

PHYSICAL THERAPY PROTOCOL

Trochanteric Bursectomy Rehabilitation

Endoscopic or Open — With or Without Iliotibial Band Lengthening

FOR THE PHYSICAL THERAPIST

Overview and Goals

This protocol governs rehabilitation following trochanteric bursectomy at the lateral hip, performed endoscopically or open, for recalcitrant greater trochanteric pain syndrome. The bursectomy is the procedure performed in every case; in some patients it is accompanied by iliotibial band (ITB) lengthening to decompress the lateral compartment and address external snapping (coxa saltans externa). The phase table below is the standard bursectomy track; when ITB lengthening is performed, apply the **ITB Lengthening Modification** in addition.

Trochanteric bursectomy is a soft-tissue procedure, and the standard track progresses relatively quickly — weight bearing as tolerated, early ROM, and a staged strengthening program. Eccentric hip abductor strengthening is the cornerstone of recovery: gluteal weakness is both a predisposing factor for and a consequence of lateral hip pain, and a minimum 12-week strengthening program is recommended for tissue remodeling.⁷

When ITB lengthening is added, the early phase becomes slightly more conservative to protect the lengthened tissue — see the ITB Lengthening Modification.

Progression is criterion-based. Time ranges represent typical windows, not gates. The evidence base for ITB-lengthening rehabilitation is limited to Level IV case series and expert opinion; this protocol is synthesized accordingly and should be individualized to surgical technique, tissue quality, and concomitant procedures.^{1,3}

READ BEFORE STARTING — SCOPE & MODIFICATIONS

- The phase table is the standard track for trochanteric bursectomy, endoscopic or open.
- If **ITB lengthening** was performed, apply the **ITB Lengthening Modification** below in addition to the standard protocol.
- If FAI correction, labral repair, or gluteus medius repair was performed concomitantly, those procedures modify weight-bearing and ROM significantly — apply the most conservative restriction and refer to the corresponding protocol. Contact Dr. Roth's office if uncertain.

Rehabilitation Phases

Standard trochanteric bursectomy track. For ITB lengthening, layer in the modifications described in the following section.

PHASE	WEIGHT BEARING	PRECAUTIONS	ROM GOALS	EXERCISES	CRITERIA TO ADVANCE
PHASE 1 Weeks 0–2 <i>Protection & pain control</i>	• Weight bearing as tolerated (WBAT) with crutches for comfort.¹⁰ • Flat-foot gait pattern; avoid lateral trunk lean	Bursectomy site: • No side-lying on the operative side • Pillow between the knees when side-lying on the non-operative side	Gentle active-assisted hip ROM as tolerated. • Progress as comfort allows.	Pain & inflammation control: • Ice, compression, elevation; NSAIDs as needed. Scar massage once incisions healed. Strengthening (isometrics only): • Quad sets • Ankle pumps, plantarflexion / dorsiflexion • Gentle isometric gluteal sets Avoid:	• Pain controlled at rest and with prescribed exercises • Active-assisted ROM within tolerance • Gluteal isometric activation symmetric on

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PHASE	WEIGHT BEARING	PRECAUTIONS	ROM GOALS	EXERCISES	CRITERIA TO ADVANCE
	(Trendelenburg pattern).			- Active hip abduction against resistance - Side-lying on the operative side	palpation
PHASE 2 Weeks 2–6 <i>Early mobility & activation</i>	- Wean off crutches as gait normalizes — typically within ~2 weeks for isolated bursectomy.¹⁰ - If ITB lengthening was performed: extend crutch use, weaning by weeks 4–6. - One contralateral crutch may be used until gait is symmetric.	Continue to avoid side-lying on the operative side until comfortable.	Progress to full hip ROM as tolerated.	Gluteus medius activation (low-level — critical): - Eccentric hip abductor weakness is a documented impairment in this population — begin early.⁷ - Supine isometric hip abduction - Double-leg bridges - Resisted terminal knee extension - Resisted knee flexion (prone hamstring curls) Why these exercises: - They activate the gluteus medius at low levels while minimizing iliopsoas co-activation.⁸ Aquatic therapy: - Pool walking / gait training once incisions fully healed Gait: - Restore normal gait; address any Trendelenburg pattern	- Normalized gait without assistive device - Full or near-full hip ROM - Low-level abductor activation tolerated without pain - No persistent Trendelenburg pattern
PHASE 3 Weeks 6–12 <i>Progressive strengthening</i>	Full weight bearing.	None.	Full hip ROM.	Eccentric hip abductor strengthening (cornerstone): - Side-lying hip abduction through full ROM (limb over the side of a plinth) — the most evidence-supported exercise for restoring eccentric abductor strength. Progress resistance from ~15 RM to 8–10 RM for tissue remodeling.⁷ Philippon EMG-guided progression: - Phase II: resisted hip extension, stool hip rotations, side-lying hip abduction with wall-sliding. Phase III: hip clams, prone heel squeezes, single-leg bridges.⁹ Core / lumbo-pelvic stabilization: - Planks, side planks, dead bug, bird dog Cardio: - Stationary cycling, elliptical trainer	- Hip abductor strength symmetry approaching 70% - Eliminated Trendelenburg pattern with single-leg stance - Tolerates side-lying abduction at moderate load without pain - Single-leg balance ≥ 20 sec
PHASE 4 Weeks 12–16+ <i>Functional training & return to activity</i>	Full weight bearing.	None.	Full pain-free ROM.	Continue eccentric abductor strengthening: - Minimum 12 weeks total to stimulate collagen synthesis and tissue remodeling.⁷ Functional / sport-specific training: - Progressive functional and sport-specific drills - Step-ups, step-downs, lunges, single-leg progressions Running progression: - Every other day, starting with easy efforts, avoiding hills initially, gradual increase in frequency and intensity.⁹	<i>See Return-to-Activity Criteria section below.</i> Return to full unrestricted activity typically at ~3–4 months.²³

PHASE	WEIGHT BEARING	PRECAUTIONS	ROM GOALS	EXERCISES	CRITERIA TO ADVANCE
				Plyometrics / agility: • As tolerated Home program: • Establish home maintenance program for ongoing strength and ROM gains beyond formal PT	

ITB Lengthening Modification

If ITB lengthening was performed with the bursectomy, the modifications below apply **in addition to** the standard protocol. The lengthened ITB requires early protection from adduction stretch; the surgical lengthening has already addressed the tightness, so aggressive stretching in the first 4–6 weeks risks disrupting the healing tissue.

ITB LENGTHENING — READ BEFORE STARTING

Weight bearing: WBAT with crutches, same as standard — but extend crutch use, weaning by weeks 4–6 rather than ~2, as gait normalizes.

ROM / stretch protection: Avoid passive hip adduction stretching and the combined deep flexion + adduction across midline that stresses the lengthening. No ITB / TFL stretching before week 4; begin gently thereafter (modified Ober, cross-body adduction).

Trendelenburg: Monitor more closely — excessive ITB release can compromise lateral hip stability. If a Trendelenburg sign persists beyond 6 weeks, intensify gluteus medius strengthening before advancing impact loading.

Return to activity: Timeline is similar — ~3–4 months to full activity — with the early phase paced more conservatively.

Procedure-Specific Considerations

Eccentric Hip Abductor Strengthening Is the Cornerstone

For both the standard bursectomy and the ITB-lengthening track, eccentric hip abductor strengthening is the single most important rehabilitation element. Gluteal weakness is both a predisposing factor for and a consequence of lateral hip pain and external snapping hip, and a minimum 12-week program is recommended to stimulate collagen synthesis and tissue remodeling.⁷ Side-lying hip abduction through full range — progressing from ~15 RM toward 8–10 RM — is the most evidence-supported loading exercise for this purpose.

Monitor for Trendelenburg Gait

A Trendelenburg sign in the early weeks is expected as the abductors recover. When ITB lengthening was performed, monitor more closely — excessive ITB release can compromise lateral hip stability. If a Trendelenburg sign persists beyond 6 weeks, intensify gluteus medius strengthening rather than progressing impact loading through the deficit.^{1,4}

When Concomitant Procedures Were Performed

Concomitant FAI correction, labral repair, or gluteus medius repair modifies the protocol significantly — particularly weight-bearing and ROM.^{10,11} Apply the most conservative restriction in each dimension and refer to the corresponding protocol; the most restrictive procedure dictates the pace. Contact Dr. Roth's office when uncertain about which procedures were performed or how to combine restrictions.

EVIDENCE BASE — LEVEL IV

No randomized trials have compared rehabilitation protocols after ITB surgery for snapping hip; the available literature is Level IV case series and expert opinion.^{1,3} This protocol synthesizes those series with hip arthroscopy rehabilitation principles and the biomechanical rationale specific to ITB surgery, and should be individualized to the patient.

Return-to-Activity Criteria

Return to activity is criterion-based. Most surgical series report return to previous activity level at approximately 3–4 months; in the Provencher series, nearly all patients returned to full unrestricted activity at mean follow-up.² Eccentric abductor strengthening should continue for a minimum of 12 weeks total, and progression into a home program with periodic check-ins is typical.

Domain	Criterion
Pain & symptoms	No lateral hip pain at rest, with activity, or with direct pressure over the trochanter; resolution of external snapping (if present)
Range of motion	Full, pain-free hip ROM
Abductor strength	LSI $\geq$ 80% on side-lying or hand-held dynamometer testing
Gait	Pain-free gait without assistive device; no Trendelenburg sign with single-leg stance
Functional tasks	Step-ups, lunges, single-leg stance, and lateral activities without pain or compensation
Time to full activity	Typically ~3–4 months; eccentric abductor strengthening continued $\geq$ 12 weeks ^{2,3}

References

1. Storgaard Jensen S, Lund K, Lange J. The Effect of Iliotibial Band Surgery at the Hip: A Systematic Review. *BMC Musculoskelet Disord*. 2023;24(1):75.
2. Provencher MT, Hofmeister EP, Muldoon MP. The Surgical Treatment of External Coxa Saltans (The Snapping Hip) by Z-Plasty of the Iliotibial Band. *Am J Sports Med*. 2004;32(2):470–476.
3. Randelli F, Mazzoleni MG, Fioruzzi A, et al. Surgical Interventions for External Snapping Hip Syndrome. *Knee Surg Sports Traumatol Arthrosc*. 2021;29(8):2386–2393.
4. Zhang S, Li C. Editorial Commentary: The Indication and Technique of Iliotibial Band Release for External Snapping Hip During Hip Arthroscopy in Patients With FAI Syndrome. *Arthroscopy*. 2022;38(6):1900–1903.
5. Ilizaliturri VM, Martinez-Escalante FA, Chaidez PA, Camacho-Galindo J. Endoscopic Iliotibial Band Release for External Snapping Hip Syndrome. *Arthroscopy*. 2006;22(5):505–510.
6. Kim DH, Baechler MF, Berkowitz MJ, Rooney RC, Judd DB. Coxa Saltans Externa Treated With Z-Plasty of the Iliotibial Tract in a Military Population. *Mil Med*. 2002;167(2):172–173.
7. Jacobsen JS, Thorborg K, Søballe K, Ulrich-Vinther M. Eccentric Hip Abductor Weakness in Patients With Symptomatic External Snapping Hip. *Scand J Med Sci Sports*. 2012;22(6):e140–e146.
8. Philippon MJ, Decker MJ, Giphart JE, et al. Rehabilitation Exercise Progression for the Gluteus Medius Muscle With Consideration for Iliopsoas Tendinitis: An In Vivo Electromyography Study. *Am J Sports Med*. 2011;39(8):1777–1785.
9. Fredericson M, Weir A. Practical Management of Iliotibial Band Friction Syndrome in Runners. *Clin J Sport Med*. 2006;16(3):261–268.
10. Hanish S, Muhammed M, Kelly S, DeFroda S. Postoperative Rehabilitation for Arthroscopic Management of FAI Syndrome: A Contemporary Review. *Curr Rev Musculoskelet Med*. 2023;16(9):381–391.
11. Quesada-Jimenez R, Sikligar D, Schab AR, Kahana-Rojkind AH, Domb BG. Midterm Outcomes of Arthroscopic Treatment for Concomitant Painful External Hip Snapping and FAI Syndrome: A Minimum 5-Year Follow-Up Study. *Am J Sports Med*. 2026.

Glossary

Coxa saltans externa — External snapping hip; the ITB or gluteus maximus snapping over the greater trochanter.

FWB — Full weight-bearing.

GTPS — Greater trochanteric pain syndrome; lateral hip pain arising from the trochanteric bursa and/or gluteal tendons.

ITB — Iliotibial band; the lateral fascial band running from the iliac crest to the proximal tibia.

LSI — Limb Symmetry Index; the operative limb's strength or performance as a percentage of the contralateral limb (operative ÷ contralateral × 100).

RM — Repetition maximum; the heaviest load that can be lifted for a given number of repetitions (e.g., 15 RM fails at 15 reps).

ROM — Range of motion.

TFL — Tensor fasciae latae; the muscle that tensions the ITB.

WBAT — Weight-bearing as tolerated; the patient loads the operative limb to comfort, weaning assistive devices as gait normalizes.



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