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Review

Greater Trochanteric Pain Syndrome: Current Concepts in Lateral Hip Pain

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Abstract

Greater trochanteric pain syndrome (GTPS) is one of the most common causes of lateral hip pain and includes a spectrum of peritrochanteric disorders involving the gluteal tendons, bursae, and surrounding soft tissues. Although historically associated with isolated trochanteric bursitis, current evidence increasingly highlights the role of gluteal tendinopathy and abductor tendon pathology in symptom development. GTPS is currently considered a multifactorial condition influenced by biomechanical, degenerative, and functional factors. Clinical evaluation remains the cornerstone of diagnosis, while imaging modalities such as magnetic resonance imaging and ultrasonography may help identify associated soft tissue abnormalities. Conservative treatment, particularly exercise-based rehabilitation focusing on hip abductor strengthening and load management, represents the first-line management strategy and is successful in most patients. In refractory cases, surgical interventions including endoscopic bursectomy, iliotibial band release, and gluteal tendon repair may provide favorable outcomes.

This narrative review summarizes current concepts regarding the pathophysiology, clinical presentation, imaging evaluation, and contemporary management strategies for GTPS and lateral hip pain.

Keywords: Greater trochanteric pain syndrome, lateral hip pain, gluteal tendinopathy, trochanteric bursitis, hip abductor tendons, rehabilitation.

1. Introduction

Lateral hip pain is a common musculoskeletal complaint that frequently affects middle-aged and older adults and may lead to substantial limitations in daily activities, sleep quality, and physical function [1]. Among the causes of lateral hip pain, greater trochanteric pain syndrome (GTPS) is considered one of the most common clinical entities. GTPS is estimated to account for a considerable proportion of patients presenting with hip pain in outpatient settings and is more frequently observed in women between the ages of 40 and 60 years [2].

Historically, lateral hip pain was primarily attributed to isolated trochanteric bursitis. However, advances in imaging and clinical research have demonstrated that GTPS represents a broader spectrum of peritrochanteric disorders rather than a single inflammatory condition [3]. Current evidence suggests that gluteus medius and gluteus minimus tendinopathy, partial or full-thickness abductor tendon tears, bursitis, and iliotibial band abnormalities may all contribute to the clinical presentation [4]. Therefore, the term GTPS is now preferred over isolated "trochanteric bursitis" in contemporary literature.

Patients with GTPS commonly report deep lateral hip pain that may radiate to the lateral thigh and is often aggravated by prolonged sitting, stair climbing, lying on the affected side, or activities involving hip loading [5]. Although the diagnosis is primarily based on clinical examination, imaging modalities such as magnetic resonance imaging (MRI) and ultrasonography may help identify gluteal tendon pathology, bursitis, and associated soft tissue abnormalities [6].

Most patients respond favorably to conservative management including activity modification, exercise-based rehabilitation, nonsteroidal anti-inflammatory drugs, and injection therapies [7]. In refractory cases, surgical management such as bursectomy, iliotibial band release, or endoscopic abductor tendon repair may be considered [4].

The purpose of this narrative review is to summarize current concepts regarding the pathophysiology, clinical evaluation, imaging findings, and contemporary management strategies for lateral hip pain and GTPS.

2. Materials and Methods

Pathophysiology and Peritrochanteric Anatomy

Greater trochanteric pain syndrome is currently considered a multifactorial disorder involving the peritrochanteric soft tissues rather than an isolated inflammatory condition of the trochanteric bursa [3]. Earlier studies mainly focused on bursitis as the primary source of lateral hip pain; however, contemporary imaging and histopathological findings have shown that gluteal tendinopathy and abductor tendon pathology play a central role in many patients with GTPS [8]. Degenerative changes, tendon thickening, partial tears, and full-thickness tears of the gluteus medius and gluteus minimus tendons are frequently observed in symptomatic individuals [9].

The peritrochanteric region has a complex anatomical structure consisting of multiple bursae, tendon insertions, and surrounding fascial tissues. The greater trochanter contains four distinct facets, including the anterior, lateral, posterior, and superoposterior facets, which serve as insertion sites for the gluteus medius and gluteus minimus tendons [4]. In addition, the trochanteric, subgluteus medius, and subgluteus minimus bursae facilitate smooth movement between the tendons and adjacent soft tissues [9].

Biomechanical factors are also thought to contribute to GTPS development. Repetitive compressive and tensile loads across the gluteal tendons may lead to tendon degeneration over time, particularly in individuals with hip abductor weakness, altered pelvic mechanics, obesity, or lower limb malalignment [3]. Friction between the iliotibial band and greater trochanter during hip motion may further increase mechanical irritation within the peritrochanteric region [3].

External snapping hip syndrome, also known as external coxa saltans, may coexist with GTPS [10]. In this condition, the iliotibial band or the anterior border of the gluteus maximus moves over the greater trochanter during hip flexion and extension, resulting in snapping sensations and repetitive soft tissue irritation [10]. Chronic mechanical friction may contribute to bursitis, gluteal tendinopathy, and persistent lateral hip pain.

Several risk factors have been associated with GTPS, including increasing age, female sex, obesity, low back pain, hip or knee osteoarthritis, and leg-length discrepancy [2]. In addition, anatomical variations such as increased femoral offset or a wider pelvis may alter hip biomechanics and increase tensile loading on the gluteal tendons [3]. Collectively, these findings support the current understanding of GTPS as a tendon-related and biomechanically influenced disorder rather than a purely inflammatory bursitis [8].

Clinical Presentation and Physical Examination

Patients with greater trochanteric pain syndrome typically present with chronic or intermittent lateral hip pain localized over the greater trochanter. The pain may radiate to the lateral thigh and occasionally extend distally toward the knee [1]. Symptoms are commonly aggravated by activities that increase compressive loading across the lateral hip, including prolonged standing, stair climbing, walking, prolonged sitting, lying on the affected side, and single-leg weight-bearing activities [3]. Many patients also report sleep disturbance due to pain while lying on the symptomatic side.

Physical examination remains the cornerstone of diagnosis. Local tenderness on palpation over the posterolateral aspect of the greater trochanter is one of the most consistent clinical findings and may reflect pathology involving the gluteus medius tendon insertion [11]. Pain reproduction during palpation is considered clinically valuable, particularly when combined with other provocative tests [5].

Several physical examination maneuvers have been described for the evaluation of GTPS. Pain during resisted hip abduction may indicate gluteal tendon pathology or abductor weakness. Commonly used physical examination tests are summarized in Table 1.

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The FABER (flexion, abduction, and external rotation) test and Ober test may also reproduce lateral hip pain by increasing tension across the peritrochanteric structures [12]. In addition, a positive Trendelenburg sign may demonstrate hip abductor insufficiency and impaired pelvic stabilization during single-leg stance [5].

Table 1 - Physical Examination Tests in GTPS [1,5,11-13]

Test	Clinical Purpose	Typical Positive Finding	Reported Diagnostic Value
Palpation of Greater Trochanter	Local tenderness assessment	Reproduction of lateral hip pain	High sensitivity, limited specificity
Single-leg Stance Test (30 s)	Gluteal tendon loading	Pain within 30 seconds	High sensitivity and specificity reported in gluteal tendinopathy
Resisted External Derotation Test	Gluteal tendon pathology	Pain during resisted external rotation	Useful for detecting gluteal tendinopathy
Trendelenburg Test	Hip abductor weakness	Pelvic drop during single-leg stance	Indicates abductor insufficiency
FABER Test	Peritrochanteric compression	Reproduction of lateral hip pain	Moderate diagnostic utility
Ober Test	Iliotibial band tightness	Restricted adduction	May indicate ITB-related pathology
FADIR Test	Differential diagnosis for FAI	Groin pain during flexion-adduction-internal rotation	More suggestive of intra-articular pathology

Diagnostic values vary among studies and should be interpreted together with clinical examination findings

Single-leg stance testing has also been reported as a useful clinical maneuver in patients with GTPS [11]. Reproduction of lateral hip pain within 30 seconds of single-leg standing may indicate gluteal tendon pathology [11]. Furthermore, gait assessment may reveal compensatory trunk lean, reduced hip stability, or antalgic gait patterns in more symptomatic patients [3].

Despite the availability of multiple provocative tests, no single physical examination maneuver is completely diagnostic for GTPS. Therefore, clinical evaluation should include a combination of patient history, palpation findings, functional assessment, and provocative testing [12]. Differential diagnosis is important, as lumbar radiculopathy, hip osteoarthritis, femoroacetabular impingement syndrome, stress fractures, and intra-articular hip disorders may present with similar symptoms [1]. Differential diagnosis is important because several lumbar, intra-articular, and extra-articular pathologies may mimic GTPS (Table 2).

Table 2 - Differential Diagnosis of Lateral Hip Pain [1,5,12]

Condition	Typical Pain Location	Distinguishing Clinical Test	Typical Findings
Greater Trochanteric Pain Syndrome (GTPS)	Lateral hip and lateral thigh	Tenderness over greater trochanter, Single-leg stance test	Pain while lying on affected side, pain during stair climbing, abductor weakness
Lumbar Radiculopathy	Low back radiating to buttock or leg	Straight-leg raise test, neurological examination	Dermatomal pain, paresthesia, neurological deficits

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Table 2 (Continuation) - Differential Diagnosis of Lateral Hip Pain [1,5,12]

Condition	Typical Pain Location	Distinguishing Clinical Test	Typical Findings
Hip Osteoarthritis (OA)	Groin and anterior hip	Reduced hip internal rotation	Morning stiffness, crepitus, reduced range of motion
Femoroacetabular Impingement (FAI)	Groin and anterior hip	FADIR test	Pain during hip flexion and rotation, mechanical symptoms
Stress Fracture	Deep groin or thigh pain	Hop test, imaging evaluation	Pain aggravated by weight-bearing activities
Meralgia Paresthetica	Lateral thigh	Sensory examination	Burning pain or numbness over lateral thigh

GTPS, greater trochanteric pain syndrome; OA, osteoarthritis; FAI, femoroacetabular impingement

Imaging Evaluation

Although the diagnosis of greater trochanteric pain syndrome is primarily clinical, imaging modalities may be useful for confirming the diagnosis, excluding alternative pathologies, and identifying associated tendon abnormalities [6]. Imaging is particularly valuable in patients with persistent symptoms, suspected abductor tendon tears, or inadequate response to conservative treatment [14].

Plain radiographs are usually obtained as the initial imaging modality to exclude other causes of hip pain such as osteoarthritis, femoroacetabular impingement syndrome, stress fractures, or avascular necrosis [1]. Radiographic findings are often nonspecific in GTPS; however, enthesophytes and irregularities at the greater trochanter may suggest underlying gluteal tendon pathology [12]. The anatomical relationship of the gluteus medius, gluteus minimus, and surrounding peritrochanteric structures is demonstrated in Figure 1. Previous studies have reported an association between trochanteric surface irregularities and abductor tendon abnormalities [9].

Figure 1 - MRI anatomy of the peritrochanteric region relevant to GTPS, demonstrating the gluteus medius subdivisions, gluteus minimus tendon complex, and surrounding soft tissues

Magnetic resonance imaging (MRI) is considered the gold standard imaging modality for evaluating peritrochanteric soft tissue pathology [15]. MRI can identify gluteus medius and gluteus minimus tendinopathy, partial- or full-thickness tendon tears, peritendinous edema, bursitis, and fatty muscle atrophy [4] (Figure 2). In addition, MRI is valuable for differentiating GTPS from intra-articular or spinal pathologies that may mimic lateral hip pain [15].

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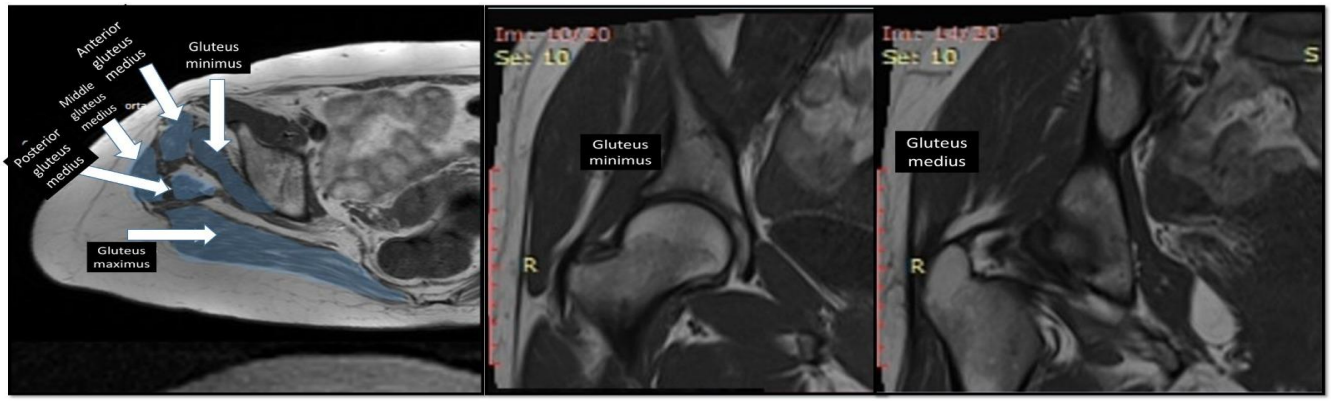

Figure 2 - MRI demonstrates asymmetric fatty atrophy of the gluteal musculature, particularly involving the gluteus medius/minimus complex

3. Discussion

Conservative Treatment

Conservative management is considered the first-line treatment for greater trochanteric pain syndrome and is successful in most patients [8]. Current treatment strategies primarily focus on reducing excessive tendon compression, improving hip abductor function, and restoring lumbopelvic biomechanics. Initial management generally includes activity modification, exercise-based rehabilitation, nonsteroidal anti-inflammatory drugs (NSAIDs), and injection therapies [3].

Patient education and load management play an important role during the early stages of treatment. Patients are commonly advised to avoid positions and activities that increase compressive forces across the lateral hip, such as prolonged side-lying on the affected side, crossing the legs, or excessive single-leg loading [3]. Temporary reduction of aggravating activities may help decrease pain and mechanical irritation around the gluteal tendons [3].

Exercise-based rehabilitation is currently regarded as one of the most important components of conservative treatment [7]. Rehabilitation programs generally aim to improve hip abductor strength, pelvic stability, and lower extremity biomechanics. Progressive strengthening of the gluteus medius and gluteus minimus muscles, together with functional and weight-bearing exercises, may reduce symptoms and improve physical function [5,7]. In addition, movement retraining and correction of abnormal loading patterns may help decrease repetitive compression of the peritrochanteric structures [7].

NSAIDs may provide short-term symptomatic relief, particularly in patients with associated bursitis or inflammatory irritation [8]. Corticosteroid injections are also commonly used and may reduce pain in the short term; however, long-term benefits appear to be more limited when compared with exercise-based interventions [7]. Ultrasound-guided injections may improve injection accuracy, especially in patients with deeper soft tissue pathology [14].

Extracorporeal shock wave therapy (ESWT) and biologic treatments such as platelet-rich plasma (PRP) injections have also been investigated in recent years [16]. Although some studies have reported promising clinical outcomes, the current evidence remains heterogeneous, and further high-quality studies are needed to clarify their effectiveness and optimal indications [8].

Most patients improve with nonoperative management, although symptom resolution may require several months. Previous recommendations suggest that conservative treatment should generally be continued for at least six months before considering surgical intervention in refractory cases [16].

Surgical Treatment

Surgical treatment may be considered in patients with persistent symptoms despite prolonged conservative management. In general, surgery is reserved for individuals who continue to experience significant pain and functional limitation after at least 6-12 months of nonoperative treatment [4]. The choice of surgical procedure depends on the underlying pathology, including bursitis, iliotibial band abnormalities, external snapping hip syndrome, or gluteal tendon tears.

Bursectomy is one of the most commonly performed procedures in patients with refractory trochanteric bursitis or persistent peritrochanteric inflammation [17]. In some cases, bursectomy may be combined with iliotibial band (ITB) release to reduce mechanical friction over the greater trochanter [18].

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Several techniques for ITB release have been described, including longitudinal release, T-shaped incision, fenestration, and Z-plasty procedures [18]. These procedures may also be beneficial in patients with external snapping hip syndrome.

In patients with partial- or full-thickness gluteal tendon tears, surgical tendon repair may be indicated [19]. Both open and endoscopic repair techniques have been described in the literature, with generally favorable clinical outcomes in terms of pain reduction and functional improvement [20]. Endoscopic repair techniques have gained increasing popularity because they are less invasive and may be associated with lower complication rates compared with open procedures.

Previous studies have reported similar clinical effectiveness between open and endoscopic abductor tendon repairs, although endoscopic approaches appear to demonstrate lower complication rates and reduced soft tissue morbidity [20]. In addition, systematic reviews have shown promising success rates following endoscopic treatment of GTPS [17].

In cases of severe tendon retraction, fatty degeneration, or advanced muscle atrophy, primary tendon repair may not be feasible [19]. In such situations, tendon augmentation procedures or muscle transfer techniques may be considered. However, the evidence regarding these advanced reconstructive procedures remains limited.

Although surgical management generally provides favorable outcomes in carefully selected patients, high-quality comparative studies are still limited [19]. Therefore, further research is needed to establish optimal surgical indications, rehabilitation protocols, and long-term outcomes following different surgical techniques.

Future Directions and Emerging Concepts

The understanding of greater trochanteric pain syndrome has evolved considerably over the past decade. Rather than being viewed solely as an inflammatory bursitis, GTPS is now increasingly recognized as a complex tendon-related disorder involving biomechanical, degenerative, and functional factors [3]. This shift in perspective has influenced both diagnostic approaches and treatment strategies.

One of the emerging concepts in GTPS is the growing emphasis on gluteal tendinopathy and load-related tendon pathology [13]. Similar to other lower extremity tendinopathies, abnormal mechanical loading, impaired pelvic control, and hip abductor weakness are believed to contribute to persistent symptoms [13]. Consequently, contemporary rehabilitation approaches increasingly focus on movement quality, lumbopelvic stability, and progressive tendon loading rather than isolated pain reduction alone [3].

Advances in imaging techniques have also improved the understanding of peritrochanteric pathology. High-resolution MRI and dynamic ultrasonography allow better visualization of gluteal tendon abnormalities, bursae, and iliotibial band disorders [9]. However, imaging findings do not always correlate with clinical symptoms, highlighting the need for more precise clinical classification systems and patient-specific treatment approaches [6].

Another important area of interest is the role of biologic and regenerative therapies. Platelet-rich plasma injections, stem cell based treatments, and other biologic interventions are increasingly investigated for the management of chronic gluteal tendinopathy [21]. Although early results appear promising in some studies, the current evidence remains limited and inconsistent [16]. Further randomized controlled trials are needed to establish their long-term efficacy and optimal clinical indications.

Surgical techniques have also continued to evolve, particularly with the increasing use of minimally invasive endoscopic procedures. Endoscopic gluteal tendon repair and iliotibial band release may provide favorable outcomes with reduced soft tissue morbidity and lower complication rates [17]. Nevertheless, standardized rehabilitation protocols and long-term comparative studies are still lacking [19].

Despite recent advances, several challenges remain in the management of GTPS. The heterogeneity of patient presentations, variability in imaging findings, and limited high-quality evidence regarding optimal rehabilitation and surgical indications continue to complicate clinical decision-making [12]. Future studies focusing on biomechanics, tendon loading strategies, patient-reported outcomes, and individualized treatment algorithms may help improve long-term outcomes in patients with lateral hip pain and GTPS.

4. Conclusions

Greater trochanteric pain syndrome is a multifactorial condition representing one of the most common causes of lateral hip pain. Contemporary evidence suggests that gluteal tendinopathy and abductor tendon pathology play a more important role than isolated bursitis in many symptomatic patients. Although imaging modalities may support the diagnostic process, clinical history and physical

examination remain essential for accurate evaluation and differential diagnosis.

Conservative management, particularly exercise-based rehabilitation focusing on hip abductor strengthening and load management, continues to be the cornerstone of treatment and is effective in most patients. In individuals with persistent symptoms despite prolonged nonoperative treatment, surgical interventions such as endoscopic bursectomy, iliotibial band release, and gluteal tendon repair may provide favorable clinical outcomes. As the understanding of GTPS continues to evolve, future research is needed to optimize individualized treatment strategies and improve long-term patient outcomes.

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Түйіндеме

Ұршық ауруы синдромы (ҰАС) — жамбас буынының бүйір аймағындағы ауырсынудың ең жиі кездесетін себептерінің бірі. Ол бөксе сіңірлерін, сарысулы сөмкелерді (бурсаларды) және айналасындағы жұмсақ тіндерді зақымдайтын периұршықтық бұзылыстардың спектрін қамтиды. Тарихи тұрғыдан бұл синдром оқшауланған ұршық бурситімен байланыстырылғанымен, қазіргі таңдағы деректер симптомдардың дамуында бөксе тендинопатиясы мен әкеткіш бұлшықет сіңірлері патологиясының рөлі жоғары екенін жиі көрсетіп отыр. Қазіргі уақытта ҰАС биомеханикалық, дегенеративті және функционалдық факторлардың әсерінен туындайтын көпфакторлы жағдай ретінде қарастырылады. Клиникалық бағалау диагноз қоюдың негізі болып қала береді, ал магниттік-резонанстық томография және ультрадыбыстық зерттеу сияқты визуализация әдістері ілеспе жұмсақ тін аномалияларын анықтауға көмектеседі. Консервативті емдеу, әсіресе жамбасты әкеткіш бұлшықеттерді нығайтуға және жүктемені басқаруға бағытталған жаттығуларға негізделген оңалту, бірінші таңдаулы стратегия болып табылады және емделушілердің көпшілігінде сәтті нәтиже береді. Ем әсер етпейтін жағдайларда эндоскопиялық бурсэктомияны, илиотибиальды тракттың босатуын және бөксе сіңірлерін қалпына келтіруді қамтитын хирургиялық араласулар жақсы нәтижелерге қол жеткізуге мүмкіндік береді.

Бұл нарративті шолуда ҰАС пен жамбас буынының бүйір аймағындағы ауырсынудың патофизиологиясына, клиникалық көрінісіне, визуализациялық бағалануына және заманауи емдеу стратегияларына қатысты қазіргі тұжырымдамалар жинақталған.

Түйін сөздер: ұршық ауруы синдромы, жамбас буынының латеральды ауырсынуы, бөксе тендинопатиясы, ұршық бурситі, жамбасты әкеткіш бұлшықет сіңірлері, оңалту.

Синдром боли большого вертела: Современные представления о латеральной боли в области тазобедренного сустава

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Резюме

Синдром боли в области большого вертела (СББВ) является одной из наиболее частых причин боли в латеральной области тазобедренного сустава. Он включает в себя спектр перивертельных нарушений, поражающих ягодичные сухожилия, сумки (бурсы) и окружающие мягкие ткани. Хотя исторически этот синдром связывали с изолированным вертельным бурситом, современные данные все чаще указывают на роль ягодичной тендинопатии и патологии сухожилий отводящих мышц в развитии симптомов. В настоящее время СББВ рассматривается как многофакторное состояние, развивающееся под влиянием биомеханических, дегенеративных и функциональных факторов. Клиническая оценка остается основой диагностики, в то время как методы визуализации, такие как магнитно-резонансная томография и ультразвуковое исследование, могут помочь выявить сопутствующие аномалии мягких тканей. Консервативное лечение, особенно реабилитация на основе физических упражнений с упором на укрепление отводящих мышц бедра и управление нагрузкой, представляет собой стратегию первой линии и оказывается успешным у большинства пациентов. В рефрактерных случаях хирургические вмешательства, включая эндоскопическую бурсэктомию, релиз илиотибиального тракта и пластику сухожилий ягодичных мышц, могут обеспечить благоприятные результаты.

В данном нарративном обзоре обобщены современные концепции, касающиеся патофизиологии, клинической картины, визуализационной оценки и современных стратегий лечения СББВ и боли в латеральной области тазобедренного сустава.

Ключевые слова: синдром боли в области большого вертела, латеральная боль в тазобедренном суставе, ягодичная тендинопатия, вертельный бурсит, сухожилия отводящих мышц бедра, реабилитация.

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