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THE OCCASIONAL INJECTION FOR TROCHANTERIC BURSTITIS

Thank you for your summary on trochanteric bursitis in the Winter 2011 issue of *CJRM*.¹

I respectfully submit that evidence is accumulating that injecting corticosteroids for tendinopathies and enthesopathies does not lead to superior outcomes in the long term. In fact, the converse is true. A recent systematic review in *The Lancet* by Coombes and coauthors² attests to this.

In the opinion of a growing number of clinicians (myself included), trochanteric “bursitis” as well as other chronic conditions such as Achilles “tendonitis” and supraspinatus “tendonitis” are misnomers. Simply put, there is usually no inflammatory pathophysiology at work (no inflammatory cells are present). The true pathology is degenerative in nature.

Thus, trochanteric bursitis should be seen as an enthesopathy; that is, degeneration of the tendosseous junction of the big hip extensors (such as gluteus maximus) as well as gluteus medius (a hip abductor).

Because there is no true inflammation at work, corticosteroids pose no plausible curative effect in these conditions. What we are observing is short-term gain for (possible) long-term pain as a result of further weakening of collagen fibres in this condition and others.

This was clearly demonstrated in the systematic review by Coombes and colleagues, with poorer outcomes at the 12-month mark compared with other interventions.

Interestingly enough, injections with lidocaine and dextrose (prolotherapy), and sodium hyaluronate were shown to have superior outcomes in the long term.

I can attest to the effectiveness of prolotherapy in my own practice. The curative effects are seen as a result of stimulation of new collagen formation, as well as diminishment of pain because of (postulated) decreases of substance P and calcitonin gene-related peptide.

Hopefully, we will see more studies published in this interesting field. To continue holding up corticosteroid injections as the gold standard injection for any of these degenerative conditions is not supported by evidence.

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REFERENCES

1. Kelly L, Minty L. The occasional injection for trochanteric bursitis. *Can J Rural Med* 2011;16:20-2.
2. Coombes BK, Bisset L, Vicenzino B. Efficacy and safety of corticosteroid injections and other injections for management of tendinopathy: a systematic review of randomised controlled trials. *Lancet* 2010; 376:1751-67.

[One of the authors replies:]

We thank Dr. Louw for his comments. We agree with his perspective that “bursitis” is a misnomer. Our paper and those we referenced made it clear that we are injecting an area of function rather than a discrete structure. We also agree that we are very likely dealing at least in part with an enthesopathy.

Whether lidocaine or steroid is the effective agent is unknown. I sometimes do repeat injections with lidocaine alone, but I generally include steroids in the first injection. Some of my colleagues use longer-acting bupivacaine alone or as an adjunct to steroids. Our assessment and injection technique would apply to injections of any ilk.

The November 2010 review by Coombes and colleagues¹ (not published at the time we wrote our article) is very interesting, but does not specifically address the treatment of trochanteric bursitis. It is a systematic review of 3824 studies encompassing 2672 patients with tennis elbow or rotator cuff tendinitis; therefore, a very large series of small studies. The authors concluded that steroid injections were useful in the short term for tennis elbow and lidocaine injections were more useful in the long term for pain reduction. The role of steroids in shoulder injections was deemed unclear.

This review does little to change my practice of using steroids with

a large volume of lidocaine for trochanteric bursitis. I have injected lidocaine alone in the rare patients with persistent symptoms because I see them as unresponsive to steroids.

The assessment and diagnosis of trochanteric bursitis was the thrust of our article. I often see patients who have had unneces-

sary radiographs and even orthopedic referrals for this common condition. Whether the medication used in the injection varies over time because of evolving science is a question that remains to be answered.

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REFERENCE

1. Coombes BK, Bisset L, Vicenzino B. Efficacy and safety of corticosteroid injections and other injections for management of tendinopathy: a systematic review of randomised controlled trials. *Lancet* 2010; 376:1751-67.

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