

GREATER TROCHANTERIC PAIN SYNDROME

Patient Information Booklet

*Understanding Your Condition, Treatment Options
& Rehabilitation Programme*

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1. Understanding Your Hip — Anatomy

The hip joint is one of the largest and most stable joints in the body. It is a ball-and-socket joint formed by the femoral head (ball) sitting within the acetabulum (socket) of the pelvis. While most people are familiar with the hip joint itself, the outer aspect of the hip — the lateral hip — is equally important and is the area affected in Greater Trochanteric Pain Syndrome.

The Greater Trochanter

The greater trochanter is the bony prominence you can feel on the outer side of your hip. It is the attachment point for several important muscles and tendons that control hip movement and stability. These structures include:

- Gluteus medius — the primary hip abductor muscle that lifts your leg sideways and stabilises the pelvis during walking
- Gluteus minimus — a deeper muscle that assists with hip abduction and internal rotation
- Trochanteric bursa — a fluid-filled sac that reduces friction between the gluteal tendons and the iliotibial band (ITB) as it passes over the greater trochanter
- Iliotibial band (ITB) — a thick band of connective tissue running from the pelvis down the outside of the thigh to the knee

These structures work together to provide smooth, pain-free movement of the lateral hip. When any of them become irritated, inflamed, or damaged, the result is lateral hip pain — commonly referred to as Greater Trochanteric Pain Syndrome.

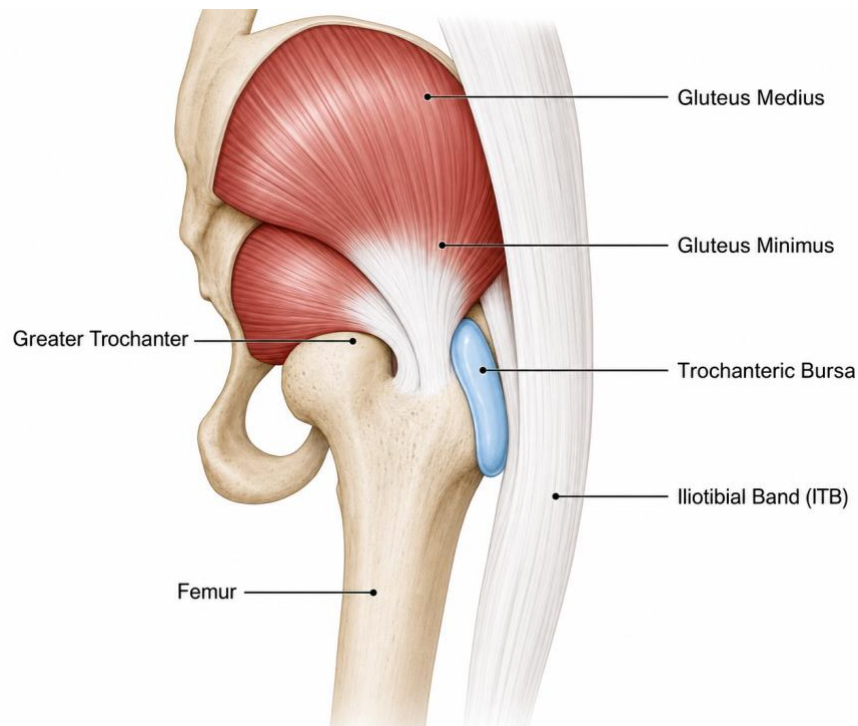


Figure 1: Lateral view of the hip showing the greater trochanter, gluteal muscles, trochanteric bursa, and iliotibial band (ITB)

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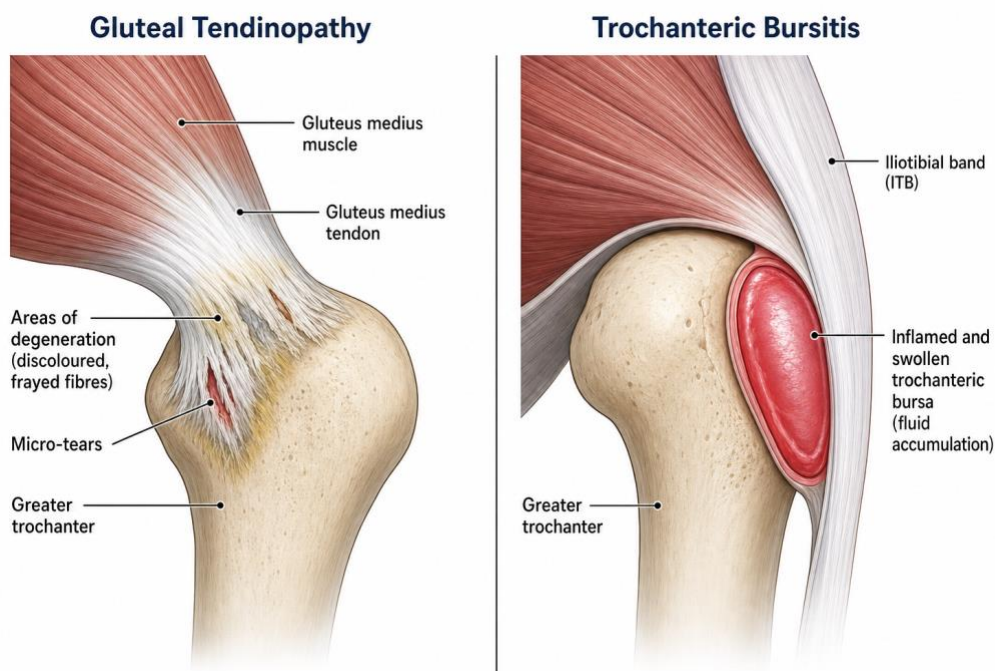
2. What is Greater Trochanteric Pain Syndrome?

Greater Trochanteric Pain Syndrome (GTPS) is an umbrella term for conditions causing pain on the outer side of the hip, over or around the greater trochanter. It affects approximately 1.8 per 1,000 adults per year in primary care and is 2–3 times more common in women, typically presenting between the ages of 40 and 60.

GTPS encompasses several related conditions:

Condition	Description	Frequency
Gluteal tendinopathy	Degenerative changes in the gluteus medius and/or minimus tendons where they attach to the greater trochanter	Most common (60–70%)
Trochanteric bursitis	Inflammation of the trochanteric bursa between the gluteal tendons and the ITB	15–20%
Gluteal tendon tears	Partial or complete tears of the gluteus medius or minimus tendons	10–15%
External snapping hip	The ITB snapping over the greater trochanter during movement	5–10%

Previously, lateral hip pain was often labelled simply as 'trochanteric bursitis.' However, research using MRI and ultrasound has shown that isolated bursitis is actually quite rare — in most cases, the primary problem is gluteal tendinopathy (degeneration of the tendons), with bursitis being a secondary finding.



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Figure 2: Comparison of gluteal tendinopathy (left) showing tendon degeneration and micro-tears, and trochanteric bursitis (right) showing inflamed, swollen bursa

3. Causes and Risk Factors

GTPS develops when the gluteal tendons and/or trochanteric bursa become irritated through a combination of compressive and tensile loading. Understanding the causes helps guide treatment and prevention.

Common Causes

Category	Examples
Overuse / repetitive loading	Running, hill walking, prolonged standing, stair climbing
Compressive loading	Sleeping on the affected side, crossing legs, prolonged sitting with legs crossed
Biomechanical factors	Wide pelvis (female anatomy), leg length discrepancy, hip adduction gait pattern
Muscle weakness	Weak gluteal muscles leading to increased tendon strain
Sudden load increase	Rapid increase in walking/running distance, new exercise programme
Post-surgical	Following hip or knee replacement (altered gait mechanics)

Risk Factors

- Female sex (2–3 times more common in women)
- Age 40–60 years (tendon degeneration increases with age)
- Obesity or being overweight
- Sedentary lifestyle with sudden activity increases
- Previous hip or knee surgery
- Low back pain or lumbar spine conditions
- Hormonal factors (post-menopausal women at higher risk)

4. Signs and Symptoms

The hallmark symptom of GTPS is pain on the outer side of the hip, directly over or around the greater trochanter. The pain may radiate down the outer thigh towards the knee.

Typical Symptoms

- Pain over the lateral hip — often described as a deep ache or burning sensation
- Pain when lying on the affected side at night (a very common complaint)
- Pain with prolonged standing or walking
- Pain climbing stairs or walking uphill
- Pain when crossing the legs or sitting with legs together
- Stiffness and pain on first standing after prolonged sitting
- Tenderness when pressing directly over the greater trochanter

Symptom Severity Stages

Stage	Description	Impact
Mild	Pain only during or after specific activities (e.g., long walks, running)	Minimal impact on daily life
Moderate	Pain with everyday activities (stairs, standing from chair) and night pain	Affects sleep and activity levels
Severe	Constant pain at rest, significant night pain, difficulty walking	Major impact on quality of life

It is important to note that GTPS does not typically cause groin pain. If you have groin pain, this may indicate a different hip condition and should be assessed separately.

5. Diagnosis

GTPS is primarily diagnosed through clinical examination. Your consultant will take a detailed history and perform specific tests to identify the source of your pain.

Clinical Examination

- Palpation — tenderness directly over the greater trochanter
- Resisted hip abduction — pain when pushing the leg outward against resistance
- Single leg stance test — pain or Trendelenburg sign (pelvis dropping on the opposite side)
- FABER test — to differentiate from hip joint pathology
- Ober's test — to assess ITB tightness

Imaging

Investigation	Purpose	Findings
Ultrasound (USS)	First-line imaging — dynamic assessment of tendons and bursa	Tendon thickening, tears, bursal fluid, calcification
MRI	Gold standard for detailed soft tissue assessment	Tendon degeneration, partial/complete tears, bone marrow oedema
X-ray	To exclude other causes (arthritis, fracture)	Usually normal in GTPS; may show calcification

Ultrasound is particularly useful as it allows real-time assessment of the tendons during movement and can guide injections directly to the affected area.

6. Treatment Options

Treatment for GTPS follows a stepwise approach, starting with conservative measures and progressing to more invasive options only if symptoms persist. The good news is that the majority of patients (up to 90%) improve with non-surgical treatment.

Treatment Algorithm

Step	Treatment	Expected Timeline	Success Rate
1 (First-line)	Education + Load Management + Physiotherapy	6–12 weeks	60–70%
2	USS-Guided Corticosteroid Injection + Physiotherapy	2–6 weeks relief	55% at 3 months
3	Extracorporeal Shockwave Therapy (ESWT)	2–3 months	68% improvement
4	PRP Injection (selected cases)	3–6 months	Evidence evolving
5 (Last resort)	Surgical intervention	3–6 months recovery	75–90%

Conservative Management (First-Line)

The cornerstone of GTPS treatment is education, activity modification, and a structured physiotherapy programme focusing on gluteal strengthening. Key principles include:

- Load management — avoid aggravating positions (crossing legs, lying on affected side)
- Activity modification — reduce but do not stop activity; maintain fitness through low-impact exercise
- Sleep modification — use a pillow between the knees when side-lying
- Progressive gluteal strengthening — the most important long-term treatment
- ITB stretching and foam rolling
- Weight management — reducing load on the tendons

Research by Mellor et al. (2018) demonstrated that education plus exercise was superior to corticosteroid injection at 12 months, with 78.6% of patients reporting global improvement compared to 58.3% in the injection group.

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7. USS-Guided Injection Therapy

Ultrasound-guided injections are used when conservative measures alone are insufficient to control symptoms, particularly when pain is preventing participation in rehabilitation exercises.

Corticosteroid Injection

A corticosteroid (steroid) injection delivers a powerful anti-inflammatory medication directly into the trochanteric bursa or around the affected tendon under ultrasound guidance. This ensures precise placement of the medication.

Aspect	Detail
Procedure time	10–15 minutes
Anaesthetic	Local anaesthetic mixed with corticosteroid
Guidance	Real-time ultrasound imaging
Pain relief onset	24–72 hours (local anaesthetic wears off first)
Duration of effect	4–12 weeks (variable)
Maximum injections	Usually limited to 2–3 per year

Important: Corticosteroid injections provide a 'window of opportunity' for rehabilitation. They are most effective when combined with a structured physiotherapy programme during the pain-free period. Used alone, the benefits are often temporary.

Platelet-Rich Plasma (PRP) Injection

PRP involves taking a sample of your own blood, concentrating the platelets (which contain growth factors), and injecting this into the affected tendon. Early evidence suggests PRP may provide longer-lasting benefit than corticosteroid in chronic cases, though more research is needed.

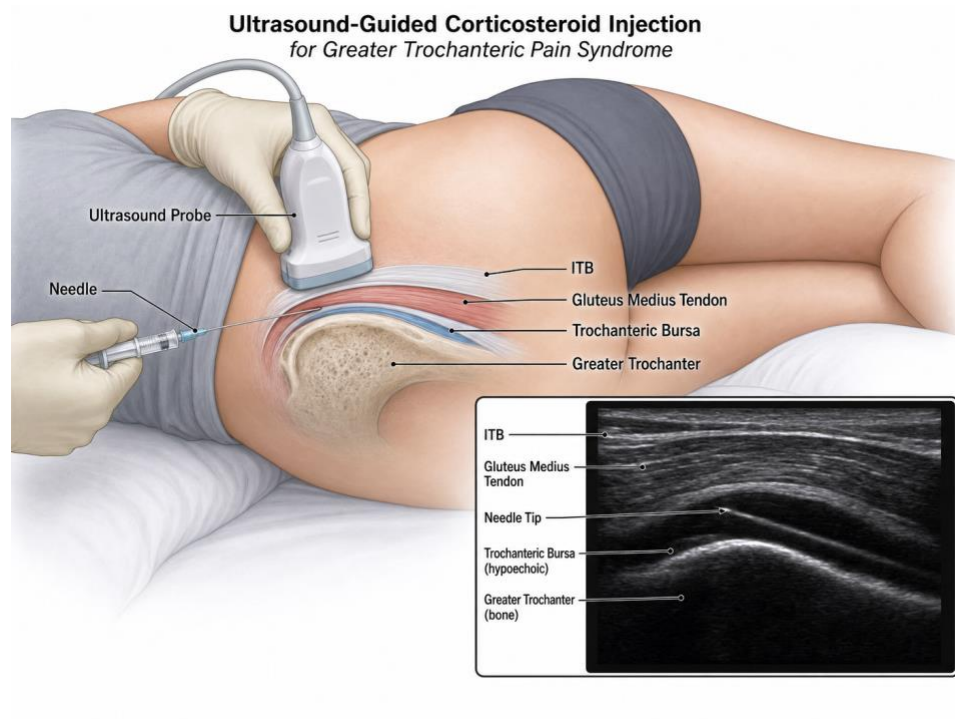


Figure 3: USS-guided corticosteroid injection for GTPS — the needle is guided under real-time ultrasound into the trochanteric bursa

8. Extracorporeal Shockwave Therapy (ESWT)

Extracorporeal Shockwave Therapy (ESWT) is a non-invasive treatment that uses focused acoustic waves to stimulate healing in damaged tendons. It has emerged as an effective treatment for chronic GTPS that has not responded to initial conservative measures.

How It Works

Shockwaves are delivered through the skin to the affected area using a handheld device. The acoustic energy stimulates blood flow, promotes new tissue formation, and reduces pain signalling. The treatment does not require anaesthesia or incisions.

Treatment Protocol

Parameter	Detail
Number of sessions	3–5 sessions
Frequency	Weekly intervals
Duration per session	15–20 minutes
Energy level	Gradually increased over sessions
Pain during treatment	Moderate discomfort (tolerable)
Return to activity	Immediately (avoid high-impact for 48 hours)

Evidence

A multicentre randomised controlled trial by Ramon et al. (2020) found that focused shockwave therapy combined with physiotherapy produced a 68.3% improvement in VAS pain scores at 2 months, significantly better than sham treatment. Rompe et al. (2009) demonstrated that ESWT was superior to corticosteroid injection at 15 months follow-up, with 68.3% reporting successful outcomes compared to 55% in the injection group.

ESWT is particularly suitable for patients who:

- Have chronic symptoms (>3 months) not responding to physiotherapy alone
- Wish to avoid repeated corticosteroid injections
- Have calcific tendinopathy visible on imaging
- Are not candidates for surgery

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9. Surgical Treatment

Surgery is reserved for patients with persistent, debilitating GTPS that has not responded to at least 6–12 months of comprehensive conservative treatment. The type of surgery depends on the underlying pathology identified on imaging.

Surgical Options

Pathology	Surgical Procedure	Approach
Isolated trochanteric bursitis	Endoscopic bursectomy	Arthroscopic (keyhole)
Bursitis + ITB tightness	Bursectomy + ITB release	Arthroscopic
Partial gluteal tendon tear (<50%)	Endoscopic tendon repair	Arthroscopic
Partial gluteal tendon tear (>50%)	Trans-tendinous repair	Arthroscopic or mini-open
Full-thickness gluteal tendon tear	Double-row suture anchor repair	Open or arthroscopic
Retracted/chronic tear	Tendon transfer (gluteus maximus/TFL)	Open

Surgical Outcomes

Annin et al. (2021) reported outcomes in 324 patients treated surgically using a classification-based approach. Results showed significant pain reduction across all categories:

Procedure	Pre-op VAS	Post-op VAS	Improvement
Bursectomy alone	5.52	2.35	57%
Bursectomy + micropuncture	5.39	1.82	66%
Endoscopic repair (<25% tear)	6.09	1.99	67%
Trans-tendinous repair (>25% tear)	5.68	2.03	64%
Double-row suture repair (full tear)	5.91	2.10	64%
Tendon transfer (retracted tear)	4.82	0.55	89%

Recovery after surgery typically involves 6 weeks of protected weight-bearing with crutches, followed by a graduated physiotherapy programme over 3–6 months.

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10. Rehabilitation Programme

A structured, progressive rehabilitation programme is the most important treatment for GTPS. The programme focuses on strengthening the gluteal muscles while managing tendon load. Research consistently shows that exercise-based rehabilitation produces the best long-term outcomes.

Rehabilitation Principles

- Progressive loading — gradually increase tendon load over time
- Avoid compressive positions — no stretching into hip adduction
- Isometric before isotonic — start with static holds before moving exercises
- Pain monitoring — mild discomfort during exercise is acceptable ($\leq 4/10$), but pain should not increase the following day
- Consistency — exercises performed daily for isometrics, 3× per week for strengthening

Phase 1: Pain Reduction and Isometric Loading (Weeks 1–4)

Goal: Reduce pain and begin tendon loading without aggravation

Exercise	Sets × Reps	Frequency	Notes
Isometric hip abduction (wall)	5 × 30–45 sec holds	Daily	Push hip into wall at 10–20° abduction
Supine clam (small range)	3 × 10	Daily	Keep feet together, open knees 30°
Bridging (double leg)	3 × 12	Daily	Focus on gluteal activation
Standing weight shifts	3 × 30 sec each side	Daily	Single leg loading tolerance

Phase 2: Isotonic Strengthening (Weeks 4–8)

Goal: Build gluteal strength through full range of motion

Exercise	Sets × Reps	Frequency	Notes
Side-lying hip abduction	3 × 12–15	3×/week	Slow and controlled, avoid hip flexion
Standing hip abduction (band)	3 × 12	3×/week	Resistance band around ankles
Single leg bridge	3 × 10 each side	3×/week	Progress from double leg
Step-ups (low step)	3 × 10 each side	3×/week	Focus on hip control
Side-lying plank (modified)	3 × 20–30 sec	3×/week	Knees bent initially

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Phase 3: Functional Loading (Weeks 8–12)

Goal: Progress to functional, weight-bearing exercises

Exercise	Sets × Reps	Frequency	Notes
Lateral step-down	3 × 10 each side	3×/week	Control pelvis — no dropping
Single leg squat (partial)	3 × 8–10	3×/week	To 45° knee flexion
Walking lunges	3 × 10 each side	3×/week	Upright trunk, controlled
Side plank (full)	3 × 30–45 sec	3×/week	Straight legs
Single leg deadlift	3 × 10 each side	3×/week	Light weight, hip hinge

Phase 4: Return to Activity (Weeks 12+)

Goal: Gradual return to sport and full activity

- Sport-specific exercises tailored to your activity goals
- Graduated return to running (if applicable) using a walk-run programme
- Continued maintenance strengthening 2–3× per week long-term
- Load management education to prevent recurrence

GREATER TROCHANTERIC PAIN SYNDROME

6 KEY REHABILITATION EXERCISES



Figure 4: Key rehabilitation exercises for GTPS — progressing from isometric to functional loading

11. Living with GTPS — Practical Advice

While undergoing treatment, the following practical modifications can significantly reduce your symptoms:

Sleep

- Avoid sleeping on the affected side
- Place a pillow between your knees when lying on the opposite side
- A memory foam mattress topper can reduce pressure on the hip
- Try sleeping on your back with a pillow under your knees

Sitting

- Do not cross your legs
- Avoid low, soft chairs — use a firm chair with armrests
- Keep knees at or below hip level
- Stand up and move every 30–45 minutes

Standing and Walking

- Avoid standing with all weight on the affected leg
- Use a walking stick in the opposite hand if needed for long distances
- Wear supportive, cushioned footwear
- Avoid prolonged standing in one position

Exercise and Activity

- Swimming and cycling are excellent low-impact alternatives to running
- Avoid hill walking and stair climbing in the early stages
- Warm up thoroughly before any exercise
- Increase activity levels gradually (no more than 10% per week)

Positions to Avoid

Avoid	Instead
Crossing legs when sitting	Keep feet flat on floor, knees apart
Lying on affected side	Lie on back or opposite side with pillow between knees
Standing on one leg (affected side)	Distribute weight evenly on both legs
Deep stretching into hip adduction	Gentle stretches within pain-free range
Sitting with knees together	Sit with knees hip-width apart

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12. Frequently Asked Questions

How long does GTPS take to resolve?

Most patients improve significantly within 3–6 months with appropriate treatment. However, some cases — particularly those with significant tendon degeneration — may take 12 months or longer. Consistency with rehabilitation exercises is the most important factor in recovery.

Will I need surgery?

The vast majority of patients (85–90%) recover with non-surgical treatment. Surgery is only considered after at least 6–12 months of comprehensive conservative management has failed to provide adequate relief.

Can I still exercise with GTPS?

Yes — in fact, exercise is essential for recovery. However, you may need to modify your activities. Low-impact exercises such as swimming, cycling, and walking on flat ground are usually well-tolerated. Avoid running, hill walking, and high-impact activities until symptoms improve.

Is a corticosteroid injection harmful?

Corticosteroid injections are safe when used appropriately and in limited numbers (usually no more than 2–3 per year). They provide valuable short-term pain relief that enables participation in rehabilitation. However, repeated injections without rehabilitation are not recommended as they may weaken tendons over time.

Why does my hip hurt more at night?

Night pain is very common in GTPS because lying on the affected side compresses the inflamed tendons and bursa against the bone. Even lying on the opposite side can cause pain if the affected leg drops into adduction. Using a pillow between the knees and avoiding the affected side usually helps.

Is GTPS the same as hip arthritis?

No. GTPS causes pain on the outer side of the hip, while hip arthritis typically causes groin pain. They are different conditions, though they can occasionally coexist. Your consultant will differentiate between them through examination and imaging.

Can GTPS come back after treatment?

Recurrence is possible, particularly if the underlying risk factors (weak gluteal muscles, poor biomechanics) are not addressed. Maintaining a regular gluteal strengthening programme long-term is the best way to prevent recurrence.

Should I use ice or heat?

Ice can help with acute flare-ups (apply for 15–20 minutes wrapped in a towel). Heat may be more helpful for chronic stiffness before exercise. Neither is a substitute for rehabilitation exercises.

What about PRP injections?

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Platelet-Rich Plasma (PRP) injections show promise for chronic gluteal tendinopathy, with some studies suggesting longer-lasting benefit than corticosteroid. However, the evidence is still evolving, and PRP is typically considered when other treatments have been insufficient.

When can I return to running?

Return to running is typically possible once you can perform single-leg exercises pain-free and have adequate gluteal strength (usually 12–16 weeks into rehabilitation). A graduated walk-run programme is recommended rather than returning to full running immediately.

13. Warning Signs — When to Seek Help

While GTPS is not a dangerous condition, certain symptoms may indicate a different or more serious problem. Please contact your GP or Mr Dehne's team urgently if you experience:

Warning Sign	Possible Concern
Sudden inability to bear weight on the leg	Stress fracture or acute tendon rupture
Severe pain with fever, redness, or swelling	Infection
Pain following a fall or trauma	Fracture
Numbness, tingling, or weakness in the leg	Nerve compression
Unexplained weight loss with hip pain	Requires further investigation
Night pain that wakes you and is not position-related	Requires further investigation
Groin pain with restricted hip movement	Hip joint pathology (different condition)

If you are unsure whether your symptoms are concerning, please do not hesitate to contact the clinic for advice.

14. Appointments and Notes

Use this section to record your appointments, progress, and any questions for your consultant.

Appointment Record

Date	Type	Notes / Outcome
	Initial Consultation	
	Follow-Up	
	Injection / ESWT	
	Physiotherapy Review	
	Follow-Up	

Pain Diary

Recording your pain levels can help track progress. Rate your pain from 0 (no pain) to 10 (worst pain imaginable):

Week	Average Pain (0–10)	Worst Pain	Best Pain	Notes
1				
2				
4				
6				
8				
12				

Questions for Your Consultant

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*This booklet is intended as a guide and does not replace individual medical advice.
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