
• **Background**
  o Affects up to 25% of women aged over 40 and accounts for 20% of all hip presentations in primary care
  o Formerly known as trochanteric bursitis, most cases are non-inflammatory and due to gluteal muscle tears or tendinopathy

• **Diagnosis**
  o **History**
    • Typically lateral hip pain, worse with weight bearing activity and at night which may radiate to the knee
    • Medial hip pain or pain into the groin suggests hip pathology such as OA, avascular necrosis or femoroacetabular impingment syndrome
  o **Examination**
    • Point tenderness (‘the jump test’) over the greater trochanter
    • Single leg stance (pain within 30 seconds of standing on one leg) & Trendelenburg test (pelvis dips on lifting unaffected leg as opposed to staying horizontal or rising slightly)
    • ROM usually preserved except at extremes
  o **Investigation**
    • Consider XRay to exclude OA or stress fracture
    • If suspicion of stress fracture or avascular necrosis despite negative XRay refer for MRI

• **Management**
  o Reassurance and explanation: [Great PIL from patient.co.uk](https://www.patient.co.uk)
  o Relative rest, ice packs & sleeping with pillow between legs on unaffected side
  o Refer for physiotherapy
    • Physiotherapy guided education and exercise classes are superior to wait and see at 8 weeks and also at 52 weeks
  o Consider a corticosteroid injection (CSI)
    • Evidence shows that CSI gives good short term analgesia for up to 3 months, maximising at 6 weeks and that ‘blind’ injection is as good as USS guided
    • At 52 weeks there is no difference in outcome between CSI and ‘wait and see’
    • Consider CSI if very symptomatic to provide an ‘analgesic window’ to enable physiotherapy and rehabilitation
  o **Refer**
    • Urgently if suspect cancer or red flags
    • If diagnosis in doubt or non-resolving despite physiotherapy and CSI