

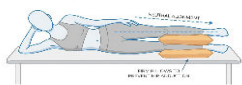
TROCHANTERIC BURSITIS & GLUTEAL TENDINOPATHY

EVIDENCE-BASED HOME EXERCISE & LOAD MANAGEMENT HANDOUT (LEAP TRIAL PROTOCOL)

CRUCIAL DAILY LOAD MANAGEMENT (POSITIONS TO AVOID VS. SAFE ALTERNATIVES)

Activity	POSITIONS TO AVOID (HIGH TENDON COMPRESSION)	SAFE ALTERNATIVES (NEUTRAL ALIGNMENT)
Sitting	• Crossing legs at knees or ankles • Sitting in low, soft, deep couches/chairs • Sitting with knees together	• Sit with feet flat, knees parallel or wide • Use a higher, firm chair with cushion support • Keep hips slightly higher than knees
Standing	• 'Hanging on one hip' (asymmetric stance) • Standing with legs crossed or feet together	• Distribute weight evenly across both feet • Keep feet hip-width apart
Sleeping	• Lying directly on painful side • Lying on uninjured side without pillow support (leg sags into adduction)	• Sleep on unaffected side with 1–2 firm pillows between knees & ankles to keep leg neutral • Or sleep on back with pillow under knees
Stretching Warning	• Do NOT pull your knee across your body or toward the opposite shoulder — this presses the tendon against bone.	• Foam rolling the outer thigh (not over the bony point) and the inner-thigh stretch in your overview sheet are fine.

SIDE-LYING POSITION FOR HIP NEUTRALITY



Sleep Tip: Side-Lying Pillow Support & Neutral Alignment

Sleep Ergonomics & Tendon Compression Relief

When lying on your unaffected side, place 1 to 2 firm pillows between your knees and ankles. Ensure your top leg remains parallel to the bed and does not drop across your midline, keeping the gluteal tendon relaxed.

Dosing: Use continuously during sleep and side-lying rest

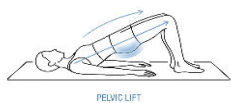
Recovery Timeline, Diligence & When to Seek Further Office Evaluation

Patience & Consistency Are Essential: Tendon tissue remodels gradually and has a lower metabolic rate than muscle. Clinical trial data (such as the LEAP trial) demonstrates that noticeable pain reduction and functional improvements typically occur within 8 to 12 weeks (2 to 3 months) of diligent exercise and load management, with continued strength gains continuing over 6 to 12 months. Daily diligence in avoiding compression (crossing legs, low chairs, ITB stretching) is just as critical as performing the exercises.

When to Seek Further In-Office Assessment: If you maintain diligent compliance with this program but experience no meaningful improvement after 12 weeks (3 months)—or if your symptoms steadily worsen despite conservative management—a formal in-office evaluation is warranted. Your clinician will re-evaluate for full-thickness tendon tears, advanced muscle degeneration, or alternative hip pathology, and discuss whether advanced imaging (MRI) or surgical consultation is indicated.

PHASE 1: PAIN RELIEF & ISOMETRIC ACTIVATION (LOW COMPRESSIVE LOAD)

DOUBLE-LEG GLUTE BRIDGE



1. Double-Leg Glute Bridge

Phase 1 — Low Compressive Load / Isometric Activation

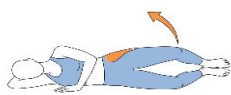
Lie on your back with knees bent and feet flat on the floor, hip-width apart. Squeeze your buttocks and lift your hips until your body forms a straight line from shoulders to knees. Hold at the top without arching your lower back.

Dosing: Hold 5–10 seconds | 8–12 repetitions | 2–3 sets daily

PHASE 2: PROGRESSIVE ABDUCTOR STRENGTHENING (MODERATE LOAD)**2. Side-Lying Hip Abduction (Anterior Log-Roll)****Phase 2 — Targeted Gluteus Medius Load (Minimal TFL)**

Lie on your uninjured side with your hips slightly rolled forward (10–15° anterior log-roll). Keep your top leg straight and toe pointing forward or slightly down. Raise your top leg 15–20° into abduction without letting your hip rotate backward.

Dosing: 10–12 repetitions | 2–3 sets | 3–4 days per week

**3. Modified Neutral Clamshell****Phase 2 — Controlled Gluteal Activation**

Lie on your uninjured side with knees bent at 45° and hips slightly extended into neutral. Keeping your heels together, raise your top knee up to 20–30° while maintaining pelvic stability and avoiding backward rotation.

Dosing: 10–12 repetitions | 2–3 sets | 3–4 days per week

STANDING HIP ABDUCTION EXERCISE

**4. Standing Hip Abduction (Table / Cabinet Support)****Phase 2 — Weight-Bearing Controlled Abduction**

Stand upright next to a sturdy table or cabinet, placing both hands on the surface for balance. Keeping your torso erect and pelvis level, smoothly lift your outer leg sideways (15–20° abduction) with the toe pointing forward or slightly inward. Hold briefly, then return with control.

Dosing: 10–12 repetitions per side | 2–3 sets | 3–4 days per week

PHASE 3: FUNCTIONAL & WEIGHT-BEARING STRENGTH (HIGHER LOAD)**5. Controlled Low-Step Step-Up****Phase 3 — Functional Closed-Chain Strength**

Stand facing a low step (4–6 inches). Step up with the affected leg, pressing through the midfoot/heel while maintaining pelvic level. Focus on keeping the knee aligned over the 2nd toe without inward collapse (valgus).

Dosing: 8–10 repetitions | 2–3 sets | 3 days per week

**6. Standing Hip Hike on Step****Phase 3 — Advanced Frontal Plane Pelvic Control**

Stand on one foot on the edge of a step with the opposite leg hanging off. Keep the standing leg straight (knee unlocked). Slowly lower the non-weight-bearing hip, then squeeze the standing glute to elevate the hip above neutral.

Dosing: 8–12 repetitions | 2–3 sets | 3 days per week

PAIN MONITORING TRAFFIC LIGHT SYSTEM (LEAP TRIAL GUIDANCE)

ZONE	PAIN LEVEL & SYMPTOMS	ACTION & ADVICE
GREEN	0–3 / 10 Pain Symptoms settle within 24 hours	Safe Zone: Continue current exercise level and progress as tolerated.
YELLOW	4–5 / 10 Pain Mild discomfort, settles by next morning	Acceptable Zone: Maintain current load. Do not increase reps or sets until stable.
RED	6+ / 10 Pain OR Morning stiffness / flare-up lasting >24h	Warning Zone: Reduce reps/sets or drop back to Phase 1 isometric exercises until pain settles.