

BE-GY 6783/ME-GY 6783 Biomechanics

Term Project:  
**“Biomechanics of Sports Injuries”**

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## Abstract

Sports injuries are a significant concern for athletes, coaches, and healthcare professionals. Understanding the biomechanics of these injuries is crucial for developing effective prevention and management strategies. This report provides an overview of the biomechanical factors and mechanisms underlying common sports injuries, such as ACL tears, ankle sprains, hamstring strains, and stress fractures. It highlights the importance of proper technique, conditioning, and equipment in reducing injury risk and discusses the application of biomechanical principles in injury prevention programs. The report also explores the role of biomechanics in rehabilitation and return to play decisions, emphasizing the need for individualized and evidence-based approaches. Furthermore, it identifies current gaps in knowledge and emerging technologies and methodologies that have the potential to advance our understanding of sports injury biomechanics. By applying these insights and staying current with the latest research findings, we can work towards minimizing the occurrence and impact of sports injuries, ultimately promoting the health and performance of athletes at all levels.

# 1. Introduction

Sports injuries are a significant concern for athletes, coaches, and healthcare professionals alike. These injuries not only impact an athlete's performance but also lead to time away from training and competition, potentially affecting their long-term health and well-being [1]. In the United States alone, it is estimated that 3.6 million sports and recreation-related injuries occur annually [2]. Understanding the mechanisms behind these injuries is crucial for developing effective prevention and management strategies.

Biomechanics, the study of mechanical principles applied to biological systems, plays a vital role in the context of sports injuries [3]. By analyzing the forces, movements, and loading patterns experienced by the body during athletic activities, biomechanics provides valuable insights into the causes and risk factors associated with various sports injuries [4]. This knowledge is essential for designing targeted interventions, optimizing training programs, and improving rehabilitation outcomes.

In this report, we will explore the biomechanics of common sports injuries, focusing on their anatomy, mechanisms, and prevention strategies. We will also discuss the role of biomechanics in rehabilitation and return to play, as well as future directions for research in this field. By understanding the biomechanical principles underlying sports injuries, we can work towards reducing their incidence and severity, ultimately promoting the health and performance of athletes at all levels [5].

## 2. Common sports injuries and their anatomy

Sports injuries can affect various parts of the body, depending on the type of activity and the mechanisms involved. In this section, we will discuss four common sports injuries: ACL tears, ankle sprains, hamstring strains, and stress fractures, along with their anatomical characteristics.

### 2.1. ACL tears

The **anterior cruciate ligament (ACL)** is a key ligament located inside the knee joint that connects the thigh bone (Femur) to the shin bone (Tibia), as shown in Figure 1. Its main function is to stabilize the knee, especially during rotational movements, by preventing the shin bone from sliding too far forward relative to the thigh bone [6]. ACL tears are common in sports that involve sudden stops, changes in direction, or landing from jumps, such as basketball, soccer, and skiing [7]. The injury often occurs when the knee is hyperextended, internally rotated, or subjected to valgus stress, which is an inward force applied to the knee joint. Valgus stress causes the knees to bend towards the body's midline or towards each other, forming a

"knock-kneed" appearance [8, 9]. This condition is known as Knee valgus, and is shown in Figure 2 [9].

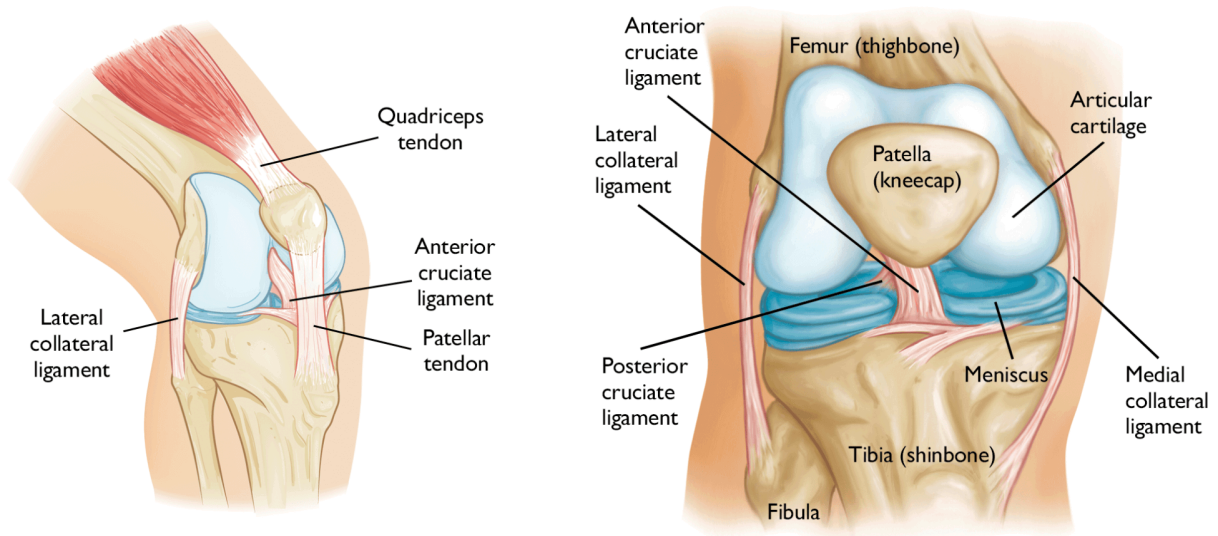


Figure 1: Anatomy of the anterior cruciate ligament (ACL), a key ligament located inside the knee joint that connects the thigh bone (Femur) to the shin bone (Tibia) [10].

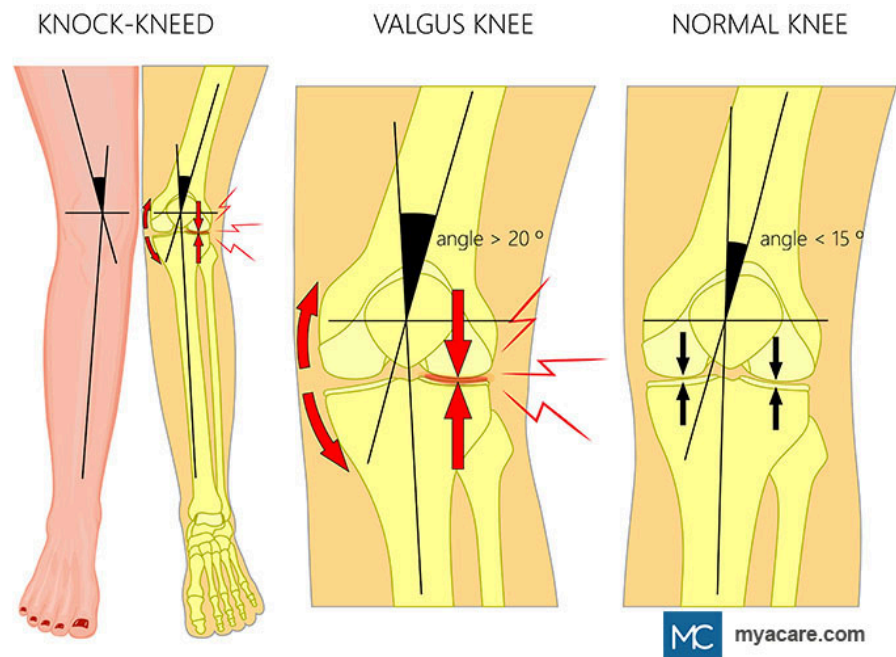


Figure 2: Knee valgus is a condition where the knees bend inward towards each other, causing the legs to form a "knock-kneed" appearance. This can happen during movements like landing

from a jump or changing direction quickly, putting extra stress on the knee joint and increasing the risk of injury, especially to the ACL ligament [11].

## 2.2. Ankle sprains

**Ankle sprains** are among the most frequent injuries in sports, particularly in activities that require running, jumping, and cutting maneuvers [12]. The ankle joint, shown in Figure 3a, is supported by ligaments on the outside of the ankle, known as the lateral ligament complex, which includes the anterior talofibular, calcaneofibular, and posterior talofibular ligaments [13]. An ankle sprain typically occurs when the foot turns inward and the toes point downward, causing these ligaments to stretch or tear, as shown in Figure 3b [14].

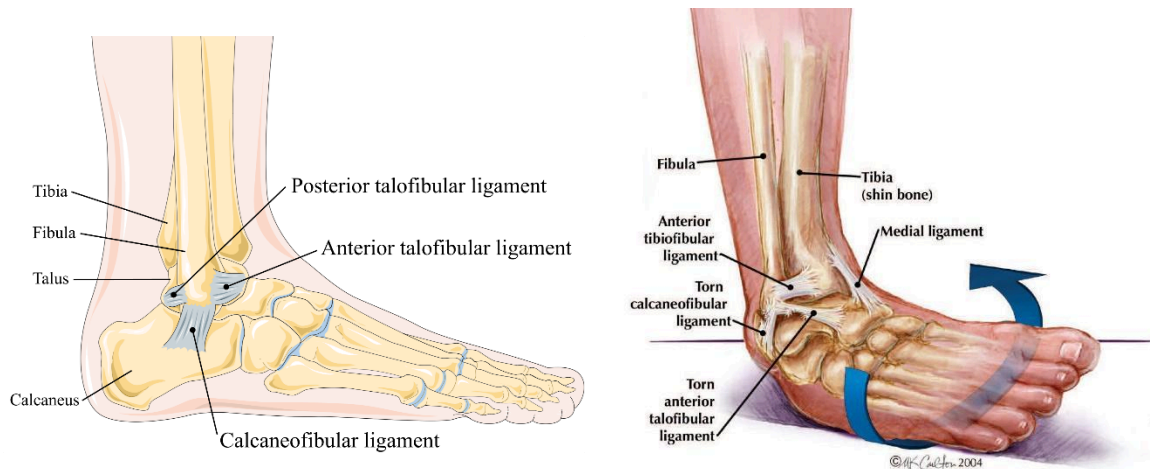


Figure 3: (a): Anatomy of ankle joint [15] (b): Illustration of ankle sprain which typically occurs when the foot turns inward and the toes point downward, causing these ligaments to stretch or tear [16].

## 2.3. Hamstring strains

The **hamstring muscle** group, located in the posterior thigh, consists of the biceps femoris, semitendinosus, and semimembranosus muscles [17]. These muscles are responsible for knee flexion and hip extension. **Hamstring strains** are widespread in sports that involve sprinting, kicking, and sudden acceleration, such as track and field, football, and soccer [18]. The injury usually occurs during eccentric muscle contractions, when the muscle is lengthening while under tension [19]. Figure 4 shows the hamstring muscles and hamstring strain.

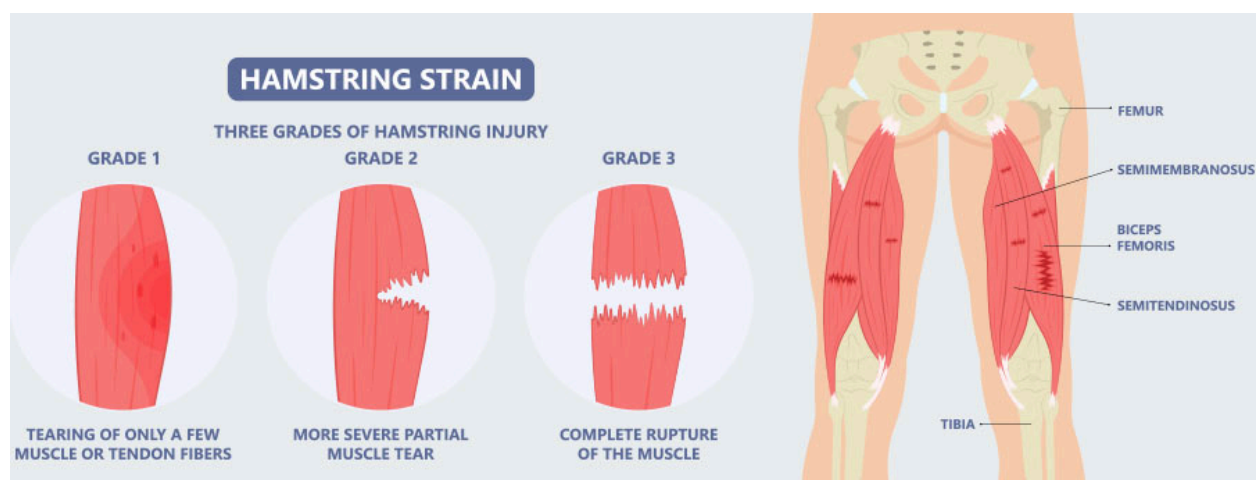


Figure 4: illustration of Hamstring strain and hamstring muscles [20].

## 2.4. Stress fractures

Stress fractures are injuries that happen when a bone is exposed to repeated stress or pressure over time, causing tiny cracks or damage to accumulate within the bone structure [21].

In simpler terms, imagine a wooden plank that you walk on every day. If you jump on the plank once, it might not break. However, if you keep jumping on the same spot day after day, small cracks will start to form and grow, weakening the plank until it eventually breaks. This is similar to how stress fractures develop in bones.

The repeated stress on the bone is usually not enough to cause a complete fracture in a single instance. Instead, the constant pressure leads to the buildup of small amounts of damage within the bone over time. If the bone is not given enough time to heal and repair itself between episodes of stress, these small cracks can grow and become more serious, resulting in a stress fracture.

These fractures, shown in Figure 5, are common in weight-bearing bones, such as the tibia, fibula, and metatarsals, and are often seen in sports that involve running and jumping, like distance running, basketball, and gymnastics [22]. Factors such as sudden increases in training intensity, poor technique, and inadequate recovery contribute to the development of stress fractures [23].

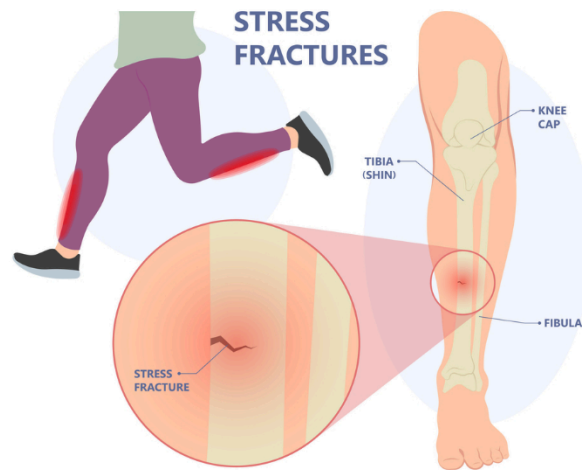


Figure 5: Illustration of stress fractures in weight-bearing bones [24]

### 3. Biomechanical factors and mechanisms

Biomechanical factors play a crucial role in the development and progression of sports injuries. Understanding the mechanical forces, loading patterns, joint alignments, muscle imbalances, and technique flaws that contribute to injury risk is essential for developing effective prevention and management strategies.

#### 3.1. Mechanical forces and loading patterns

The human body is subjected to various mechanical forces during sports activities, including compression, tension, shear, bending, and torsion [25]. The magnitude, direction, and duration of these forces, as well as the loading patterns (e.g., acute vs. repetitive), can significantly influence injury risk [26]. For example, the ACL is more likely to be injured during movements like slowing down, landing, or changing direction, where the knee experiences strong inward bending and twisting forces [27].

#### 3.2. Joint alignment and muscle imbalances

Abnormal joint alignments and muscle imbalances can change how stress is spread across joints and soft tissues, leading to increased injury risk [28]. For example, knee valgus alignment, which can happen due to tight muscles on the inside of the thigh or weak muscles on the outside of the hip, is associated with a higher chance of injuring the ACL (a knee ligament) [9]. Similarly, imbalances between the quadriceps (muscles in the front of the thigh) and hamstring muscle

groups (muscles in the back of the thigh), where the quadriceps are much stronger than the hamstrings, can contribute to hamstring strains and other leg injuries [29].

### 3.3. Technique flaws and overuse

Improper technique and overuse (overworking the body) are common reasons for sports injuries. Using the wrong technique, like landing with the knees bent too far inward (excessive knee valgus) or running with excessive rearfoot eversion (the feet rolling in too much), can lead to abnormal loading patterns and put extra stress on the body in ways it's not meant to handle [30]. Figure 6 shows the excessive rearfoot eversion, which leads to ankle sprain. Overuse injuries, like stress fractures, frequently happen when an athlete repeatedly puts stress on their body without giving it enough time to rest and heal (repetitive submaximal loading) [31]. These risks can be reduced by having a coach teach proper techniques, analyzing movements to spot problems, and creating a training plan that includes enough rest [32].

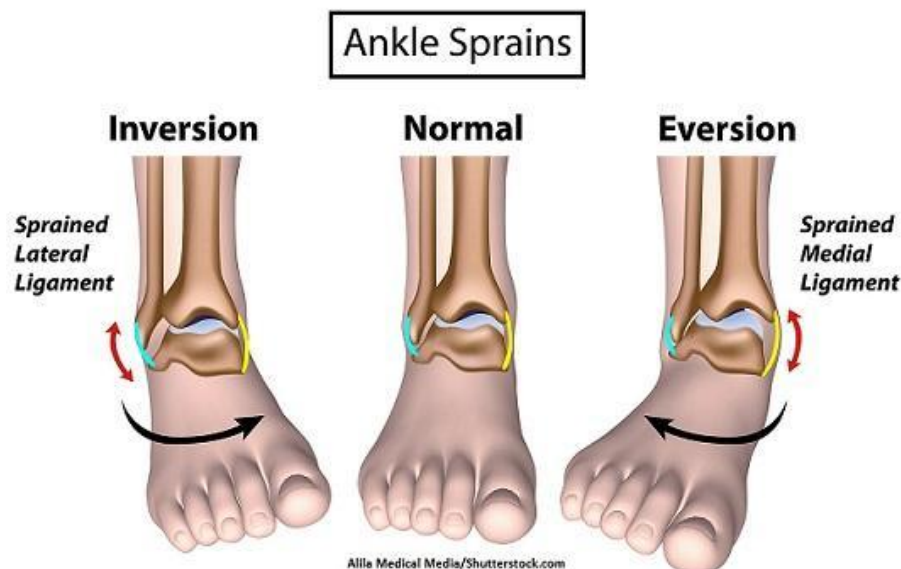


Figure 6: illustration of the two ankle sprain cases (Inversion vs Eversion)[33].

### 3.4. Acute vs. chronic injury mechanisms

Sports injuries can be classified into two main types based on how they happen and progress over time. The first type is acute injuries, such as ankle sprains or ACL tears, which occur suddenly, usually as a result of a single traumatic event [34]. The second type is chronic injuries, which develop slowly over time. These injuries, such as stress fractures or tendon problems, happen because of repeated small injuries that don't heal properly [35]. To prevent and treat



these injuries effectively, it's important to understand the specific ways in which they occur and affect the body [36].

## 4. Biomechanical principles

Biomechanical principles can provide insights into the mechanical factors that influence injury risk and therefore guide the development of targeted prevention strategies. Some of the key biomechanical principles include:

### 4.1. Force-velocity relationship

The force-velocity relationship is a key concept in understanding how muscles work and how they can be injured. In simple terms, it means that the force a muscle can produce depends on how quickly it's contracting or shortening [37, 38].

When a muscle contracts and shortens, it's called a concentric contraction. During this type of contraction, the faster the muscle tries to shorten, the less force it can generate. This is important because many athletic activities, like sprinting or jumping, require muscles to generate high forces at high speeds [37, 39].

For example, when you're sprinting, your leg muscles need to contract quickly to propel you forward. The force-velocity relationship tells us that there's a limit to how much force these muscles can produce at high speeds. If you try to run faster than your muscles can handle, you risk overloading them and causing a strain injury [38, 40].

This principle also helps explain why different types of training can improve athletic performance and reduce injury risk. For instance, plyometric exercises, which involve rapid stretching and contracting of muscles (like jumping), can help train muscles to generate more force at high velocities. This can improve sprinting speed and jumping height [39, 41, 42].

On the other hand, heavy resistance training, which involves lifting weights at slower speeds, can help muscles generate more force at lower velocities. This type of training is important for building overall strength and power, which can also reduce injury risk [41, 43].

In summary, the force-velocity relationship describes how muscle force output changes with contraction speed. Understanding this principle can help coaches and athletes design training programs that optimize performance and minimize injury risk by considering the specific demands placed on muscles during different activities [37, 41].

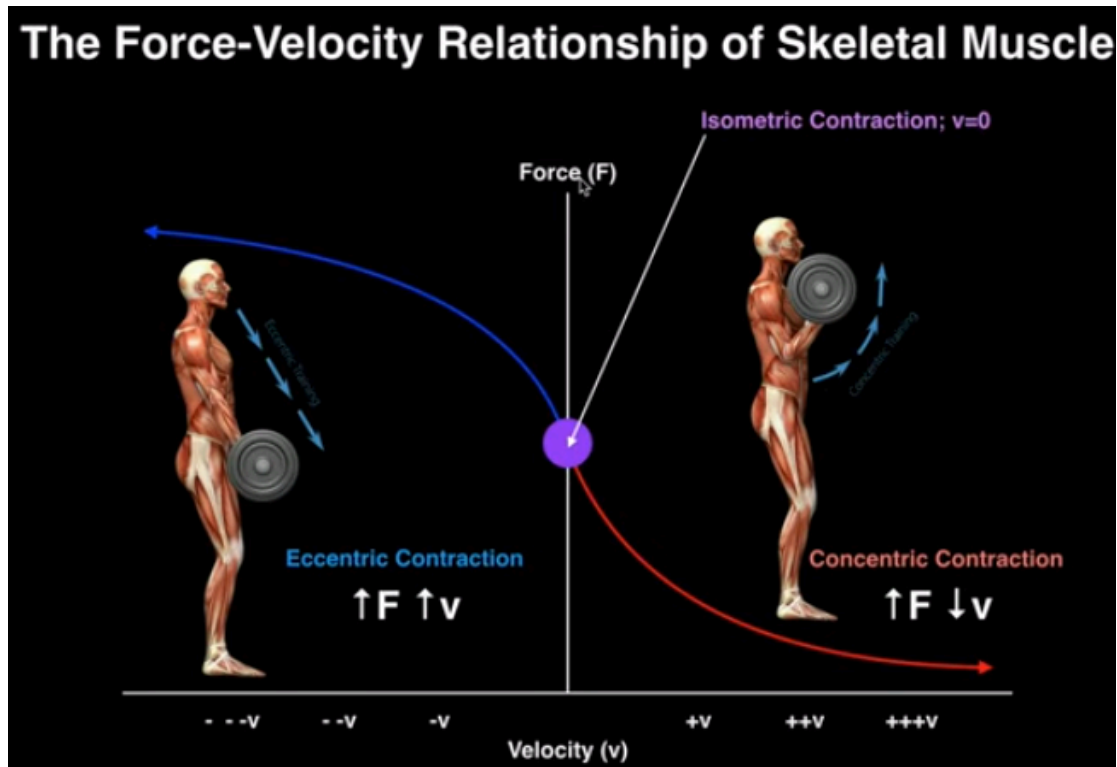


Figure 7: The force-velocity relationship of skeletal muscle [44].

#### 4.2. Viscoelastic properties of tissues

Biological tissues, such as ligaments and tendons, exhibit viscoelastic behavior. They have both elastic properties (ability to return to original shape after deformation) and viscous properties (resistance to deformation that depends on loading rate) [45]. The viscoelastic nature of these tissues allows them to absorb and dissipate energy, but also makes them susceptible to fatigue and overuse injuries. For instance, the Achilles tendon can store and release elastic energy during running, but repetitive loading without sufficient recovery can lead to tendinopathy [46].

#### 4.3. Joint kinematics and kinetics

Joint kinematics and kinetics are two essential concepts in understanding human movement and injury risk. Kinematics refers to the angles, speeds, and accelerations of joints during movement, while kinetics describes the forces and moments acting on those joints. Joint angles, such as the knee angle between the thigh and lower leg (shown in Figure 8), can influence the stress placed on the joint and the risk of injury. High joint velocities and accelerations can also increase the stress on joints and surrounding tissues. Forces experienced by muscles, bones, and other tissues during movement can compress, pull apart, or slide the joint in different directions, and excessive force can lead to injury. Moments, which are rotational forces causing a joint to bend or twist, can also contribute to injury risk when they are high. By analyzing joint

kinematics and kinetics, researchers can identify high-risk movement patterns and develop targeted interventions [25, 47, 48] ,[49].

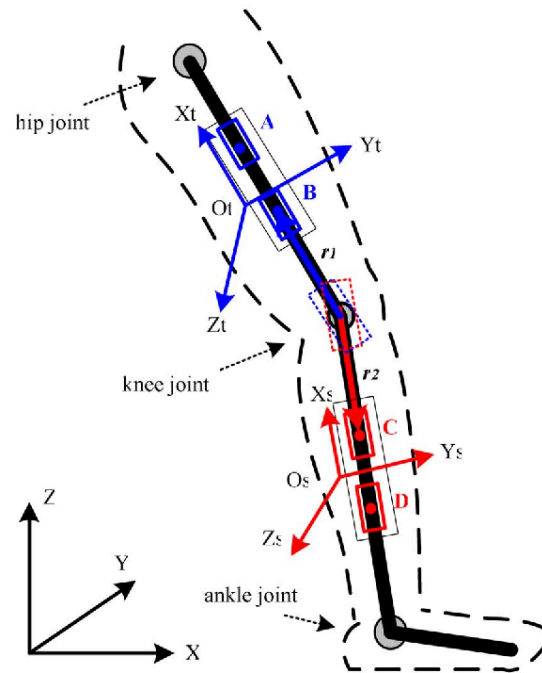


Figure 8: Illustration showing the placement of sensors on the leg to measure knee angles [50].

#### 4.4. Ground reaction forces

The forces exerted by the ground on the body during weight-bearing activities, such as running and jumping, are known as ground reaction forces (GRF). The magnitude, direction, and timing of these forces can influence injury risk [51]. For instance, when we land from a jump, if the force pushing up against our feet is too strong, it can lead to small cracks in our bones called stress fractures, as shown in Figure 9. Similarly, when we quickly change direction while running, strong sideways forces can stretch the ligaments in our knees and ankles too much, causing sprains [52].

By changing the way we land from jumps or change direction while running, we can reduce the peak ground reaction forces. This means the maximum force acting on our body at any given moment will be lower. When we lower these peak forces, we can reduce our chances of getting injured.

Think of it like jumping onto a hard floor versus a cushioned mat. The mat absorbs some of the force, making the impact on your body less intense. Similarly, by landing more softly or changing direction more smoothly, we can decrease the stress placed on our bones and ligaments, lowering the risk of injury.

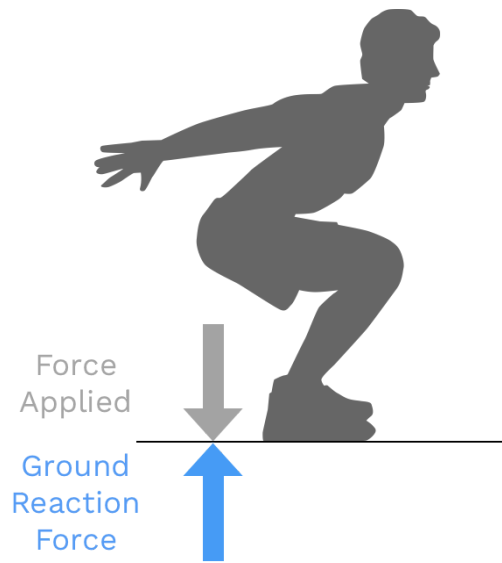


Figure 9: Illustration of the ground reaction force (GRF), which is the force exerted by the ground on the body during weight-bearing activities, such as running and jumping [53].

## 5. Injury prevention strategies

Preventing sports injuries is a key priority for athletes, coaches, and healthcare professionals. By applying biomechanical principles, emphasizing proper technique, conditioning, and interventions, and considering equipment factors, the risk of injury can be significantly reduced.

### 5.1. Application of biomechanical principles

Understanding and applying the biomechanical principles is essential for preventing sports injuries. This involves analyzing the forces, movements, and loading patterns associated with specific activities and developing strategies to minimize excessive stress on tissues [54]. For example, teaching athletes proper landing mechanics, such as landing with a softer, more flexed knee and avoiding excessive knee valgus, can help reduce the risk of ACL injuries [55].

### 5.2. Proper Technique, Conditioning, and Targeted Interventions

Coaches and trainers should focus on teaching athletes the correct way to move, position their bodies, and perform skills to reduce the risk of getting hurt. This means showing them how to run, jump, and land properly. Scientists have developed special training programs that target specific risk factors and include exercises to improve strength, balance, and muscle control. These programs have been shown to help prevent injuries [4, 56, 57].

There are specific programs designed to prevent certain types of injuries. For example, soccer players can do exercises to learn how to land safely, improve their power and control through

jumping exercises, and strengthen their core muscles to help prevent ACL (knee) injuries. Basketball players can work on balance exercises and strengthen the muscles on the outside of their lower leg to help prevent ankle sprains. By making these targeted exercises a regular part of their training, athletes can lower their chances of getting hurt by improving the way they move and addressing risk factors related to how their body works [5, 58, 59].

### 5.3. Equipment considerations

The use of appropriate equipment can play a significant role in preventing sports injuries. This includes wearing properly fitted and maintained protective gear, such as helmets, mouthguards, and padding, which can help absorb impact forces and reduce the risk of traumatic injuries [60]. Additionally, using appropriate footwear that provides adequate support, cushioning, and traction for the specific sport and playing surface can help prevent overuse injuries like stress fractures and ankle sprains [61].

## 6. Rehabilitation and return to play

After an injury, proper rehabilitation and a well-planned return to play process are essential for athletes to recover fully and minimize the risk of reinjury. Biomechanical considerations, progressive loading, functional movement, and assessing readiness to return to sport are key components of this process.

### 6.1. Biomechanical considerations in rehabilitation

During rehabilitation, it's important to consider the biomechanical factors that may have contributed to the initial injury and address them through targeted exercises and interventions [62]. For instance, if an athlete has recently sprained their ankle, the rehabilitation process should include exercises that improve balance, help the athlete better sense the position of their ankle, and strengthen the muscles around the ankle joint. This can be accomplished through activities like balancing on one foot, using resistance bands, and practicing on uneven surfaces like wobble boards, as shown in Figure 10 [63].



Figure 10: single-leg balancing exercise on uneven surface for ankle sprain rehabilitation [64].

## 6.2. Progressive loading and functional movement

Progressive loading involves gradually increasing the stress placed on the injured tissue to stimulate healing and improve its capacity to handle forces [65]. This is typically done through a combination of strength training, cardiovascular conditioning, and functional exercises that mimic the demands of the athlete's sport [66]. For instance, a basketball player recovering from a hamstring strain might start with gentle stretching and light resistance exercises, then progress to running, jumping, and finally, sport-specific drills like layups and defensive slides.

Functional movement refers to exercises that simulate the movements and demands of the athlete's sport [67]. These exercises help retrain proper movement patterns, improve neuromuscular control, and build confidence in the injured area. Examples include running and cutting drills for soccer players, throwing progressions for baseball pitchers, and plyometric exercises for volleyball players.

## 6.3. Determining readiness for return to play

Deciding when an athlete is ready to return to their sport is a critical step in the rehabilitation process. This decision should be based on a combination of factors, including pain, range of motion, strength, endurance, and the ability to perform sport-specific tasks without compensation or increased injury risk [68]. Objective criteria, such as strength and functional performance tests, can help guide this decision [69].

For example, a soccer player recovering from an ACL reconstruction might be required to demonstrate a certain level of quadriceps and hamstring strength, complete a series of agility drills without pain or hesitation, and participate in full-contact practice without any issues before being cleared to return to competition.

Throughout the rehabilitation and return to play process, ongoing biomechanical assessment and monitoring can help ensure that the athlete is progressing appropriately and minimize the risk of reinjury [70].

# 7. Emerging technologies and methodologies

Despite significant advancements in understanding the biomechanics of sports injuries, there are still areas where more research is needed.

New technologies and research methods are providing exciting opportunities to advance our understanding of sports injury biomechanics. For instance, wearable sensors, like accelerometers and gyroscopes, can be used to track athlete movements and loads during training and competition [71]. This real-time data can help identify high-risk movement patterns or workload levels that may increase injury risk, allowing for earlier intervention and prevention.

Advanced imaging techniques, such as high-resolution MRI and CT scans, are also providing new insights into the structure and function of tissues involved in sports injuries [72]. These techniques can help researchers better understand how injuries occur at the tissue level and develop more targeted rehabilitation strategies.

Computer modeling and simulation are another promising area of research. By creating digital models of the human body and simulating various sports movements and loading scenarios, researchers can study injury mechanisms and test potential prevention strategies without putting athletes at risk [73]. These models can also be used to optimize rehabilitation protocols and guide return to play decisions.

## **Conclusion & Future work**

In conclusion, understanding the biomechanics of sports injuries is crucial for effective prevention and management strategies. By examining the factors and mechanisms underlying common injuries, such as ACL tears, ankle sprains, hamstring strains, and stress fractures, we can emphasize the importance of proper technique, conditioning, and equipment in reducing injury risk. These insights have significant implications for sports injury prevention and management, highlighting the need for individualized rehabilitation programs, evidence-based return to play decisions, and ongoing research using emerging technologies and methodologies. By applying these biomechanical principles and staying current with the latest research findings, we can work towards a future where sports injuries are less prevalent, and athletes can perform at their best while minimizing the risk of injury.

While much has been learned about the biomechanical factors contributing to sports injuries, there are still many questions that remain unanswered. For example, although we know that certain movement patterns, like landing with knock knees, can increase the risk of ACL injuries, we don't fully understand why some athletes with these patterns get injured while others don't [74]. More research is needed to identify additional risk factors, such as genetics or psychological factors, that may interact with biomechanics to influence injury risk.

## References

1. Prien, A., et al., *Health problems in former elite female football players: prevalence and risk factors*. Scandinavian journal of medicine & science in sports, 2017. **27**(11): p. 1404-1410.
2. *Sports and recreational injuries*. 2022 [cited 2024 04/28/2024]; Available from: <https://injuryfacts.nsc.org/home-and-community/safety-topics/sports-and-recreational-injuries/>.
3. Knudson, D.V. and D. Knudson, *Fundamentals of biomechanics*. Vol. 183. 2007: Springer.
4. Bahr, R. and T. Krosshaug, *Understanding injury mechanisms: a key component of preventing injuries in sport*. British journal of sports medicine, 2005. **39**(6): p. 324-329.
5. Emery, C.A., et al., *Neuromuscular training injury prevention strategies in youth sport: a systematic review and meta-analysis*. British journal of sports medicine, 2015. **49**(13): p. 865-870.
6. Duthon, V., et al., *Anatomy of the anterior cruciate ligament*. Knee surgery, sports traumatology, arthroscopy, 2006. **14**: p. 204-213.
7. Griffin, L.Y., et al., *Understanding and preventing noncontact anterior cruciate ligament injuries: a review of the Hunt Valley II meeting, January 2005*. The American journal of sports medicine, 2006. **34**(9): p. 1512-1532.
8. Shimokochi, Y. and S.J. Shultz, *Mechanisms of noncontact anterior cruciate ligament injury*. Journal of athletic training, 2008. **43**(4): p. 396-408.
9. Hewett, T.E., G.D. Myer, and K.R. Ford, *Anterior cruciate ligament injuries in female athletes: Part 1, mechanisms and risk factors*. The American journal of sports medicine, 2006. **34**(2): p. 299-311.
10. *Anterior cruciate ligament (ACL) injury*. [cited 2024 04/28/2024]; Available from: <https://complete-physio.co.uk/anterior-cruciate-ligament-acl-injury/>.
11. Alimoradi, M. *KNOCK KNEES (GENU VALGUM): SYMPTOMS, CAUSES, DIAGNOSES, AND TREATMENT*. 2021; Available from: <https://myacare.com/blog/knock-knees-genu-valgum-symptoms-causes-diagnoses-and-treatment>.
12. Fong, D.T.-P., et al., *A systematic review on ankle injury and ankle sprain in sports*. Sports medicine, 2007. **37**: p. 73-94.
13. Golanó, P., et al., *Anatomy of the ankle ligaments: a pictorial essay*. Knee Surgery, Sports Traumatology, Arthroscopy, 2010. **18**: p. 557-569.
14. Hertel, J., *Functional anatomy, pathomechanics, and pathophysiology of lateral ankle instability*. Journal of athletic training, 2002. **37**(4): p. 364.
15. Christ, T. *Kenneth Walker's Foot Injury*. 2022 [cited 2024 04/28/2024]; Available from: <https://fantasyinjuryteam.com/2022/12/06/kenneth-walkers-foot-injury/>.
16. *Ankle Sprains*. [cited 2024 04/28/2024]; Available from: <https://instituteforathleticmedicine.com/specialties/foot-and-ankle/ankle-sprains/>.
17. Koulouris, G. and D. Connell, *Evaluation of the hamstring muscle complex following acute injury*. Skeletal radiology, 2003. **32**: p. 582-589.



18. Opar, D.A., M.D. Williams, and A.J. Shield, *Hamstring strain injuries: factors that lead to injury and re-injury*. Sports medicine, 2012. **42**: p. 209-226.
19. Heiderscheit, B.C., et al., *Hamstring strain injuries: recommendations for diagnosis, rehabilitation, and injury prevention*. Journal of orthopaedic & sports physical therapy, 2010. **40**(2): p. 67-81.
20. *Hamstring Injury: Causes, Symptoms And Treatment*. 2021.
21. Warden, S.J., D.B. Burr, and P.D. Brukner, *Stress fractures: pathophysiology, epidemiology, and risk factors*. Current osteoporosis reports, 2006. **4**(3): p. 103-109.
22. Bennell, K.L. and P.D. Brukner, *Epidemiology and site specificity of stress fractures*. Clinics in sports medicine, 1997. **16**(2): p. 179-196.
23. Romani, W.A., et al., *Mechanisms and management of stress fractures in physically active persons*. Journal of athletic training, 2002. **37**(3): p. 306.
24. *STRESS FRACTURE: TYPES, SYMPTOMS, CAUSES & TREATMENT*. [cited 2024 04/28/2024]; Available from: <https://orthoimplantsindia.com/stress-fracture-types-symptoms-causes-treatment/>.
25. Nigg, B.M. and W. Herzog, *Biomechanics of the Musculo-skeletal System*. 2007: Wiley.
26. Zernicke, R. and W. Whiting, *Mechanisms of musculoskeletal injury*. Biomechanics in Sport: Performance Enhancement and Injury Prevention, 2000: p. 507-522.
27. Hewett, T.E., et al., *Biomechanical measures of neuromuscular control and valgus loading of the knee predict anterior cruciate ligament injury risk in female athletes: a prospective study*. The American journal of sports medicine, 2005. **33**(4): p. 492-501.
28. Sahrmann, S., *Diagnosis and Treatment of Movement Impairment Syndromes-E-Book*. 2001: Elsevier Health Sciences.
29. Croisier, J.-L., *Factors associated with recurrent hamstring injuries*. Sports medicine, 2004. **34**: p. 681-695.
30. Boling, M.C., et al., *A prospective investigation of biomechanical risk factors for patellofemoral pain syndrome: the Joint Undertaking to Monitor and Prevent ACL Injury (JUMP-ACL) cohort*. The American journal of sports medicine, 2009. **37**(11): p. 2108-2116.
31. Warden, S.J., I.S. Davis, and M. Fredericson, *Management and prevention of bone stress injuries in long-distance runners*. Journal of orthopaedic & sports physical therapy, 2014. **44**(10): p. 749-765.
32. Vescovi, J. and J.L. VanHeest, *Effects of an anterior cruciate ligament injury prevention program on performance in adolescent female soccer players*. Scandinavian journal of medicine & science in sports, 2010. **20**(3): p. 394-402.
33. *Inversion and Eversion*. Available from: <https://www.registerednurses.com/inversion-and-eversion/>.
34. Krosshaug, T., et al., *Research approaches to describe the mechanisms of injuries in sport: limitations and possibilities*. British journal of sports medicine, 2005. **39**(6): p. 330-339.

35. Cook, J. and C.R. Purdam, *Is tendon pathology a continuum? A pathology model to explain the clinical presentation of load-induced tendinopathy*. British journal of sports medicine, 2009. **43**(6): p. 409-416.
36. Bahr, R. and I. Holme, *Risk factors for sports injuries—a methodological approach*. British journal of sports medicine, 2003. **37**(5): p. 384-392.
37. Hill, A.V., *The heat of shortening and the dynamic constants of muscle*. Proceedings of the Royal Society of London. Series B-Biological Sciences, 1938. **126**(843): p. 136-195.
38. Lieber, R.L. and J. Fridén, *Functional and clinical significance of skeletal muscle architecture*. Muscle & Nerve: Official Journal of the American Association of Electrodiagnostic Medicine, 2000. **23**(11): p. 1647-1666.
39. Cormie, P., M.R. McGuigan, and R.U. Newton, *Developing maximal neuromuscular power: Part 1—Biological basis of maximal power production*. Sports medicine, 2011. **41**: p. 17-38.
40. Garrett Jr, W.E., *Muscle strain injuries: clinical and basic aspects*. Medicine and science in sports and exercise, 1990. **22**(4): p. 436-443.
41. Haff, G.G. and N.T. Triplett, *Essentials of strength training and conditioning 4th edition*. 2015: Human kinetics.
42. Markovic, G. and P. Mikulic, *Neuro-musculoskeletal and performance adaptations to lower-extremity plyometric training*. Sports medicine, 2010. **40**: p. 859-895.
43. Suchomel, T.J., et al., *The importance of muscular strength: training considerations*. Sports medicine, 2018. **48**: p. 765-785.
44. *Exercise Physiology | Skeletal Muscle Force-Velocity Relationship*.
45. Fung, Y.-c., *Biomechanics: mechanical properties of living tissues*. 2013: Springer Science & Business Media.
46. Magnan, B., et al., *The pathogenesis of Achilles tendinopathy: a systematic review*. Foot and Ankle Surgery, 2014. **20**(3): p. 154-159.
47. Zajac, F.E., *Muscle coordination of movement: a perspective*. Journal of biomechanics, 1993. **26**: p. 109-124.
48. Hamill, J. and K.M. Knutzen, *Biomechanical basis of human movement*. 2006: Lippincott Williams & Wilkins.
49. Winter, D.A., *Biomechanics and motor control of human movement*. 2009: John wiley & sons.
50. Kun, L., et al., *Ambulatory Estimation of Knee-Joint Kinematics in Anatomical Coordinate System Using Accelerometers and Magnetometers*. IEEE Transactions on Biomedical Engineering, 2011. **58**: p. 435-442.
51. Besier, T.F., et al., *External loading of the knee joint during running and cutting maneuvers*. Medicine & Science in Sports & Exercise, 2001. **33**(7): p. 1168-1175.
52. Zadpoor, A.A. and A.A. Nikooyan, *The relationship between lower-extremity stress fractures and the ground reaction force: a systematic review*. Clinical biomechanics, 2011. **26**(1): p. 23-28.
53. *Force Plate Technology*. Available from: <https://success.spartascience.com/en/knowledge/force-plate-technology>.
54. McGinnis, P.M., *Biomechanics of sport and exercise*. 2013: Human Kinetics.

55. Myklebust, G., et al., *Prevention of anterior cruciate ligament injuries in female team handball players: a prospective intervention study over three seasons*. Clinical journal of sport medicine, 2003. **13**(2): p. 71-78.
56. Lauersen, J.B., D.M. Bertelsen, and L.B. Andersen, *The effectiveness of exercise interventions to prevent sports injuries: a systematic review and meta-analysis of randomised controlled trials*. British journal of sports medicine, 2014. **48**(11): p. 871-877.
57. Sugimoto, D., et al., *Specific exercise effects of preventive neuromuscular training intervention on anterior cruciate ligament injury risk reduction in young females: meta-analysis and subgroup analysis*. British journal of sports medicine, 2015. **49**(5): p. 282-289.
58. Silvers-Granelli, H., et al., *Efficacy of the FIFA 11+ injury prevention program in the collegiate male soccer player*. The American journal of sports medicine, 2015. **43**(11): p. 2628-2637.
59. Taylor, J.B., et al., *Prevention of lower extremity injuries in basketball: a systematic review and meta-analysis*. Sports health, 2015. **7**(5): p. 392-398.
60. McIntosh, A.S. and D. Janda, *Evaluation of cricket helmet performance and comparison with baseball and ice hockey helmets*. British journal of sports medicine, 2003. **37**(4): p. 325-330.
61. Yeung, S.S., E.W. Yeung, and L.D. Gillespie, *Interventions for preventing lower limb soft-tissue running injuries*. Cochrane database of systematic reviews, 2011(7).
62. Houglum, P.A., *Therapeutic exercise for musculoskeletal injuries 4th edition*. 2016: Human Kinetics.
63. Kaminski, T.W., et al., *National Athletic Trainers' Association position statement: conservative management and prevention of ankle sprains in athletes*. Journal of athletic training, 2013. **48**(4): p. 528-545.
64. *CobbleFoam™ Uneven-Surface Balance Trainer*. Available from: <https://www.optp.com/Cobblefoam-Uneven-Surface-Balance-Trainer>.
65. Lorenz, D.S., M.P. Reiman, and J.C. Walker, *Periodization: current review and suggested implementation for athletic rehabilitation*. Sports Health, 2010. **2**(6): p. 509-518.
66. Reiman, M.P. and D.S. Lorenz, *Integration of strength and conditioning principles into a rehabilitation program*. International journal of sports physical therapy, 2011. **6**(3): p. 241.
67. Leetun, D.T., et al., *Core stability measures as risk factors for lower extremity injury in athletes*. Medicine & Science in Sports & Exercise, 2004. **36**(6): p. 926-934.
68. Ardern, C.L., et al., *2016 Consensus statement on return to sport from the First World Congress in Sports Physical Therapy, Bern*. British journal of sports medicine, 2016. **50**(14): p. 853-864.
69. Kyritsis, P., et al., *Likelihood of ACL graft rupture: not meeting six clinical discharge criteria before return to sport is associated with a four times greater risk of rupture*. British journal of sports medicine, 2016. **50**(15): p. 946-951.

70. Paterno, M.V., et al., *Biomechanical measures during landing and postural stability predict second anterior cruciate ligament injury after anterior cruciate ligament reconstruction and return to sport*. The American journal of sports medicine, 2010. **38**(10): p. 1968-1978.
71. Chambers, R., et al., *The use of wearable microsensors to quantify sport-specific movements*. Sports medicine, 2015. **45**: p. 1065-1081.
72. Linklater, J.M., *Imaging of sports injuries in the foot*. AJR Am J Roentgenol, 2012. **199**(3): p. 500-8.
73. Erdemir, A., et al., *Model-based estimation of muscle forces exerted during movements*. Clinical biomechanics, 2007. **22**(2): p. 131-154.
74. Bahr, R., *Why screening tests to predict injury do not work—and probably never will...: a critical review*. British journal of sports medicine, 2016. **50**(13): p. 776-780.