

# Distal iliotibial band lengthening for refractory greater trochanteric pain syndrome

Interventional procedures guidance

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[nice.org.uk/guidance/ipg375](https://www.nice.org.uk/guidance/ipg375)

## 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. However, 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.

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.

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.

## 1 Guidance

- 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 1.5–2 cm is performed. The fascia is repaired with sutures.

Sections 2.3 and 2.4 describe efficacy and 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](#).

## 2.3 *Efficacy*

- 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*

- 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.

## 3 Further information

- 3.1 For related NICE guidance see our [website](#).

## *Information for patients*

NICE has produced [information on this procedure for patients and carers](#) ('Understanding NICE guidance'). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

## **4 About this guidance**

NICE interventional procedure guidance makes recommendations on the safety and efficacy of the procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS. It is for healthcare professionals and people using the NHS in England, Wales, Scotland and Northern Ireland, and is endorsed by Healthcare Improvement Scotland for implementation by NHSScotland.

This guidance was developed using the NICE [interventional procedure guidance](#) process.

We have produced a [summary of this guidance for patients and carers](#). Information about the evidence it is based on is also [available](#).

### **Changes since publication**

2 January 2012: minor maintenance.

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Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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## *Endorsing organisation*

This guidance has been endorsed by [Healthcare Improvement Scotland](#).

## *Accreditation*

