ORTHO PRECISION

✓ GP CLINICAL GUIDE

Trochanteric bursitis: the step-by-step GP attack plan

Recognise it as GTPS, treat the tendon-led problem, use adjuncts selectively and know when to reassess, collaborate and refer - Dr Yas Edirisinghe FRACS FAOrthA MSurg

START WITH PAIN LOCATION

Ask the patient to point with one finger

GTPS - outer hip

Focal, pointable pain over the greater trochanter; may track down the lateral thigh.

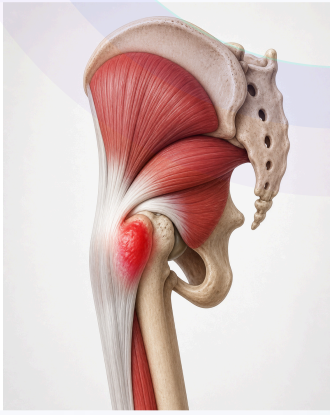
Hip OA - deep groin

Deep joint pain with anterior thigh or knee symptoms, stiffness and loss of rotation.

Feature	GTPS	Hip OA
Pain	Outer bony point	Groin / anterior thigh
Side-lying	Often intolerable	Variable
Passive ROM	Usually preserved	Restricted, especially IR
Shoes / socks	Usually manageable	Often difficult

WHAT IT USUALLY IS

Think tendon first, not "inflamed bursa"



GTPS is an umbrella diagnosis. The common primary lesion is gluteus medius/minimus tendinopathy with secondary bursal irritation.

- Compression rises when the hip sits in adduction.
- Abductor tears and external snapping hip sit on the same spectrum.

Imaging signal alone is not the diagnosis: gluteal tendon changes may also appear in asymptomatic hips.[2]

RAPID CLINICAL CLUSTER

Four checks usually settle the diagnosis

1 History

Outer-hip pain, worse with side-lying, hills, stairs or prolonged standing.

2 Palpation

Reproduce the familiar pain directly over the greater trochanter.

3 Resisted abduction

Reproduction of lateral pain increases the probability of GTPS.

4 ROM and gait

Preserved passive ROM supports GTPS. Weakness or Trendelenburg suggests tear.

Positive palpation followed by positive resisted abduction shifted post-test probability from 59% to 96%; both negative reduced it to 14%.[3]

Best first-line treatment: education, load management and progressive exercise

In the LEAP RCT, education plus exercise produced better global improvement than corticosteroid injection at both 8 and 52 weeks.[1]

79%	58%	12 wk
improved at 52 weeks with education and exercise	improved after corticosteroid injection	minimum progressive programme

Do not miss

- **Weakness or Trendelenburg gait:** suspect gluteal tendon tear.
- Fever, marked rest pain, major trauma or systemic features.
- Dermatomal pain or neurological signs suggesting lumbar referral.

Imaging: plain radiograph if OA is suspected. Reserve ultrasound or MRI for uncertainty, suspected tear or refractory symptoms.

Your patient, your care - our shared plan.

Refer for diagnostic confirmation, suspected tear or stalled recovery. Ortho Precision keeps the GP central and returns the patient with a clear plan.

Same day referral acknowledgement

1-2 weeks usual appointment access

Within 48 h specialist correspondence

GP Referrer Hub guides, referral channels and priority access

GTPS management: a clear five-step pathway

Move down the timeline. Progress according to symptoms and function rather than chasing complete rest.

THE PRACTICAL SEQUENCE

Decompress first, then rebuild tendon capacity

Give the matching Ortho Precision patient guide so the GP, physiotherapist and patient use the same explanation and pain rules.

Simple pain-monitoring rule

Mild discomfort up to 5/10 is acceptable if it settles that evening and is not worse the next morning.

1 Educate and decompress

DAY 1

- Explain a **loaded, compressed gluteal tendon** - not simply an inflamed bursa.
- Avoid leg crossing, hip hanging, painful side-lying, ITB stretching and foam rolling directly over the trochanter.
- Sleep on the other side with support between knees and ankles, or supine with knees supported.
- Modify hills, stairs and very long walks temporarily; do not prescribe total rest.

GP checkpoint

The patient should understand why compression hurts and leave with two or three practical changes they can start tonight.

2 Load progressively

WEEKS 0-12

- Physiotherapy or a supervised home programme: isometrics, then isotonic or heavy-slow resistance, then functional control.
- Exercise most days initially and progress for at least 8-12 weeks.
- Progress by function: sleep, walking, stairs, single-leg control and return to preferred activity.
- Use simple analgesia or a short NSAID course only when clinically appropriate.

GP checkpoint

Confirm that exercise is being progressed, not merely repeated. A static programme often explains a plateau.

3 Use adjuncts selectively

IF PAIN BLOCKS REHABILITATION

- Corticosteroid injection may provide short-term relief, but it does not outperform education and exercise long term.[1,4,5]
- If injection is used, frame it as a window to continue rehabilitation - not as a replacement for loading.
- Shockwave plus exercise can be considered for recalcitrant symptoms; outcomes improve later than injection.[4]
- Avoid serial injections as a substitute for reassessment and tendon rehabilitation.

Use sparingly

Adjuncts are most useful when high irritability or night pain prevents meaningful participation in rehabilitation.

4 Reassess

AT 8-12 WEEKS

- Recheck hip OA, lumbar referral, total load, adherence and exercise progression.
- Look again for abductor weakness or Trendelenburg gait.
- If advanced imaging is likely to change management, Ortho Precision can coordinate appropriate imaging and interpretation.

Change the question

Do not simply repeat the original treatment. Ask whether the diagnosis, load dose or tendon integrity has been missed.

5 Collaborate and refer

EARLIER IF TEAR SUSPECTED

- Refer sooner for weakness, Trendelenburg gait, significant post-THA pain, diagnostic uncertainty or severe night pain preventing rehabilitation.
- If there is no clear improvement after a well-executed three-month programme, refer for specialist review.
- Call the rooms at any stage if you would like to discuss whether referral or imaging is appropriate.

Shared-care aim

Diagnostic clarity, targeted imaging when needed, and a clear recommendation returned to the referring GP.

When the pathway stalls: refer with a clear question

Ortho Precision welcomes early discussion, diagnostic review and collaborative management of difficult lateral hip pain.

WHAT THE PATIENT NEEDS TO SEE

1 - Decompress

Good side down; pillow between knees and ankles.

2 - Modify, do not stop

Reduce hills, stairs and very long walks temporarily.

3 - Start loading

Isometrics can settle pain while beginning tendon load.

4 - Build capacity

Progress to functional hip and leg strength.

Refer sooner when

- Weakness, Trendelenburg gait or suspected abductor tear.
- Diagnostic uncertainty or concern about OA, spine or stress injury.
- Significant post-THA lateral pain.
- Severe night pain preventing rehabilitation.
- No clear progress after 8-12 weeks of correctly delivered care.

Useful details to include

- Exact pain location, duration, night pain and functional limits.
- Trochanteric tenderness, resisted abduction, passive ROM and gait.
- Any weakness, Trendelenburg sign or neurological findings.
- Physiotherapy, injections, analgesia and response to treatment.
- Available radiographs, ultrasound or MRI reports.

Open collaboration with Dr Yas Edirisinghe

Australian-trained specialist hip and knee surgeon, FRACS FAOrthA MSurg, and Director of Orthopaedic Surgeon Training, NALHN. Refer for diagnostic clarity, a suspected tendon tear or stalled conservative care. Your patient remains part of a shared plan and returns to you with clear recommendations.

Refer, discuss or ask a question

Phone 08 7081 4100

Fax 08 7078 7744

admin@orthoprecision.com.au

orthoprecision.com.au/refer-your-patient/

Ashford - Elizabeth Vale - Gawler - Magill

Your patient, your care - our shared plan.

The GP remains central to every decision. We aim to make specialist input accessible, clinically useful and easy to hand back to primary care.

Same day	1-2 weeks	Within 48 h
referral acknowledgement	usual appointment access	specialist correspondence

SELECTED REFERENCES

1. **Mellor R, et al.** Education plus exercise versus corticosteroid injection versus wait-and-see for gluteal tendinopathy. BMJ. 2018;361:k1662.
2. **Ganderton C, et al.** Demystifying the clinical diagnosis of GTPS in women. J Womens Health. 2017;26:633-643.
3. **Kinsella R, et al.** Diagnostic accuracy of clinical tests for GTPS: systematic review with meta-analysis. J Orthop Sports Phys Ther. 2024;54:1-24.
4. **Rompe JD, et al.** Home training, corticosteroid injection or radial shockwave for GTPS. Am J Sports Med. 2009;37:1981-1990.
5. **Brinks A, et al.** Corticosteroid injections for GTPS in primary care. Ann Fam Med. 2011;9:226-234.
6. **Grimaldi A, Fearon A.** Gluteal tendinopathy: pathomechanics and clinical management. J Orthop Sports Phys Ther. 2015;45:910-922.
7. **Redmond JM, et al.** Greater trochanteric pain syndrome. J Am Acad Orthop Surg. 2016;24:231-240.
8. **Disantis A, et al.** ISHA physiotherapy consensus on GTPS assessment and treatment. J Hip Preserv Surg. 2023;10:48-56.

Need a specialist view on lateral hip pain?

Call to discuss the case, clarify whether imaging is worthwhile, or arrange a review.

GP-to-specialist collaboration

Diagnostic clarity, targeted imaging when needed, and a practical plan returned to you.

CALL DR YAS AND THE TEAM

08 7081 4100

or refer online at orthoprecision.com.au