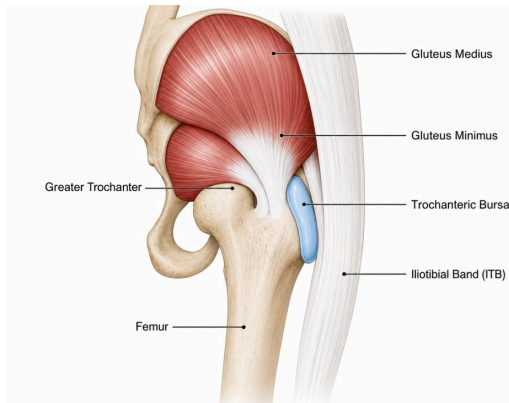


ONE-PAGE PATIENT SUMMARY

Greater Trochanteric Pain Syndrome (GTPS)

Understanding outer hip pain, treatment and rehabilitation



Lateral hip anatomy showing the greater trochanter, gluteal tendons and muscles, trochanteric bursa, and iliotibial band.

Outer hip pain: protect, strengthen, progress

GTPS is pain over the bony outer side of the hip, where the gluteal tendons, bursa and iliotibial band meet. It commonly involves gluteal tendon irritation or degeneration; isolated bursitis is less common. Care usually focuses on reducing aggravating compression and progressively rebuilding hip strength.

What it can feel like

- Deep ache or burning over the outer hip, sometimes towards the knee.
- Pain when lying on the affected side, often disturbing sleep.
- Pain with prolonged walking, standing, stairs or uphill walking.
- Tenderness directly over the greater trochanter on the outer hip.
- Groin pain is not typical and should be assessed separately.

Treatment pathway

1 Protect and modify activity

Avoid aggravating compression, such as crossing legs or lying on the painful side. Reduce, rather than stop, activity; choose low-impact options when needed.

2 Build gluteal strength

A structured physiotherapy programme is central. Start with isometric loading, then strengthen and progress to functional activity under clinical guidance.

3 Consider targeted options

If pain prevents rehabilitation, an ultrasound-guided corticosteroid injection may provide a temporary rehabilitation window. ESWT may suit chronic symptoms not responding to physiotherapy.

4 Escalate selectively

PRP may be considered in selected chronic cases, but evidence is evolving. Surgery is reserved for persistent, debilitating symptoms after comprehensive conservative treatment.

Rehabilitation and aftercare

1 Early loading

Begin static hip-abduction holds and simple gluteal exercises, avoiding aggravation and compressive positions.

2 Strength and function

Progress to controlled strengthening, step work and single-leg control as symptoms and capacity allow.

3 Activity return or surgery

Activity return is gradual. After surgery, six weeks of protected weight-bearing with crutches is typical, followed by graduated physiotherapy over 3–6 months.

Your pain-response rule

Mild discomfort during exercise may be acceptable if it is no more than 4/10 and is not worse the following day. If next-day pain increases, reduce the load or seek advice. Do not stretch deeply into hip adduction; it increases tendon compression.

Seek urgent medical advice if

You suddenly cannot bear weight; have severe pain with fever, redness or swelling; pain after a fall or trauma; numbness, tingling or leg weakness; unexplained weight loss; or night pain that wakes you and is not position-related. Seek assessment for groin pain with restricted hip movement.

Important limitations and safety

Recovery varies, especially with significant tendon degeneration. Corticosteroid injections can give short-term relief but work best alongside rehabilitation; repeated injections without rehabilitation may weaken tendons and are usually limited to 2–3 each year. ESWT, PRP and surgery require individual clinical selection. This guide does not replace personalised medical advice.

Need advice tailored to you? This poster supports, but does not replace, individual assessment or consent.

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