KISS: Greater Trochanteric Pain Syndrome

Based on NICE-CKS 2016, BJGP 2018, BMJ 2018 & J Orthop, Syst Review 2016

- **Background**
  - Affects upto 25% of women aged over 40 and accounts for 20% of all hip presentations in primary care
  - Formerly known as trochanteric bursitis, most cases are non-inflammatory and due to gluteal muscle tears or tendinopathy
- **Diagnosis**
  - **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
  - **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
  - **Investigation**
    - Consider XRay to exclude OA or stress fracture
    - If suspicisios of stress fracture or avascular necrosis despite negative XRay refer for MRI
- **Management**
  - Reassurance and explanation: Great PIL from patient.co.uk
  - Relative rest, ice packs & sleeping with pillow between legs on unaffected side
  - Refer for physiotherapy
    - Physiotherapy guided education and exercise classes are superior to wait and see at 8 weeks and also at 52 week
  - Consider a corticosteroid injection (CSI)
    - Evidence shows that CSI gives good short term analgesia for upto 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 'analegesic window' to enable physiotherapy and rehabilitation
  - **Refer**
    - Urgently if suspect cancer or red flags
    - If diagnosis in doubt or non-resolving despite physiotherapy and CSI