beginning with clinical lectures that will allow the subsequent imaging lectures to be placed in context. All aspects of imaging will be discussed but will concentrate on the use of ultrasound, conventional MR imaging and MR arthrography for the diagnosis, staging...
and prognosis of sporting injuries. Therapeutic image guided intervention using fluoroscopy, CT and ultrasound will also be demonstrated.

13 RCR category one CME credits have been awarded.

Further details: Carol Bailey, Course co-ordinator, MRI Department, B Floor, Clarendon Wing, Leeds General Infirmary, Leeds LS1 3EX; tel: +44 (0)113 3922826; fax: +44 (0)113 3922824; email: Carol.Bailey@ledsthi.nhs.uk

BASEM Conference 2004
14–17 October 2004, Belfast, UK

Main themes: Overuse Sports Injuries and Muscle Injuries. Keynote speakers include: Chris Bradshaw, Medical Director, Olympic Park Medical Centre, Melbourne and Kim Bennell, Assistant Professor, School of Physiotherapy, Melbourne University.

Further details: Email: fionnuala.sayers@greenpark.n-linhs.uk

2nd International Ankle Symposium
15–16 October 2004, Newark, DE, USA

The meeting will examine ankle instability and other related ankle pathologies from a multidisciplinary perspective. Attendees will include clinicians and scholars from the disciplines of orthopedics, podiatry, physical therapy, athletic training, biomechanics, and sports medicine. This conference aims to build on the success of the inaugural symposium held in Ulm, Germany in December 2000. Emphasis will be on oral and poster presentations of original research along with selected plenary presentations.

The deadline for abstract submissions is July 1, 2004.

Further details: Jay Hertel, PhD, ATC, FACSM, Conference Co-Chair, Penn State University, email: jnh3@psu.edu, or Thomas Kaminiski, PhD, ATC, FACSM, Conference Co-Chair and Host, University of Delaware, email: kaminiski@udel.edu. Website: http://www.udel.edu/ias/

1st World Congress on Sports Injury Prevention
23–25 June 2005, Oslo, Norway

This congress will provide the world’s leading sports medicine experts with an opportunity to present their work to an international audience made up of physicians, therapists, scientists, and coaches. The congress will present scientific information on sports injury epidemiology, risk factors, injury mechanisms and injury prevention methods with a multidisciplinary perspective. Panel discussions will conclude symposia in key areas providing recommendations to address the prevention issue in relation to particular injuries and sports.

Further details: Oslo Sports Trauma Research Centre and Department of Sports Medicine, University of Sport and Physical Education, Sognsvann 220, 0806 Oslo, Norway. Email: 2005congress@nih.no; website: www.ostrc.no