



Masters News June 2026

Races coming up

SCVAC Kent league

Information with timetable [SCVAC Kent Vets league 2026](#)

Team managers:

- Men: Mark McAllister – markmcallister@hotmail.co.uk
- Women: Grazia Manzotti – grazia.manzotti@gmail.com

BMAF competitions

- 11-13 September- British Masters track and field championship. [Entries via OpenTrack](#)

For more information on BMAF competition see the [BMAF website](#)

SCVAC final

- Sunday 27th September SCVAC final at Thames Valley -more information to follow.

Other masters races

- Saturday 26th September, Southern road relays (4 in a team men, 3 in a team women) Aldershot
- Saturday 24th October, British masters cross country relays, Oxford.
- Saturday November 21st, Kent masters Cross Country championships, Dartford (Date TBC)
- Saturday November 28th, Southern masters Cross Country championships (Date TBC)

- Sunday November 29th, British Masters 5km road championships, Battersea park. Entries now open. [Home | BMAF 5K Champs](#)

Vets League Match 5 Ashford Men's

We went into this match knowing that we had to win and will then be all on the final match held on our home turf, I knew that it would be very close as Dartford are strong in Hammer and 800m, this is where we are usually weak and need to call up the distance runners to drop down to 800m, Tom Richards, a great 400m and 400m hurdles athlete stepped up and had a great 800m race to win the M35 age group in 2:03.4 , Neil McClements (Distance runner) got 3rd place in the M40 group with a time of 2:13.7 Matt Smith (Distance runner) ran the M50 race in 2:19.8 coming 2nd which is impressive, as only moments before his race managed to also get 2nd in the M50 long Jump with 4.52m, Phil Coleman was 5th in the M60 Group and Alan Newman M70 got 4th place, we gained massive points here that contributed to the win that we needed, we were very strong in the 100m, LJ, Shot and won the 4x100m relay.

Match 6 will be at home and I'm confident that we can win this match and keep the cup for another year.

	Total Mt Pts
1. Tonbridge 65 points	22
2. Dartford 59 points	22
3. Ashford 54 points	13
4. Cambridge 51 points	12
5. M&M 47 points	9
6. B&B 38 points	6

Division 2 Men's team

This team is also doing so well and could also win, they are 1 point behind Bromley Vets, so this will also be down to the final match.

Matt Holt (M45) won the M35 100m in 13.2

Ian Roberts (M45) won the M40 100m in 13.6

Mark Jessup (M55) won the M50 100m in 13.6

Matt Holt won the M35 Hammer and M35 Long Jump also

Ian Crawley (M60) won the M35 shot

Ian Roberts, Matt Holt, Mark Jessup and Chris Hyatt Twynam won the 4x100m relay.

There were a few gaps in some areas, so would have won this with a full teamsheet.

The Finals will be held on 27th September at Thames Valley against all the other regions in the south, it will cover all of the events we have done throughout the 6 matches, so please put this date in your diary.

SCVAC league last match - Friday 24th July at Tonbridge

The final league match takes place on Friday 24 July in Tonbridge, and we need a strong turnout to help us retain our league title. Mark and I have already circulated a draft team sheet, and we'd really appreciate your support in helping us fill the remaining places.

Despite having a very small squad available, the women's teams delivered an impressive performance at Ashford, finishing in 4th place overall. With only four athletes competing in team B for instance, this was an achievement and a testament to commitment and determination.



Overview of distance running injuries

The following is a general overview and there are caveats to some of the statements.

Every athlete is different and any treatment plan should be individualised rather than following a template.

What runners really want to know is can they continue running – the guidance is a pain level of up to 3/10 when running is acceptable but that it should settle within 24 hours. Having to run with a limp is a definite no-no.

- Very common, up to 80% injured every year.
- Rarely serious – the most serious being a stress fracture (more on this later).
- Running is generally good for joint health – runners are (generally) less prone to osteoarthritis than the sedentary. Runners also tend to have thicker, healthier spinal discs.
- The two biggest risk factors for injury are older age and previous injury (we cannot change these!) but often the cause is multifactorial.
- Usually also linked to “training error” such as a sudden spike in training intensity and/or volume (the advice is not to increase the two simultaneously).
- Other factors can include gender, biomechanics and genetic conditions (e.g. hypermobility), poor diet, reduced quality sleep and alcohol intake (slows healing).
- Essentially injury occurs as we exceed the capacity of our tissues to tolerate the load applied.
- Loads can be very high when we run and average out at about 2.5 to 3 times body weight per step but are higher in the lower leg with the Achilles and soleus muscle taking up to 7 times body weight.
- Most injuries occur around the knee and below.
- Enigmatically, the human body is well designed for running (hence the book Born to Run by Chris McDougall).
- Often cited ways to reduce injury risk such as stretching and having the “right shoes” are not supported by research. Stretching can aggravate some injuries, such as insertional Achilles tendinopathy, proximal hamstring tendinopathy and gluteus medius tendinopathy. Comfort and fit are thought to be the most important shoe qualities.
- There’s no agreed definition what constitutes excessive pronation (foot rolling in) and its link to injury risk is tenuous – don’t believe everything a

running shop tells you with “gait analysis”. Pronation is a normal part of the gait cycle and is the way the body naturally absorbs shock and winds up energy into the Achilles and plantar fascia which is then released on toe off.

- We do not yet have data to support the growing trend of strength training to reduce injury risk, but we do know it can increase performance (by making tendons mechanically stiffer). Tendons act like springs when we run.
- You will see on social media exercises to strengthen glute medius (lateral hip) muscles to address knees collapsing in, but we know getting stronger does not change our kinematics (how we run).
- We all move differently but overstriding (when the foot lands too far ahead of the body) has been associated with increased loading spikes. A low cadence and being noisy on a treadmill can indicate over striding. The ideal cadence is thought to be 170 to 190 steps per minute (at moderate pace).
- Whether we are a heel striker or forefoot striker does not appear to change the risk of injury but sudden change from one to the other can!

Ideas to reduce injury risk

1. Load management – it’s usually advised having 80% of running at easy pace (less stress on the body) if you’re doing reasonable mileage.
2. Bear in mind that running uphill and quicker running is especially stressful on the calf area and hamstrings and needs to be factored in. Running downhill is more stressful on the knees and quadricep muscles.
3. Avoid sudden changes as the body takes time adapt to different stresses. For example, changing from a maximalist shoe to minimalist shoe, suddenly adding sprint training to your schedule and/or increasing volume too aggressively (no more than 10% weekly is often quoted), or changing from heel striking to forefoot striking as you read it is the “right” way to run!
4. Vary running surfaces. Hard surfaces are not always the worst option (the most aggravating surface for a sore Achilles is soft sand or mud) but surfaces that are very even and lack variety add to the repetitive load of running.
5. Rotate shoes – different shoes will load the body differently.
6. QUALITY SLEEP – very important!
7. Good nutrition. It is thought distance runners need higher levels of protein to aid muscle repair. Vitamin C aids the synthesis of collagen (which makes up tendons). It is quite common in the UK to have low levels of vitamin D which is essential for bone health (you can be tested through the NHS).
8. Listen to your body – if you are sore/stiff after a race or hard training session it is because you have damaged your soft tissue and it has gone into

an inflammatory state to repair; this should settle in a few days but it's telling you to take it easy.

Note: it has nothing to do with lactic acid! Further, inflammation is the body's natural healing process – so should we be icing acute injuries, use ice baths or ibuprofen? Probably not! Forget RICE or PRICE, the new advice is PEACE and LOVE (look it up!).

9. Although shoes per se may not reduce injury risk if you have a history of Achilles issues a shoe with a reasonable heel drop may be better. Runners with knee issues may be better off with a less cushioned, zero heel drop shoe. Some super shoes are very stacked and can increase load on the tibialis posterior tendon (the inside of the ankle area) especially if the runner's ankle is prone to collapse in. This can lead to tibialis posterior tendinopathy which is very hard to treat and can lead to rupture. Those with osteoarthritis in the big toe are usually better off with a stiff, rocker type shoe, so that the joint does not have to extend much.

Common Injuries

Achilles Tendinopathy

The most common injury for the older runner and is due to degeneration and overload. The tendon can be sore and stiff especially in the morning and appear thickened and sometimes have lumps and bumps. Usually feels better when warmed up. The standard treatment is heel drop exercises but it's imperative to be assessed first as there are different types of Achilles pain/tendinopathy and heel drops can make some worse.

The common type is "mid portion" whilst the rarer type is insertional. The plantaris (an additional tendon medial to the Achilles) can also be the culprit as can the the sural nerve or paratenon (sheath around the tendon).

Differential diagnosis is essential to get the correct treatment and management.

Bone Stress Injuries/Stress Fractures

These can be serious and need to be diagnosed quickly to avoid complications.

Common sites are the medial tibia (shin bone) and bones in the feet (e.g. metatarsals).

Symptoms include pain on weight bearing (walking or running, getting worse the further you go) pain on hopping, night pain and may show bruising/swelling and sharp pain on palpation.

They can take 3+ months to heal and “high risk” sites such as neck of femur (hip), anterior tibia and navicular bone (medial foot area) need to be especially carefully managed to avoid displacement and non-union and possible surgery.

They are often missed on x-ray but show on MRI.

Proximal Hamstring Tendinopathy (PHT)

This is literally a pain in the butt and can be difficult to treat. The hamstring muscles attach to the ischial tuberosity bone (our sitting bones) via a tendon which again can degenerate as we get older. Sitting on hard surfaces or after long car journeys can be painful, as are quick runs and uphill running.

Hamstring stretching can aggravate it further by compressing the tendon on the bone. Quicker running and uphill running can also aggravate it.

Management centres around strengthening the pelvic area.

Iliotibial Band (ITB) Syndrome

The ITB originates from the ilium area (lateral pelvis) and inserts below the knee into the tibia. It's fascia rather than muscle and is designed to be stiff as it acts like a spring when we run and stabilises the knee and pelvis when we run. Pain can arise in the lateral knee area, which is thought to be from the compression of a fat pad (which has lots of nerve endings) between the ITB and bone (femoral condyle). It is linked to high volume running (too high leading to fatigue when running), a narrow and cross over gait pattern, over striding and worsens with downhill running.

It cannot be stretched and foam rolling on the painful area can worsen the symptoms as this adds to the compression.

Treatment centres around modification of training loads and gait changes.

Strength training may help too.

Patellofemoral Pain Syndrome

This is also known as runner's knee and is where there is pain under the patella. Again, causes are multifactorial, but it is more common in female runners. Differential diagnosis is important as there are other conditions which can present in similar ways, for example fat pad irritation and patella tendinopathy (jumper's knee).

Muscle Strains

Distance runners have less strains than sprinters but doing shorter, quicker intervals can still strain the hamstrings, gastrocnemius (main calf) and rectus femoris (a quadricep muscle at the front of the thigh). These muscles are all biarticular (work over two joints) and so are prone to strains. There is usually sharp pain and an inability to continue running and bruising may appear later.

Distance runners may also develop a gradual strain in the soleus (a single joint muscle) which lies deep to the gastrocnemius. Strains are graded, in ascending order, 1 to 3. A typical, moderate, strain (grade 2) will usually take at least 6 weeks to heal.

Shin Splints

This is non-specific term for pain in the shin area and not a diagnosis. The most common type is medial tibial stress syndrome (MTSS) which I see mainly in novice runners. There is diffuse pain along the medial (inside) area of the shin (a stress fracture is a sharper, more focal pain). Other possible causes of shin pain include tibialis anterior tendinopathy and exertional compartment syndrome.

Meniscus

Knees have a medial and lateral meniscus. They are made of fibrocartilage and are crescent moon shaped. They act as shock absorbers and increase the congruency of the joint. Older runners (and non-runners) can suffer from degenerative tears (usually the medial one), which can manifest as an achy pain with some sharp pain, especially on twisting. But many runners (and others) can have a tear showing on MRI and be asymptomatic.

If the problem is particularly painful, cause locking or giving way, an arthroscopy (keyhole) procedure may be considered, where part of the meniscus is trimmed and debrided, but the research indicates that physio is as good as surgery in the longer term.

Any queries welcome.

By Phil Coleman (Chartered Physiotherapist)
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TAC Masters Officiating

You will all be aware the club relies on a small number of qualified officials to fulfil our quotas at league and championship events.

The officials are divided between those who want to progress to reach a level where they can be selected for Diamond League / major championships held in the UK and those who have done the basic qualification to be able to help out here and there to ensure TAC events can take place.

It is this latter category that most of the master's should look to be part of. Able to stand in for part of an event to release others to enjoy taking part as well. Or to be able to help out when injured and not able to compete. Most masters have good knowledge of their sport, certainly field eventers know the technical requirements. If you are a parent of a young athlete you will score points for the teams in the KYL, YDL and NAL.

In the league the club contributes financially to a pot to pay Qualified officials who are signed up to the google live sheet by the Sunday before and sign in on the night. They receive a flat rate £15 expenses. The system is that the money goes back to the club to distribute. At TAC we have a system where officials can claim expenses. By being qualified it helps the club to recover the original contribution.

Please sign up to a course of your choice at <https://www.englandathletics.org/coaches-and-officials/officiating-journey/step-one/>

Here you can choose your speciality, then whether you do an online course or an in person course. The club will refund the cost and assume that you will make yourself available from time to time.

Mark Pitcairn-Knowles
TAC Chairman

North West Combined Events Championships

Sarah Westrap-Boon won the gold in the W50 Heptathlon



This is 7 events spread over 2 days

80m hurdles

High Jump

Shot Put

200m

Long Jump

Javelin

800m

By Mark McAllister