Background: An 18 year old female collegiate softball player presented with an antalgic gait and complained of intermittent soreness and pain along her medial instep, when walking and running. Previous history of injury includes pain along the medial longitudinal arch that began two months previous while changing directions when running. At that time, the athlete had an antalgic gait, pain of 5/10 over the left navicular tuberosity when palpated, a deficit of strength of 3/5 in combined dorsiflexion with inversion and 4+/5 dorsiflexion during manual muscle testing and a positive finding for pronation during fiese line testing. The athlete was differentially diagnosed with a calcaneonavicular ligament sprain and anterior tibialis strain. She was removed from play, given a strength and proprioceptive rehabilitation protocol, fitted with a walking boot and referred to her PCP. The athlete stated she had been doing her rehabilitation and walking without the walking boot for one month, but had been unable to perform cardiovascular exercise due to pain. Upon current evaluation, tenderness to palpation was revealed over the navicular tuberosity and along the distal posterior tibialis tendon from the insertion at the navicular to the medial malleolus. Observation revealed inflammation over the navicular tuberosity, and through palpation an abnormality of the navicular bone was noted. Active and passive motions of combined plantarflexion with inversion and combined dorsiflexion with inversion elicited pain of 5/10. The athlete was removed from play and referred to the team physician. Differential Diagnosis: Posterior tibialis tendonitis, Posterior tibialis strain, Accessory navicular. Treatment: X-ray imaging confirmed the presence of an accessory navicular. The athlete was directed to ambulate in a walking boot for four weeks, take a prescription anti-inflammatory and a cortisone injection was recommended. The athlete and her family declined the cortisone injection. Rehabilitation and all weight bearing athletic activities were discontinued. Treatment was altered to include thermal ultrasound treatment once daily and ice treatments three times daily. Following one week of treatment, the athlete reported no pain. US treatments were discontinued and the athlete was treated symptomatically. Prior to her follow up visit, the coaching staff removed the athlete from the roster and reassigned her to the position of team manager for reasons unrelated to her injury. The athlete remained in the walking boot and was treated for intermittent pain throughout the next three weeks. Four weeks after the initial assessment, the athlete returned to the physician and received options to either continue symptomatic treatment or to pursue surgery. Three days after the visit, the athlete discontinued activities with the softball team and communication with the athletic training staff. In a recent discussion, the athlete reported pain of 3/10 when walking long distances and progression to exercising on the elliptical machine. The athlete does not plan on pursuing any surgical treatment. Uniqueness: Collectively, the three types of accessory navicular have an incidence rate of 4-21%, but only type II and III present symptomatically. The incidence rate of type II and type III are 3.1 and 4.6% respectively. Due to the pathology associated with a type II or III, the majority of accessory navicular are discovered following a posterior tendon tear. Conclusion: Often, effective treatment for accessory navicular includes treatments to decrease inflammation and fitting of orthotic devices. This athlete did not continue with treatment long enough that orthotic intervention was attempted. A correlation reported between increased BMI and increased foot pain would also suggest that decreasing an athlete’s BMI through diet may also decrease symptoms. Word Count: 577