Gluteal Tendinopathy, Trochanteric Bursitis, Greater Trochanteric Pain Syndrome (GTPS)

WHAT IS GLUTEAL TENDINOPATHY, TROCHANTERIC BURSITIS OR GTPS?

Pain over the side of the hip is commonly related to changes in the health of the tendons that join the gluteal (buttock) muscles to the hip, and sometimes of the nearby bursae (fluid filled sacks that help reduce friction between tendons and bones) (Figure 1). The condition may be diagnosed as gluteal tendinopathy or tendinitis, trochanteric bursitis or Greater Trochanteric Pain Syndrome (GTPS) which encompasses both. The good news is, that regardless of the diagnostic term and whether in your case the tendons or bursae seem to be most affected, the underlying cause appears to be the same and strategies to improve health of one, will help the other as well.

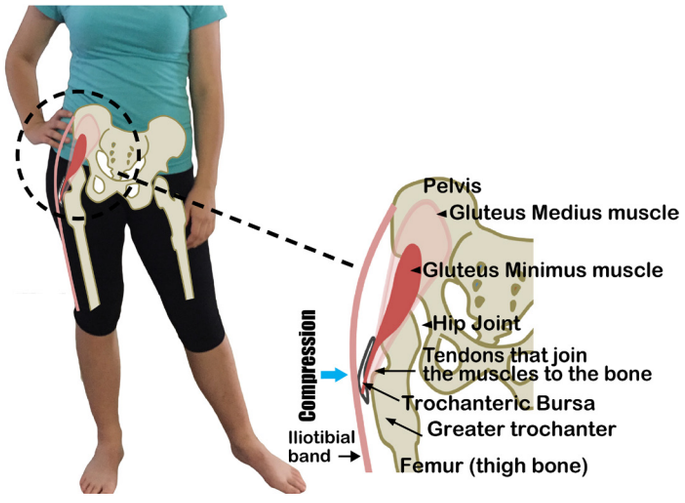


Figure 1: Close-up of the anatomy of the side of hip and demonstration of how these structures interact.

WHAT ARE THE USUAL SYMPTOMS?

The main symptom is pain and tenderness over the bony prominence (bump) at the side of the hip, called the greater trochanter (Figure 2). Pain may also spread down the outer surface of the thigh towards the knee and sometimes just below the knee.

Pain that extends all the way to the foot is more likely to be related to a problem in the lower back.

Gluteal tendinopathy (+/- bursitis) may interfere significantly with quality of life with impacts on sleep quality and activity levels.

Figure 2: Typical area of pain

Pain over the side of the hip is typically experienced when:

- Lying on the side at night
- Walking uphills and stairs
- Standing on one leg, for example when dressing
- Sitting in low chairs especially with crossed legs
- Getting up from chairs and during the first steps

WHAT CAUSES GLUTEAL TENDINOPATHY?

Many factors influence the health of the tendons and bursae at the side of the hip, but either too much or too little stimulus may result in tissue changes. Particular postures or movement patterns may over time contribute to reduced tendon health. Recent Australian research has shown that the gluteal (buttock) muscles (gluteus medius and minimus) of those with painful gluteal tendinopathy are weaker and activate in different ways to those with painfree hips. Those with lateral hip pain also tend to move in ways that result in higher than normal loads passing across their gluteal tendons (Figure 3).

Figure 3: Those with painful gluteal tendinopathy tend to walk with greater pelvic tilt (as demonstrated by the dotted line) or side-shift or lean their body a little more to the side.

Changes in tendons and bursae seen on scans are not necessarily painful, but if weakened tendons are unable to cope with their workload, pain may develop. Pain is often triggered by sudden increases in activity levels, where the tendons have not been given adequate time to adapt to the new loads. This might occur when taking up a new sport or activity or returning to activity after illness, injury or pregnancy, going on holidays and walking lots of hills or stairs or for long distances along the beach.

Sudden loads on the tendon during a slip or fall can also result in pain and injury or a gain in weight may add more load to these tendons that support your bodyweight when standing on one leg.

Eighteen percent of the population aged over 50 suffers with lateral hip pain and women are 3 times more likely to develop the condition.

Change in hormones are thought to contribute to the development of tendon changes, but there are usually a number of casual factors. The onset of pain associated with a combination of hormonal change during menopause, weight gain during this time and a sudden increase in activity levels to deal with this, is a common story related to health professionals.

GETTING HELP: WHAT IS THE TREATMENT FOR GLUTEAL TENDINOPATHY?

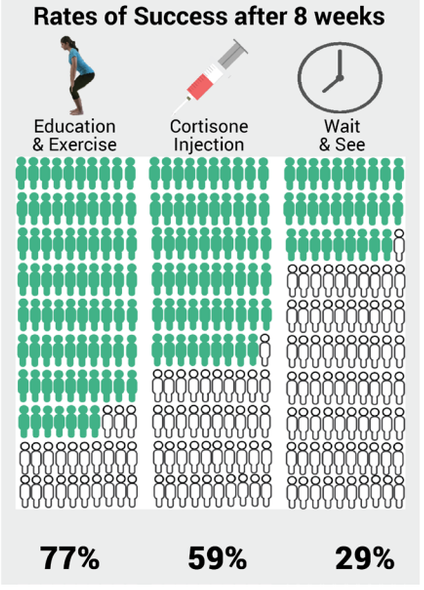
A high-quality research study published in the British Medical Journal compared three common treatment approaches: Education and Exercise provided by physiotherapists, Cortisone Injection and adopting a Wait-and-See approach with simple advice. These participants were on average 54.8 years old; 82% were female; 42% had gluteal tendon tears.

They found:

1. Education and exercise was superior to wait-and-see in both the short (8 weeks) and long term (12 months)

2. Education and exercise was superior to injection in both the short (8 weeks) and long term (12 months)

3. Injection is no more successful than wait and see in the long term (12 months)



Mellor, R., Bennell, K., Grimaldi, A., Nicolson, P., Kasza, J., Hodges, P., Wajswelner, H. and Vicenzino, B. (2018). Education plus exercise versus corticosteroid injection use versus a wait and see approach on global outcome and pain from gluteal tendinopathy: prospective, single blinded, randomised clinical trial. BMJ, Nov;52(22):1464-1472.

1.Education

Understanding what the problem is and what types of positions and activities are likely to irritate the tendons and bursae can help significantly in controlling pain at the side of the hip.

2.Exercise

Another key component of a treatment plan for gluteal tendinopathy is the exercise program. Improvements in symptoms can occur within a couple of weeks, but it is recommended that you persist with an exercise program for at least 3-6 months to see the full effect.

An exercise program can have many benefits such as:
- improving health and co-ordination of the gluteal muscles
- improving control of body position and tendon loads
- reducing pain
- improving ability to perform normal daily tasks
- increasing confidence in your hip and staying active
- improving quality of life

3.Injections

Cortisone (corticosteroid) injections have been shown to have only short-term effect and may reduce health of the tendons with repeateded injections. Therefore, it is usually best to learn about ways you can help reduce your pain and trial a period of committed exercise first. *Platelet Rich Plasma (PRP) injections* are sometimes suggested but the evidence for these remains unclear.

4.Shockwave

Shockwave therapy may be used for those who do not response initially to an education and exercise program. Further evidence for Shockwave is still required. Shockwave should always be provided with high quality exercise.

5.Surgery

Surgery is usually only considered if there has been a poor response to an extended period of high-quality rehabilitation - usually 6-12 months. Surgical repairs of large tendon tears that are effecting function,are sometimes undertaken. It is important to note that a large proportion of older adults have painfree tendon tears. Most tears do not need repair and recovery of full painfree function is still possible.