



Elusive trochanteric bursitis relief

Bruce Rothschild¹

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An interesting observation draws attention to technique issues. Nissen et al. [1] found that intra-trochanteric injection with betamethasone produced no greater long-term benefit than saline injections for greater trochanteric pain syndrome. One, three, and six month post-injection pain intensity was unaffected by this intervention. Their recommendation that future patients be advised of unlikely long-term benefit would seem reasonable, except for two fundamental methodologic flaws precluding such clinical application of their findings. Betamethasone is water soluble [2] and the terminology trochanteric bursa may be misleading. There are actually four bursa surrounding attachments to the femoral greater trochanter [3]. Those have been variously reported to include the gluteus medius, gluteus minimus, subgluteus medius, and subgluteus minimus tendons [3, 4].

There does not appear to be evidence that involvement in individuals with the greater trochanteric pain syndrome is limited to a single bursa. My personal approach is to inject all four of the above-delineated bursa, as I, too, found that injection of a single bursa did not provide long-term relief. The injection procedure is to note presence of pain on positioning the needle in each bursa, prior to the injection of each. That not only confirms the appropriate site for injection but also notes that bursa is inflamed. My observation is that all four bursa are inflamed, or at least sources of clinical symptoms, in almost all individuals with greater trochanteric pain syndrome.

Returning the first point, it is unclear that water-soluble, highly diffusible agents remain in sufficient quantity (levels) in the injected areas to provide long-term relief or even to allow healing of the inflammatory process. This concern for bursal injections is predicated upon noted lack of efficacy of most water soluble, contrasted with water-insoluble

corticosteroids efficacy for knee joint injections [5]. It should be noted that joint (as opposed to bursa) steroid injections are no longer favored because of the damage to joint cartilage [6], not an issue in bursal closed spaces. My choice of injectable is the water-insoluble/depot drug, triamcinolone, assuring that all inflamed bursa are injected.

Compliance with ethical standards

Disclosures None

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✉ Bruce Rothschild
spondylair@gmail.com

¹ Indiana University, Carnegie Museum, 4400 Forbes Ave,
Pittsburgh, PA 15213, USA