

Gluteal tendon repair and iliotibial band release

This leaflet is for patients having an operation to repair damage to the gluteal tendons. It outlines what the surgery entails, including risks and benefits. If you have any questions, please discuss them with your consultant or one of the team.

Hamstring muscles and injuries

The hip joint is a ball-and-socket joint. The ball (femoral head) is the top end of the thighbone (femur) and the socket (acetabulum) is part of the pelvis (see Figure 1A). The femoral head is connected to the femur with a femoral neck. The hip joint is surrounded by ligaments and muscles, which provide support and generate movements of the joint.

One of the main groups of these muscles is abductor muscles of the hip. These muscles (gluteus medius and gluteus minimus) are attached with tendons to the greater trochanter (see Figure 1B). They allow you to move the leg to the side when you are standing on the opposite leg (abduction), but also, crucially, prevent your body from tipping to the opposite side when you are standing on the same leg, thus preventing a limp. Iliotibial band is a band of condensed tissue that stretches over the whole length of the thigh down its side.

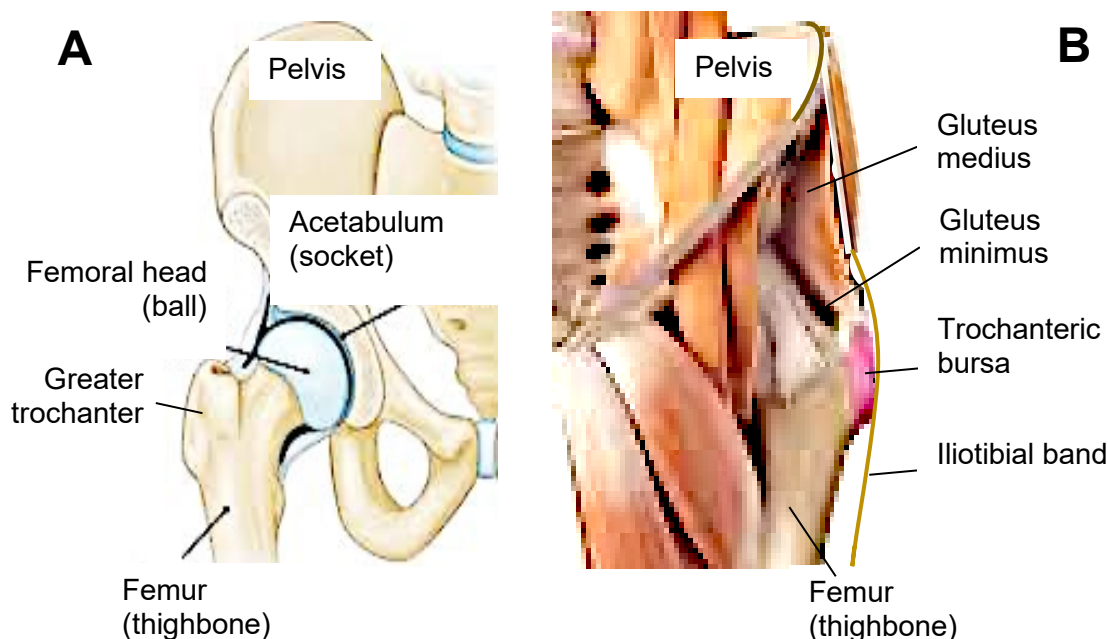


Figure 1. A. Diagram of bony structures of the right hip joint. Greater trochanter is the bony prominence that you can feel on the side of your hip. **B.** Diagram of the muscles and other soft tissues surrounding the left hip joint. Note the gluteus medius and gluteus minimus attaching to the greater trochanter. Note the iliotibial band stretching over the greater trochanter and sometimes irritating the trochanteric bursa, which cushions the Iliotibial band from the greater trochanter.

Why do I need surgery?

Sometimes, the abductor tendons undergo wear and tear, and develop tendon tears or a complete detachment from the greater trochanter. This will cause pain, weakness and a limp. At the same time or as an independent event, the iliotibial band can become too tight. As a result of the pressure it causes over the side of the greater trochanter, or, sometimes, as a completely separate event, the trochanteric bursa cushioning the iliotibial band from the underlying greater trochanter becomes irritated and also causes pain (see Figure 1B).

What does repair surgery entail?

If your pain is not helped by non-surgical treatment (i.e. rest, painkillers, physiotherapy, injections, shockwave therapy) and your tests show relevant findings, you may need an operation. Surgery is the best option if your tests suggest a gluteal tendon tear or a detachment from the greater trochanter.

The surgery involves an arthroscopic operation performed through small skin incisions (keyholes) using a small camera, called an arthroscope, and thin instruments. During the procedure, any damage to the tendons is assessed and, if technically possible, the tendons are re-attached back to the greater trochanter using tiny suture-anchors. Sometimes, a special patch is used to re-enforce the repair (known as augmentation). If the iliotibial band is found to be tight, it is also released at the same time.

The surgery aims to treat the pain and restore the gluteal muscle strength. Although the re-attachment may have been successful, it still relies upon the ability of your body to heal the tendon back onto the bone. If the healing fails to take place effectively, the repair is likely to fail with time, leading to recurrence of the original symptoms.

What are the aims of this surgery?

- Restore muscle strength and function
- Improve hip pain
- Improve hip function
- Improve overall quality of life and mobility

What are the risks of this surgery?

- Wound or deep infection
- Nerve injury
- Failure to improve symptoms/dissatisfaction
- Recurrence of symptoms
- Failure of the tendons to heal
- Need for further surgery
- Heart attack
- Chest infection

- Clots in the veins of your legs that may travel to your lungs (deep vein thrombosis (DVT) and pulmonary embolism)

Advice following surgery

Pain relief: Local anaesthetic is used at the end of surgery to numb the pain. It is normal to feel pain come back as the local anaesthetic wears off and you will need to take painkillers regularly to help with this. It is important to take the painkillers as prescribed to keep pain to a minimum and allow mobilisation.

Mobilisation: A physiotherapist will see you on the ward. You will be toe-touch or partial weight bearing on crutches 6-8 weeks after your surgery. After that, try to return to walking as close to a 'normal' walking pattern as possible, e.g. with an even step length on both sides and not leaning to one side. You will also be shown how to safely get up- and down-stairs using your crutches if required.

Hospital stay: Your operation can take between 1 and 3 hours, depending on how much work needs to be performed. You may need to stay in hospital overnight following your procedure. The length of your hospital stay may vary depending on the extent of your surgery, your medical history and also on how you are managing to mobilise with help from the physiotherapists.

Range of movement and strengthening exercises: In order to allow muscle tendon to heal, active abduction (movements of the leg away from the midline of the body) needs to be restricted for up to 6 weeks. However, it is important to re-establish the muscle strength and hip joint movements as soon as possible. Ensure that you take pain relief medications about one hour before your exercises. Following your surgery, you will go through a phased rehabilitation programme. The specifics will be explained to you by your physiotherapist, but in broad terms your rehabilitation will include restoration of hip and knee joint range of movement, strengthening/conditioning muscle exercises, stamina, and exercises for return to specific sport. You will also be referred for outpatient physiotherapy to ensure on-going progress with walking and exercises. If you have any questions or need any advice about your exercises, please contact the Physiotherapy Department between 9am – 4pm Monday to Friday on 0118 322 7811 (Royal Berkshire Hospital) or 01635 273362 (West Berkshire Community Hospital).

Do I need a brace? There may be occasions where the use of a brace is needed, although usually you will be advised to mobilise without a brace.

Self-care: It is important to get back to your normal daily routine as soon as possible after the surgery. Initially, you will need help from the ward staff with mobilisation and self-care. By the time you go home you are likely to be independent with normal self-care activities.

Wound care: Keep your wounds clean and dry. It is normal for the wound sites to leak a little bit of blood or fluid for the first few days after your surgery. These need to be redressed if the dressings become soaked. If you are changing the dressings, clean the wound with soap and clean water, pat it dry with a towel/paper towel and even use a hair dryer (cool setting) to ensure complete dryness of the skin before applying new dressing. The stitches need to be removed 12-14 days after the surgery. The nursing staff will also provide you with wound care information on leaving hospital.

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Work: Your return to work will depend on the job you do and the speed of your recovery. It may take a couple of weeks before you are able to return to an office job, and longer if the job is physical. Your physiotherapist or consultant will be able to provide further advice. An initial sick certificate can be provided by the ward – please ask the nurse before you leave the ward. Subsequent certificates will need to be obtained from your GP, if required.

Driving: You should not drive while you are still using crutches and your knee is in a brace. Once you feel you have sufficiently recovered and can perform an emergency stop (usually 6-8 weeks after surgery), you can try to drive on a quiet road. You may need to inform your insurance company prior to returning to driving that you have had an operation and have now recovered.

Leisure and sport: Return to sports will be guided by what you have had done during your surgery and by your progress with rehab. It can take up to 3-6 months before you are able to return to competitive sports.

Glossary

Femur – thighbone

Acetabulum – socket of the hip joint

Femoral head – ball of the hip joint

Femoral neck – connects to the head to the shaft of the femur

Greater trochanter – bony prominence on the side of your upper thigh, which is a part of the top and of the femur

Abductor muscles – two muscles (gluteus medius and gluteus minimus) are attached with tendons to the greater trochanter.

Trochanteric bursa – cushion on the outside of greater trochanter

Abduction – movement of the lower limb away from the midline

Iliotibial band – a band of condensed tissue that stretches over the whole length of the thigh down its side

Arthroscopy – surgery performed through small skin incisions (keyholes)

Arthroscope – small camera used during surgery

Repair augmentation – sometimes the tendon repair needs to be re-enforced with a special patch

Contacting us

Clinical Admin Team (CAT 5) Orthopaedics: 0118 322 7415 email: rbbh.CAT5@nhs.net

Redlands Ward: 0118 322 7484/5

Orthopaedic Outpatient Reception (RBH): 0118 322 8334

Outpatient Physiotherapy Department 0118 322 7811 (Royal Berkshire Hospital) or 01635 273362 (West Berkshire Community Hospital).

To find out more about our Trust visit www.royalberkshire.nhs.uk

Please ask if you need this information in another language or format.

Tony Andrade / Vitali Goriainov, RBFT Orthopaedics, July 2023. Next review due: July 2025

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