Editorial

Iliotibial band bursectomy and osteotomy of the posterior facet of greater trochanter for greater trochanteric pain syndrome

Volume 4 Issue 3 - 2016

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Received: January 09, 2016 | **Published:** February 12, 2016

Editorial

Trochanteric bursitis causes pain to be felt on the side of your hip which may be particularly felt at night if sleeping on the affected side.

Although most patients respond to corticosteroid injections, rest, physiotherapy, stretching, and anti-inflammatory medications, those with persistent symptoms may require an operation. A bursa is a fluid-filled sac that functions as a gliding surface to reduce friction between tissues of the body. The hip bone has a bony prominence that can be felt on the side of the hip which is known as the greater trochanter. The Trochanteric bursa is located over this bony prominence, and is the bursa that is most commonly inflamed around the hip.

Greater trochanteric pain syndrome (GTPS) is a term used to describe pain overlying the lateral aspect of the hip radiating along thigh to the knee; most cases are self-limited and are treated by simple measures. More invasive surgical interventions have been reported to provide pain relief when conservative treatment modalities fail (Figure 1).

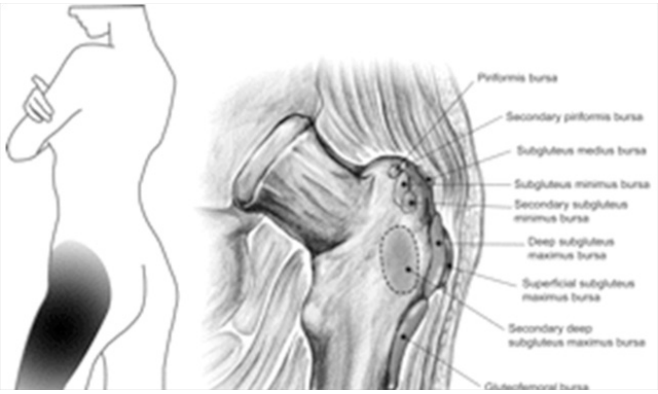

Figure 1 Greater trochanteric pain syndrome.

Non-Surgical Treatment

Anti-inflammatories

Anti-inflammatory, commonly known as non-steroidal anti-inflammatory drugs (usually abbreviated as NSAIDs or NAIDs) are used primarily to treat mild to moderate pain associated with inflammation. This inflammation may be the result of muscular tears, bursitis, tendonitis, arthritis, labral tears, or synovitis. Anti-inflammatory are also used as a first line treatment in conjunction with a strengthening program. Post-operatively, they are prescribed as well.

Physical therapy

Physical therapy is an integral component to the multi-faceted team approach of examining and treating hip pain. The importance of physical therapy at the center for Hip Preservation is to assist in gaining an understanding of the underlying causes of hip pain and then to collaborate with a team of physicians in order to design a comprehensive treatment approach. Rehabilitation is useful in many ways. It may be used as a non-invasive approach to treatment, whereby surgery for the patient is not or no longer indicated.

The hip joint is a very deep joint surrounded by almost 30 muscles. Physical therapy aims to strengthen these muscles, increase flexibility, maintain range of motion of the joint, and decrease the associated inflammation. In the case of a labral tear, physical therapy will not heal the tear. With the appropriate muscular training and activity modification, however, the condition may become asymptomatic and therefore require no surgery.

If operative treatment is inevitable, a pre-operative physical therapy program will provide the ability to address nearly all underlying joint problems or muscle imbalance, which ultimately leads to a better outcome. Additionally, in the event of surgery, post-operative therapy is essential in educating the patient regarding daily activities and in providing an appropriate recovery course. Physical therapy is an integral component in the management of hip pain.

Injections

Injections are commonly prescribed to help relieve a patient's pain as well as to diagnose the direct cause of the pain. Following an injection of a numbing drug into the area, immediate relief from pain will help confirm that the source of pain. If complete pain relief is achieved, the area is likely to be the source of pain. If not, further consideration of a possible cause is needed.

Surgical treatment

The operation involves removing the inflamed bursa and releasing the tension in the iliotibial band by making an incision in the band where it crosses the greater Trochanteric and removing any bone spur that cause the irritation.

The scar is behind the hip area, and relatively small. The old treatment protocol after establishing the diagnosis and excluded other causes was starting with conservative physiotherapy and anti-inflammatory medication treatment and proceed to steroid injections, acupuncture, shock wave therapy and IT band stretching exercise, if all modalities exhausted then surgical excision and cleaning of the granulation tissues plus-minus IT Z-Y plasty. However, the recurrent rate was quite high.

Our method is not much different from the above stepwise treatment approach, the only difference we paid attention to the posterior structure of the greater trochanter which is the rubbing area with IT band anatomically and we found almost all cases of Chronic GT bursitis has a bony spur or provenance that might cause the recurrent of the condition even after a proper surgical excision of the bursa. So we added small posterior facet of GT osteotomy to the surgical procedure.

We had17 consécutive patients aged 21 to 76 (2 male and 15 female) from March 2013 to December 2014 (2 had native hip, 4 had THR and one had labral surgery). Were selected based on peripheral signs. 15 patients had one US guided injection and 6 had second injection. The procedure did include Iliotibial band (ITB) bursectomy and minimal osteotomy of the posterior facet of greater trochanter using lateral approach.

Our results were 14 Patients had good results with relief of symptoms and were discharged at 6 months. 2 patients had no relief (one with abductor weakness with tendency to fall, second had Z-Y plasty with bursectomy for external snapping hip - MRI possible labral tear with no relief after intra-articular injection) and one patient had recurrence of symptoms - awaiting THR.

The Complications after these procedures were; One patient had post op haematoma - spontaneousresolution, one patient had post op ooze - settled and one patient had superficial wound infection - treated with antibiotics.

Soseveral surgical techniques have been reported. We think that bursectomy along with minimal osteotomy of the bare posterior facet of greater trochanter address the tensile strains of ITB and fascia lata, implicated as the source of GTPS. There was no risk of any stress fracture after minimal osteotomy.

Conclusion

ITB bursectomy and osteotomy of the posterior facet of greater trochanter successfully reduces pain in patients with GTPS and allows them to return to their previous level of activity. The great majority of patients were satisfied with results of the procedure.

Acknowledgments

None.

Conflicts of interest

None.