Background. A 20 year old male ice hockey player reported after a game complaining of pain on the medial aspect of his right foot after blocking a shot in the second period. He reported no complaint during the game and was able to continue. Initial evaluation showed pain over the most prominent aspect of the navicular, and along the posterior tibialis tendon with active eversion, active and passive dorsiflexion, and resisted inversion. Distraction and compression of the surrounding joints and Morton’s test were negative. The injury was treated as a contusion, a custom pad was worn on the skate, and the athlete was limited in practice and games based on his symptoms. He was also restricted from plyometric and single leg activities during conditioning. He continued to report “soreness", and was treated with ice cup, cold whirlpool, ice and electrical stimulation. The athlete received arch taping, massage and passive ROM exercises. Over the next week the soreness localized to the navicular. Approximately one week S/P, the athlete found improvement with heat. Ten days S/P, the athlete saw the team physician, who confirmed the diagnosis and prescribed a topical lidocaine and ketoprofen mixture for pain. Improvement was noted, however after 8 more days point tenderness was still present. At this time, the physician ordered radiographs, and placed the athlete in a walking boot. Differential Diagnosis. Navicular contusion, acute posterior tibialis tendonitis, fracture. Treatment. Radiographs were negative for fracture, therefore an MRI was ordered. Results identified a non-displaced stable subcortical navicular fracture. The athlete was treated with immobilization, bone stimulator, NSAIDS, ice, and ROM exercises. The physician cleared him to continue participation as symptoms allowed. The athlete progressed, continued strength and balance training and wearing the boot for ADLs. He was removed from the boot 10 weeks S/P and began light plyometrics. At 12 weeks S/P the athlete returned to full play without incident. Uniqueness. The outer most layer of the bone, the cortical region, was fractured in this athlete, leaving the remainder of the tissue intact. Radiographs were unable to differentiate the layers of boney tissue, and therefore were unreliable identifying the injury. Radiographs may not be sensitive to subcortical fractures because they do not produce detailed images of the bone and in this case, the structure of the bone was not changed drastically. Because the fracture was non-displaced and did not travel to the inner layers of the bone, x-rays produced a false negative result. The MRI was able to identify the fracture because it creates a magnetic field around and through the foot which allows for disturbances within and around the bone to be identified. Conclusion. Treatment for subcortical fractures is typically conservative, consisting of ice, non-weight bearing, rest, and pain control. Despite the delay in obtaining radiographs, the injury healed within an acceptable time frame. Had radiographs been obtained immediately, a false negative would still have resulted and treatment would have been the same. Navicular fractures commonly occur due to overuse in runners and gymnasts due to impact forces and jumping involved. The foot does not receive the same impacts while skating. Studies show that peak ground reaction forces are high in athletes who run track, perform gymnastics, and play sports that involve bounding and jumping. Sports where the foot leaves the ground and moves in an anteriorposterior motion create higher ground reaction forces than in ice hockey, where the foot moves in a mediolateral motion. The athlete was able to continue participating primarily due to the fracture affecting a small aspect of the bone, and because of the typical forces involved in ice hockey.