How To Avoid and Fix Runner's Knee, IT Band Syndrome and Achilles Tendinitis

Three simple steps to fix three common running injuries in new and advanced runners

00:01.162 Daren DLake Runs: Picture this, you're a runner and you got hurt. You're searching all over the internet for quick fixes, hacks, so that you can keep running, but you get more confused and don't know who to trust and what to trust. In this episode, we'll hopefully cut through all of that and make it so easy for you to get back to the road of recovery with pro medical advice from a professional. What you'll learn along the way of all this diagnosis, short-term and long-term treatment from a professional physio slash physical therapist of the following, runner's knee, IT band syndrome, and Achilles tendinopathy, and a bunch more. Oh, why should you believe me? And who am I? Well, I'm Darren D. Lake Runs. I've been running since 1994. I'm a three-hour marathon runner and a 10-hour Ironman triathlon finisher and still trying to get sub-60 minutes in the 5K. Still trying. TBD on that. And since 2012, I've been researching, experimenting, and talking to experts on how to get 1% better each day in my training, racing, and life, all to make it that much simpler and easier for you. I'll be joined by Sam Shearman, a Sydney-based physio slash physical therapist who specializes in running-related injuries. She holds first class honors degree in exercise and sports science and a master's of physiotherapy. Her experience spans various settings, including sports clubs and institutes. She also developed the 10W2S 10 Weeks to Strength for Runners app, which is so dope and simple and one of the best strength training apps for all types of runners that I think, and is passionate about

helping runners manage their training and their injuries. Last, if you're listening via audio only, please make sure to have a look at the links in the show notes, specifically the episode website because in our convo sam goes into super detail about a lot of things like how to do strength training movements body position etc and having a visual alongside of these concepts will help you understand it much better enough from me let's go case number one We have Sarah, who is a 32 year old woman who has recently started running after being relatively sedentary. So she's been sitting around, not doing anything. She's completed a couch to 5k program. Everyone loves that. It's now running three or four times per week, but has been experiencing pain in her knee. Specifically, she reports pain around the kneecap, especially when going up or downstairs or when sitting for long periods with her knees bent. So with our framework, that I've described, what would you diagnose her with?

02:32.907 Sam - 10W2S: This sounds like patellofemoral pain syndrome, also known as runner's knee.

02:40.514 Sam - 10W2S: Oh, I see lots of these actually, and I always want to reassure the athlete or the patient, like this is okay, this is normal, these things can happen with running, particularly more so with novice runners. Considering it's her first injury, a lot of it is education on how to balance. running training. She's just finished the Couch to 5K program, which I think is fantastic to have that gradual increase in time and kilometers. But I do see once they finish that program and they start, they got, you know, really confident and start running, you know, 5Ks four times a week, and it's still rapidly loading up the structures in her knee, and that's what's led to this presentation. So a bit of education with the first session. Secondly, I don't recommend anti-inflammatories for all injuries, but this one would do well with a bit of ibuprofen. So I'd recommend ibuprofen twice a day, five days or so. I prefer ibuprofen over other anti-inflammatories because it's better for your tendons. Then we'd look at doing a bit of quads release work, simply because when the knee's in pain, quads don't fire as well. We just want to get a bit of release work through there. Then we can start looking at strength. Now, my go-to exercise for presentation... Oh, hold on.

03:47.313 Daren DLake Runs: Sorry, so that was immediate treatment, so she came in for that first visit. Yes, yeah. And now, would you do strength even in that first visit? Absolutely, yeah. Oh, okay.

03:54.338 Sam - 10W2S: All right, cool. So what we'd do with her is we'd get the ball rolling with strength. Likely go to doing a wall sit. Wall sits are a nice way to get some quads activation without actually stressing the knee joint. You just need to make sure the person has the feet far enough in front of their body so when they sit down into the squat, they're not compressing the knee joint because we already know it's inflamed. That's usually the first place where I'd start. Get them to have the ibuprofen. Unfortunately, no running this week. The pain is too high. And then in the week's time, we could see if it's settled down and whether or not we can get her doing some run, walk, run stuff again. I don't like to hold runners or patients back from running too long because then we just see a further decrease

in their load tolerance and it gets harder for them to re-enter the training they've been doing. But the pain's got to be at an acceptable level.

04:41.277 Daren DLake Runs: All right, so what would ongoing treatment and strength training program be for Sarah?

04:47.539 Sam - 10W2S: So the best evidence with patella femoral pain syndrome is strengthening the quadriceps as well as the hip, the glute medius, so hip stabilizers. So a lot of her training will be around that. You usually start with something less functional and then you want to then progress into function. So you may start off with a side-lying leg raise with a band to start getting some work through the glute medius. And also again, your wall squats, split stance wall squats, eventually moving into exercises such as the Bulgarian split squat, because it's targeting both our key muscles, the quads and the glutes.

05:21.356 Daren DLake Runs: Which we talked about in possibly the episode before this or after this, and we'll have videos and stuff on that. Keep going.

05:29.167 Sam - 10W2S: As she progresses, and this is once her pain's more on an acceptable level, and I say acceptable being less than a 5 out of 10, it's responding well in that 24 hours after running, we then look at, you know, continuing to improve at the kilometers that she's doing. I probably would have re-entered her somewhere in the Couch to 5K program, you know, you could always do like three weeks back to, you know, four weeks back, whatever she can comfortably do and continue on with. You could also consider gait retraining. Again, I'd leave this to later on because you don't want to throw too much stuff at this novice runner straight away. But once she's back running, we could look at how many steps she's doing per minute, what her stride looks like, and see if we can take the load off the knee by increasing cadence.

06:09.902 Daren DLake Runs: Is gait retraining similar to like running form?

06:12.424 Sam - 10W2S: Yeah, it's looking at your running form and what we can do differently to offload certain structures.

06:17.228 Daren DLake Runs: Got you. All right, so you've already talked about the follow-up, the ongoing strength training, immediate training, and what the diagnosis is. Anything else you want to say that people might not know about runner's knee?

06:28.798 Sam - 10W2S: Well, runner's knee in general, well, it's an umbrella term, so it's considered a clinical pain syndrome, so it's not one specific structure that we can blame for this presentation, but it may be the cartilage is a little bit irritated, it may be that there's some joint inflammation, even the neural structures, whether or not they're a bit sensitive at the moment, but it's a combination of factors which leads to this presentation.

06:50.611 Daren DLake Runs: All right, so it's not something to freak out about, as you said?

06:54.634 Sam - 10W2S: No, no, no, and I understand how, again, more novice runners get a bit freaked out with this condition, but it's just about settling the pain and then getting things stronger again and gradually building up your running kilometers.

07:06.540 Daren DLake Runs: Yeah, would you say, my last kind of Darren weirdo contrarian question, you don't see this in the advanced and more experienced and pro runners, would you say that more injuries for elite runners happen below the knee and then more of the novice runners it happens like above the knee in the hip area?

07:28.197 Sam - 10W2S: Not quite, because the most common condition with all runners, but again, particularly more so in novice runners, is medial tibial stress syndrome. So that's shin splints. So that's a key one we see a lot of the time. But runners' knee I do see, again, more frequently with novice runners. I haven't got any data on it, but just from my clinical observations, I see much more newer runners with this condition.

07:49.382 Daren DLake Runs: Right now is the part where I go, hey, if you're not feeling this, make sure you subscribe. Right. Share it out with your friends about how amazing this is. Rah, rah, rah, rah, rah. All right. While you should go out and do that anyway, how about I actually give you something that will help you? Is the running, health and fitness and endurance sport internet too much sometimes? Is it too much conflicting content on how to train right? Or you just don't have time to read and watch the latest trends on how to, I don't know, carb cycle for your next marathon. Don't worry. I'll take care of that for you by showing you how to train, race and live 1% better consistently. To do this, just sign up for my free newsletter, OPB. I figure out this whole 1% better thing so you don't have to by scouring the endurance sports deepest and darkest corners of the internet. Go to DLakeCreates.com forward slash news, all spelled the normal way, to be inspired and motivated on the regular. Let's get back into it. All right, moving on to the next case, number two. We've got John, who is a 45-year-old male who has been running consistently for the past year, averaging about 15 miles per week. That is 25 miles, is that? Yeah, 25-ish mile, uh, 25 kilometers. So 25 per week, sorry. Yeah, so, yeah, 15 miles for Americans, because I know half my audience, if not more, is American, and then, uh, 25 kilometers per week for the rest of the world that uses a system that makes sense on the 10 scale. Uh, Americans get it right, please. I say this all the time. I'm looking at Americans, get it right. and that will never happen. He has recently been experiencing pain on the outside of his left knee that he describes as a dull ache or burning sensation. The pain tends to come on during longer runs, especially when going downhill, and he rates it as a 7 out of 10 at its worst. He has tried foam rolling and stretching that area and as well as taking a few days from running, but the pain persists. What would you call this?

09:41.966 Sam - 10W2S: This sounds like iliotibial band syndrome, also known as ITB syndrome.

09:48.210 Daren DLake Runs: All right, just that straight up. I mean, it's a case study. What would be the immediate treatment for it?

09:55.035 Sam - 10W2S: So with ITB syndrome, what happens is the iliotibial band, which is a thick band of fascia that runs along the outside of our leg, it originates from two muscles. So your TFL, tensor fasciae latae, and also your glute max. Where's the TFL? Right at the front of the hips, if you get your hip bone at the front of your hip, you bring your hands down slightly and a little bit more lateral, that's where the TFL sits. ITB comes from those two muscles. It runs down the outside of the leg and attaches onto the tibia. Now with the ITB, if it starts to tension, it will start to compress a little fat bad and bursa that sits on the outside of your knee. That's what gets inflamed. So the immediate treatment sometimes is again, Here I'm recommending anti-inflammatories here, but this is another one I'd say start with some ibuprofen twice a day, five days. This is the initial treatment. You don't want to take anti-inflammatories for too long because it can cause gastrointestinal uptick and stomach ache. So I don't want everyone with ITB to, every time pain comes on, start popping anti-inflammatories. But it's an initial treatment. This hasn't happened before. That would be my go-to. In terms of release work, we want to focus on releasing the TFL in particular. Lots of people think about massage the ITB, let's foam roll the ITB, but that does nothing for the fascia. It's strong and it's thick. There was one study, I can't remember how much force was placed through it, but they put a huge amount of force through the ITB. there was basically almost little to none no stretch through it. You need to focus on releasing your TFL as well as the glutes. And then in terms of strengthening exercises, we want to improve our glute medius strength, because that will stop the TFL, you know, trying to kick in, trying to tension up and that in turn tensions the ITB.

11:40.708 Daren DLake Runs: All right, so ongoing eight to 12 weeks has gone, they've seen you a couple times, what would you then have them like, they're like, Let's say they're 100%. What would you have them do to maintain?

11:52.438 Sam - 10W2S: Oh, I'd make sure they're maintaining their strength. So with more strength with ITV syndrome, you want to start with, you know, your simple glute exercises. You want to do them with your knee extended, such as like a side-lying leg raise, because anything like clamshells and whatnot, While the knee is bent, it's going to be painful. So you want to do your glute exercises with a long, long leg. And then as we progress, they begin to become more functional. Bulgarian split squats work well here. Again, pain needs to be minimal, nothing more than a three, four out of 10. As they continue to progress through their rehab where, you know, maintaining, you know, building their kilometers back up, we can have a look at gait retraining. I am mindful of changing a runner's gait too much, but if there's anything glaring out there that needs to be addressed, it would be a good time to review what they're looking like on the treadmill.

12:39.947 Daren DLake Runs: Anything else you want to add about, I call it IT I call IT band issues like ITB syndrome. Yeah. Uh, anything else you want to say about this? And you know, this is a big thing that comes up in the runners community. Um, anything.

12:56.060 Sam - 10W2S: Oh, I mean, it was my major running injury when I trained for my first marathon. It was when I first started physio. Many training errors were made. I made a

few mistakes. And I did it on the Blackmoor's half marathon a month out from the Melbourne marathon. Did it. It was extremely painful. Look, I had pain. I had just like a slight injury in my hip. And silly me just, you know, went and did the half marathon. And halfway through, I was like, why does the outside of my knee hurt? I'm like, is this referred pain coming from my hip? Soon as I finished the run, I was like, oh my god. Couldn't walk, had ITV syndrome straight away. So again, first line treatment. I don't think I've actually ever seen a patient walking without how bad mine was looking. But first line treatment, again, anti-inflammatories, lots of release work, start working the glutes. But I rested for two weeks because it was so painful. But unfortunately, when I started to run again, the pain was still there. And I was two weeks out from my marathon. Now, I'm doing a whole do as I say, not as I do moment. But I looked at the research evidence for ITV syndrome and cortisone injections. Now, this would not be first-line treatment. I'd hardly recommend this, but doing this marathon meant a lot to me. And plus, I wanted to be a little bit of an experiment guinea pig on myself. So I went to the doctors, got a referral. I got an injection two weeks out from the marathon. I looked at the research on ITV syndrome, and it said you have a trend for decline in pain after one week and a significant decline in pain after two weeks. And that's exactly what happened to the run before the marathon. Happy days, off I go. Did the marathon, but then afterwards, the outer part of my knee just didn't feel quite right, and this was for a few months. So it felt almost stiff. It was a really peculiar feeling. So I don't want people to take away from this, oh, I'm going to get a cortisone, it'll fix everything up. Cortisone's a steroid, it's detrimental for tissues. Luckily for the ITB, it's just into the fat pad and the bursa, but I still would not recommend it unless you've exhausted all options and you've gone to a sports doctor, you've gone to specialist because, as I said, it's helpful in one regard but can be harmful in another. Once again, I was a very, very fresh physio. Hadn't quite gotten to the running stuff yet and yes, many training errors were made. Did the run though.

15:09.562 Daren DLake Runs: All right, case number three, the last one, Lisa. We have Lisa. She is a 30-year-old hardcore endurance athlete who trains and competes in various endurance events, including marathons, triathlons, and ultra marathons. She typically trains two to three times a day, including running, cycling, and swimming, and strength training, and has been doing so for the past five, six years. However, she has been recently experiencing pain and stiffness in her Achilles tendon. Especially in the morning or after prolonged periods of sitting the pain is localized to the back of her heel at the bottom of the heel and rates as a 4 out of 10 at worst asterisked She actually had one of the worst issues with it about four weeks ago. She decided to wear her zero millimeter flats on concrete and do a one mile time trial and then do sprints uphill right after that. And that spiked it up to about an eight out of 10 and she was in extreme, extreme pain. I know Lisa very, very closely. She's a dear friend of mine. That's a joke.

16:18.148 Sam - 10W2S: So, what do you think she has? Sounds like an insertional Achilles tendinopathy. And the difference between, I guess, a mid-portion and an insertional Achilles tendinopathy just depends on where the area of pathology or tendinopathy is. The

insertional one is where the tendon wraps kind of under onto the calcaneus, as opposed to the mid part of the tendon, and it affects how we manage them.

16:42.554 Daren DLake Runs: All right. I have had this before, so I know a lot about this, but you're the expert. So what's the immediate treatment? She comes into your office, what are you going to do?

16:51.080 Sam - 10W2S: Yeah, she's still at that high, sort of 8 out of 10. She dropped back down below. Where is she at with her pain at this stage? Sorry.

16:56.744 Daren DLake Runs: So she was 8 out of 10 four weeks ago. She thought it would go away, and it's really hovering between that 4 out of 5. Sorry, 4 to 5 out of 10. So what would you do?

17:04.268 Sam - 10W2S: So first of all, I think I would test what she's like doing her single leg calf raises and how painful does it get. If it's getting quite, you know, almost up at that 8 out of 10 while we're just doing, you know, bodyweight calf raises or even weighted calf raises, I'd be starting with an isometric exercise.

17:20.914 Daren DLake Runs: And that's the holding? That's the holding.

17:22.435 Sam - 10W2S: So an isometric exercise, once again, it's when you're holding a muscle contraction, but you're not moving the joint through range. So for her, again, if she's got high irritability, I'm getting her to do either a double leg or a single leg calf raise, hold it for 45 seconds, and then repeat four sets. Now, with this kind of injury, you can do this up to four times a day. It is actually relieving for tendon pain. If she is less irritable, I would get her straight onto, well, she's already in the gym, so I'd probably get her onto a heavy slow resistance strength training program. And the exercises would look like, we could play around with it a bit, but things like calf raises on the leg press, calf raises on the squat rack, seated bent knee calf raises. You could do the standing calf raises, the standing bent knee calf raises. I usually pick three and make sure they're not back to back. So you kind of fit them in with your other exercises that you're doing. And again, when I say heavy slow resistance strength training program, tempo is usually a 3-2-3 tempo, so 3 seconds up, 2 second hold, 3 seconds down. And the weight needs to be heavy, like you don't want to be able to do any more than 1 or 2 reps afterwards. Furthermore, because the tendon is insertional, you don't want to be doing Like if you're standing on a step and letting your heel drop down, reason being as the heel drops down, it places more compression on that insertion of the tendon and the tendon won't like that. So for an insertional Achilles tendinopathy, you're doing these calf exercises where the heel lands flat back on the ground.

18:49.624 Daren DLake Runs: With podcasts, you might have zoned out when she was speaking about the difference between an Achilles tendinopathy and the insertional Achilles tendinopathy. It's the pain at the lower heel. For me, it almost feels like plantar, like almost an ankle issue. Like I feel like pulling and I get really confused with it. And the chunk, which

is the Achilles, that big fat chunk where everyone knows their Achilles tendon is, that's absolutely fine. And it confused me because I was like, do I have plantar fasciitis? Do I have that? So just again, I'm dumbing it more down so people know the difference. But with the regular Achilles tendinopathy, so the- Mid portion. Mid portion, yeah. Sorry, not regular, mid portion. Well, it's more common. Oh, it is more common.

19:32.481 Sam - 10W2S: Again, I haven't got stats for that.

19:34.401 Daren DLake Runs: Clinical observation. Yes. The people coming in and having issues. I'm the weirdo with the insertional one. You want to drop, you want to be on a stair or raised point and drop below for that.

19:45.005 Sam - 10W2S: Correct. Because it increases the range of motion. You also have more eccentric activity.

19:49.686 Daren DLake Runs: Got you.

19:50.306 Sam - 10W2S: And eccentric is the muscle lengthening phase of a movement.

19:52.907 Daren DLake Runs: Which is the down for this exercise. Yes. And concentric is going up. Correct. We'll talk about that actually in the episode either before or after this, we talk about the difference between concentric, eccentric and isometric because I'm sure you've heard that, but you may be like, what the hell is the difference? And I've got some cool ways of remembering that, but I digress from that. So she's somewhat healed. Kind of never goes away because the Achilles is the Achilles tendon is deteriorating as she gets older AKA me and It's always kind of there. It's tolerable. It's always a one out of two. Sometimes you get one. Sometimes you get three What would the follow-up be over the next one or two years even we've gotten it tamed she can increase her load Which is volume and intensity. Yeah, she's now running 100 K's a week or whatever. She's doing, you know smashing herself What would you say to make it never go back to that? Um, shoe choices, heel drop, any of that?

20:49.780 Sam - 10W2S: Oh, yeah. I mean, you would be, I mean, I still like runners to vary, like, you know, provide variation in what shoes they're wearing, but if it's again, more irritable, you do want to have a higher heel. Um, whereas if you're constantly running in a, you know, a flatter heel drop, um, it's going to place more stress on the tendon. So I think if you're wanting to protect longevity is. Obviously have a shoe with a bit more of a stack, but be mindful if you're going to make any rapid changes from one to another. Hopefully by this stage, the athletes had a bit of education on how to manage these things when they tend to pop up, because sometimes they pop up, go away, and then pop up again, and you need to be really well aware with what you're doing in your training. Obviously, the strength stuff needs to be consistent. It needs to be, you know, three, especially with a painful tendinopathy, three times a week. And then other things I recommend, and this is a little bit, again, it's going to be no fix, but it may be an adjunct to what you're doing. But there's a bit of evidence coming out around collagen supplementation, particularly with Achilles

tendinopathy. So again, it's not going to fix the condition, but I'm more of one of those people, you throw the book with things. I have collagen in my coffee every day because I know it's good for my tendons. But there's stuff coming out as exciting. So here's an example. They had one group that did the strength training program where one group didn't, Plus the collagen, the other group just did the strength alone. The group that had the collagen had a faster resolution of symptoms, as well as another trial that looked at Achilles tendinopathy. One group took Voltiron, which again is an anti-inflammatory. The other group took collagen, and the group that took collagen again had a faster reduction in pain levels. So I think that's kind of interesting in that context. But really, when it's becoming more of a managing condition, it's about listening to symptoms when they pop up, modifying your training, not stopping completely unless it's too painful, keeping up the strength work. And yeah.

22:36.016 Daren DLake Runs: Awesome. All right. I'm going to end it with, uh, with my take on it, because this is actually an injury that I know very, very well. I'm not going to say I'm an expert on treating it, but I know how to treat myself. Um, I managed it with strength training, collagen supplement, um, and the heel drop in the shoe. I actually went as high as 12 millimeter, which I thought was gross and it felt like I was wearing high heels. But luckily Millie and Trent at Balmain Sports and Sigrid. They are all fantastic. Yes. And I ended up being able to test out these different, you know, eight millimeters. So I went from I got away from zero, I don't think I'm ever gonna really touch zero ever again, except for walking around. Four millimeter is like my usual hangout shoe, run-easy shoe. Eight millimeter is my normal shoe, and then I was messing around with 12 millimeters. I actually have 12 millimeter again, and that's the heel drop, and most runners should know what the heel drop is. You can explain what the heel drop is or you can Google it, but I'll have you explain in a second. And cycling between, so if I really felt a lot of pain, I didn't just stay in my 12 millimeter. Eight millimeter for a lot of the fast runs and the longer runs. And then again, like I said, I dropped down to four, so I'd be cycling between the three and that works very well for me. So how about we explain heel drop in the next one? That's more podiatry, but we'll explain that in the next one. So yeah, thank you. Anything else you want to say?

24:00.870 Sam - 10W2S: With Achilles tendinopathy, again, it can be one that can stick around for a little bit and frustrate runners, or it may go away and then come back again. If it has been that real chronic, you know, around for a long time, It's often that area of tendon that has the tendinopathy, it's never quite going to get back to where it was. I don't want to alarm people with that, but basically you want to get the rest of the tendon as strong as it can be. Lots of people have tendinopathy in their bodies and they don't even know about it. And that's what we're aiming to do is get the rest of the tendon as strong and as healthy as it can be. So it becomes one very good functioning unit.

24:33.776 Daren DLake Runs: Thanks for watching this far. To end the episode, we've got a bit of a bonus section that gets into more of the things that Sam is annoyed by around the strength training world. In the strength training world, her morning routine and how she's getting her second master's degree. Yes, it is crazy. This is on the podcast only. So if you're

listening, keep listening in the next five seconds. But if you're watching it on YouTube or somewhere else, just hit the link below to put it in your ears and walk around and get it on your next run or wherever. on to the next section.

25:19.472 Sam - 10W2S: you know, 20 plus repetitions. As we've previously discussed in an earlier episode, we don't want to be replicating running with, you know, lots and lots and lots and lots of repetitions. We actually want to go heavier. So our tendons are more efficient at producing force. You can think of the tendons like a rubber band. If you stretch the rubber band and then let go, it has that elastic recoil and strength training can help with that.

25:42.348 Daren DLake Runs: What is your morning routine?

25:44.060 Sam - 10W2S: Well, that depends, because I work different hours. I'm a physio or a physical therapist. I start late on Monday, so not till 1. Tuesdays and Thursdays are a 12-hour day, so I start at 7. Wednesdays off, Friday mornings from 7. So it's quite variable. But I try and run on the mornings that I have off. And then my long days, little gets done there. Days off, run. I try to ensure I get some gym work done as well. We've got a gym at my work, which is really helpful. Warnings is quite variable, but I always have collagen in my coffee.

26:18.268 Daren DLake Runs: So you got two masters, a bachelor's, you're a full-time physio slash physical therapist. You've created an app, you have a product, you own a product, a technology product, and you obviously manage your personal life, family, friend relationships, everything in between. How do you do it in one sentence? And let me know if I got anything wrong with your master's degree. So just tell me how you did it. One sentence.

26:44.370 Sam - 10W2S: Try and keep the wheels on the track. I feel like if you throw a spanner in the works, it only takes a little bit to set everything off. But so far, so good.

26:53.703 Daren DLake Runs: Amazing. And so the one master's is, so go through the master's really quick.

26:58.888 Sam - 10W2S: Yeah, so the first master's is what we call a graduate entry master's. So because I've done a prior degree in exercise and sports science, the graduate entry master's for physio is a two-year degree, and it's basically everything you need to know about physiotherapy in two years. Now, I've been practicing in a sports medicine center for a while, but I'm now doing my Master's of Exercise and Sports Physiotherapy. Now, in Australia, this recognizes you a bit more as a specialist in your field. It also opens the door, I guess, to work a bit more with elite sport, should you want to go down that path, and it increases your depth of knowledge. So I'm really enjoying it so far, just not enjoying managing the time, but it's all good.

27:39.016 Daren DLake Runs: You've made it to the end. Thank you so much for listening to all this stuff on how we try to make running and training and life and all that stuff work, because time is a resource that no one can make more of. Not yet, at least. So we appreciate you taking the time out of your day to listen, watch and generally consume all this stuff. Accessibility is pretty cool nowadays, so we have a transcript for all the episodes. Make sure you go to the show notes section of this episode on whatever podcast player you're listening to, or you can go to the description of the YouTube video, or just go to podcast.delaycreates.com to find the episode and the transcript. All of this was produced in Sydney, Australia, so I acknowledge the Gadigal of the Eora Nation, who are the traditional custodians of the land. I pay my respects to elders past, present, and emerging. A lot of people ask how they can support us, and I think the easiest way is to just share this out to people you know that would like this. So whether it's a podcast link from Apple Podcasts, Spotify, Google Podcasts, whatever you're listening to, or watching on YouTube, send them a link, just flick it to them. Email it, text it, you know, Instagram, whatever. Send them a link of this episode, or my newsletter, or whatever you can, the YouTube link, whatever you can. The second easiest way is to rate, like, or subscribe to this podcast and or video on YouTube, or even subscribe to my newsletter. If you have any feedback, feel free to hit me up. Talk at DLakeCreates.com. That's T-A-L-K at DLakeCreates.com. Spelled the normal way, train smart, race, and live easy. Peace.