I Fix Most Gluteal Tears
Mini Debate: Peritrochanteric Space is Overrated

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I. Abductor tendinopathies
   A. Common source of symptoms with what appears to be recalcitrant trochanteric bursitis
   B. MRI diagnosis
      1. Clinical relevance established by history & examination
      2. Changes often observed as normal consequence of aging
   C. Clinical findings
      1. Positive Trendelenburg sign (Fig. 1&2)
      2. Abductor lurch (Trendelenburg gait) (Fig. 3)
         - Often substantial gait pattern disturbances
      3. Differential palpation & strength testing for gluteus medius (Fig. 4&5)

![Figure 1. Normal firing of abductors maintains level pelvis.](image1)
![Figure 2. Positive Trendelenburg sign: With abductor weakness, pelvis drops when contralateral foot lifted off ground.](image2)
![Figure 3. Trendelenburg gait: With abductor weakness, trunk shifts towards involved hip to shorten lever arm for center of gravity.](image3)
Figure 4. Knowledge of lateral anatomy allows palpation of specific structures.

Figure 5. Manual testing for abductor strength can isolate various structures.
D. **Ultrasound guided injections**

1. Area of tendinosis/tendinopathy easily identified (Fig. 6)
2. Anesthetic injection has diagnostic value to establish clinical relevance of lesion (Fig. 7)
3. Concomitant corticosteroid may have therapeutic value
4. PRP efficacy uncertain but may be further option of conservative tx
E.  Rotator cuff tears of the hip
   1. Most commonly gluteus medius; sometimes minimus
   2. Clinical presentation
      a) Often describe pop or sudden injury
      b) 6th & 7th decades
      c) Females > males
      d) Positive exam findings
      e) Failure of conservative treatment
         - Temporary relief from injections
      f) MRI usually confirmatory

II. Peritrochanteric Space
   A. Space between greater trochanter and iliotibial band
      - Analogous to subacromial space of shoulder
   B. Reliable endoscopic access and definable anatomy
      1. Initial access provided by two anteriorly based portals
      2. First portal enters peritrochanteric space underneath IT band at level of vastus lateralis ridge (Fig. 8)
         - Entering at vastus lateralis ridge avoids inadvertent deep penetration of vastus lateralis or gluteus medius muscle
      3. Next portal placed under arthroscopic visualization with prepositioning of spinal needle (Fig. 9A&B)
III. Endoscopic abductor repair\textsuperscript{6,7,8}

A. Endoscopic & footprint anatomy well defined\textsuperscript{4,9}

B. 3 laterally-based portals (Fig. 10)
   1. Posterior to vastus lateralis ridge for arthroscope (30°) - Analogous to posterior subacromial viewing portal in shoulder
   2. Large diameter cannula distal to vastus ridge for suture management - Analogous to lateral subacromial portal for rotator cuff repair in the shoulder
   3. Portal proximal to vastus ridge for anchor placement

C. Optimize/maximize repair security
   1. Anchor pull-out strength
   2. Double row fixation (when applicable)\textsuperscript{7,8}

D. Hollow core anchors optimize biological environment for tendon healing (Fig. 11)

E. Postop rehab\textsuperscript{10}
   1. 6-8 weeks PWB depending on security of fixation
   2. Precautions 4 months to optimize healing

F. Preliminary experience favorable with endoscopic repair\textsuperscript{11,12}
   - Compared to FAI, patients tend to be older, with lower baseline preoperative scores, but exhibit substantially more improvement\textsuperscript{12}

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<th>Glut Tears\textsuperscript{12}</th>
<th>FAI\textsuperscript{13}</th>
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<tbody>
<tr>
<td>Age</td>
<td>56.6 years</td>
<td>34 years</td>
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<tr>
<td>Baseline mHHS</td>
<td>42 points</td>
<td>65 points</td>
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<tr>
<td>Improvement mHHS</td>
<td>40 points</td>
<td>21.5 points</td>
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Figure 10

Figure 11
References


