NICE National Institute for Health and Care Excellence

NICE guidance

Distal iliotibial band lengthening for refractory greater trochanteric pain syndrome

HealthTech guidance

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Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account, and specifically any special arrangements relating to the introduction of new interventional procedures. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties. Providers should ensure that governance structures are in place to review, authorise and monitor the introduction of new devices and procedures.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guidance replaces IPG375.

1 Recommendations

1.1 Current evidence on the efficacy and safety of distal iliotibial band lengthening for refractory greater trochanteric pain syndrome is inadequate in quantity and quality. Therefore, this procedure should only be used in the context of research. Research studies should clearly define patient selection, and outcomes should include measures of function and quality of life.

2 The procedure

2.1 Indications and current treatments

2.1.1 Greater trochanteric pain syndrome is a disorder that affects the (lateral) side of the hip or hips. Greater trochanteric pain may be associated with inflammation of the trochanteric bursa (also known as trochanteric bursitis). The trochanteric bursa is a small fluid-filled sac that separates the greater trochanter of the femur and the overlying fascia lata to allow smooth movement. Greater trochanteric pain may also be associated with direct injury, tendon damage, infection, differences in leg length or hip-replacement surgery.

2.1.2 Greater trochanteric pain syndrome is usually managed conservatively with rest, physiotherapy, anti-inflammatory medication and corticosteroid injections. In patients refractory to conservative treatment, surgical options such as bursectomy or supratrochanteric fasciotomy may be used.

2.2 Outline of the procedure

2.2.1 The aim of distal iliotibial band lengthening for refractory greater trochanteric pain syndrome is to relieve the pressure between the greater trochanter and the fascia lata by lengthening the iliotibial band (a thickened and reinforced part of the fascia lata which runs longitudinally throughout its length).

2.2.2 Distal iliotibial band lengthening for greater trochanteric pain syndrome is carried out with the patient under local or general anaesthesia. Through a short lateral incision above the knee a 'Z' lengthening of the iliotibial band of approximately 1.5 cm to 2 cm is performed. The fascia is repaired with sutures.

2.3 Efficacy

This section describes efficacy outcomes from the published literature that the committee considered as part of the evidence about this procedure. For more detailed information on

the evidence, see the overview.

2.3.1 A case series of 11 patients reported a mean Harris hip score of 61 before the procedure and 91 at a mean 43-month follow-up (the Harris hip score measures functional ability, hip dynamics and range of movement on a scale from 0 to 100, in which a higher score indicates a better health outcome).

2.3.2 The case series of 11 patients reported a mean pain score (measured on a scale from 0 to 100; a higher score indicates worse pain) of 83 before the procedure and 13 at a mean follow-up of 43 months.

2.3.3 A case series of 12 patients reported a significant increase in mean EQ-5D score (a standardised assessment of mobility, self care, usual activities, pain and/or discomfort and anxiety and/or depression; a higher score indicates a better health outcome) from 0.26 before the procedure to 0.67 at a mean 28-month follow-up ($p<0.005$).

2.3.4 The specialist advisers expressed doubt about the conceptual mechanism of action of this procedure. They listed key efficacy outcomes as pain relief, patient satisfaction, hip function (measured using the isokinetic strength Harris hip score) and quality of life (measured using SF-36 or Euroqol scores).

2.4 Safety

This section describes safety outcomes from the published literature that the committee considered as part of the evidence about this procedure. For more detailed information on the evidence, see the overview.

2.4.1 Seroma was reported in 1 patient in the case series of 11 patients (timing of event not stated); this was successfully treated by surgical drainage.

2.4.2 The specialist advisers considered that loss of strength in the lower limb was a theoretical adverse event.

Update information

Minor changes since publication

January 2026: Interventional procedures guidance 375 has been migrated to HealthTech guidance 246. The recommendations and accompanying content remain unchanged.

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Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.