The Effects of Kinesio Tape in a Therapeutic Setting

Hannah Frankamp  
*Pacific University*

Erin Kelly  
*Pacific University*

Nicole Wayda  
*Pacific University*

Michelle Apsley  
*Pacific University*

Cory Warner  
*Pacific University*

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The Effects of Kinesio Tape in a Therapeutic Setting

Disciplines
Occupational Therapy | Rehabilitation and Therapy

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The Effects of Kinesio Tape in a Therapeutic Setting.

Kinesio Tape was developed by Dr. Kenzo Kase, chiropractor and acupuncturist, in 1979. The claimed effects of Kinesio Tape include correcting muscle function, improving circulation, reducing inflammation, relieving pain, repositioning subluxed joints, and relaxing and supporting muscles and joints. Kinesio Tape debuted in the 2008 Beijing Olympics and is now commonly used by professional athletes. In addition, it is commonly used in a therapeutic setting by physical and occupational therapists. It is popular due in part to the endorsement by professional athletes as well as its affordability, accessibility, latex free properties, water resistance, extended wear times, and its unique ability to stretch. Therapists can become certified in applying Kinesio Tape, although the certification is not required. For most of the studies, participants were treated in a clinical setting and taped by a licensed therapist.

Is Kinesio Taping effective in a therapeutic setting?
15 studies were examined and were grouped in relation to population or diagnosis. The overall findings within each category are as follows:

**Pediatrics (2):**

**Study title:** Pilot Study: Investigating the effects of Kinesio Taping in an acute pediatric rehabilitation setting.

**Purpose:** The purpose of the study was to describe the use of the Kinesio Taping method for upper extremity in enhancing functional motor skills in children admitted into an acute rehabilitation program.

**Conclusion:** The study concluded that the change associated with the use of the Kinesio Taping emerged after 3 days post-intervention, and is not a long enough assessment of the outcome to support the widespread use of this intervention. However, the pilot study investigated the initial outcome of taping that could ultimately provide the basis for a controlled study to support and document changes in relation to using the Kinesio Taping technique over longer periods.

**Study title:** Treatment of a brachial plexus injury using kinesio taping and exercise.

**Purpose:** The purpose of the current case report is to describe the treatment and subsequent progress of a 2-year-old child whose brachial plexus injury was treated successfully with Kinesio Tape exercise.

**Conclusion:** The child displayed significant functional change with conservative physical therapy and taping to facilitate stabilization of the scapula on the thoracic spine using Kinesio Tape over the course of 5 months. The taping appeared to be just the assist she needed to allow normal play and facilitate muscular and boney change. It is difficult to generalize the results of this study because it is a case study of one and every neonatal brachial plexus injury presents differently.

**Mechanical Neck Pain (1):**

**Study title:** Short-effects of Kinesio Taping versus cervical thrust manipulation in patients with mechanical neck pain. A randomized clinical trial.

**Purpose:** The purpose of this study is to examine the short term effects of using Kinesio Tape versus cervical spine manipulation on neck pain intensity, self-reported disability, and cervical range of motion (CROM) in patients with mechanical neck pain.

**Conclusion:** Those who received the thrust manipulation experienced a greater increase in CROM than those using kinesio taping. Both groups had similar effects for reducing pain and was significantly significant. Similar results between groups with cervical flexion, extension, and lateral flexion in both directions. Both cervical spine thrust manipulation and KT similarly reduced self-report disability.

**Sternal skin stress (1):**

**Study title:** Application of Kinesiotape to reduce sternal skin stress during functional movements.

**Purpose:** To explore the effectiveness of taping to reduce sternal skin stress during functional movements. The study explores yet another application of taping that may be useful in clinical practice.

**Conclusion:** The study concluded that sternal skin taping is a viable option to reduce stress on sternal skin following surgery. Can be used in addition to current practices of teaching sternal precautions and transfer training.

**Multiple Sclerosis (1):**

**Study Title:** Effect of kinesio taping on standing balance subjects with multiple sclerosis: A pilot study.

**Purpose:** The purpose of the study was to assess the effect of Kinesio Taping applied to the back of the ankles of participants in improving body stability in a quiet standing with eyes closed in people who have multiple sclerosis.

**Conclusion:** The preliminary findings of the study suggest that the use of ankle taping may be useful in immediately establishing body posture. Results of the study showed a trend towards a reduction of amplitude and velocity of sway in antero posterior axis with the application of kinesio tape.

**Radial Nerve Entrapment (1):**

**Study title:** Kinesio tape management for superficial radial nerve entrapment: A case report.

**Purpose:** The purpose of the study is to determine if radial nerve entrapment can be treated through the use of kinesio tape versus surgical decompression.

**Conclusion:** Kinesio tape was applied with the aim of reducing pain, inflammation, and providing mechanical support. The study indicated that mechanical interfaces can be treated with KT application and that the effects obtained can be maintained for a period of 6 months. However, further investigations are required to substantiate findings.

**Shoulder implications (3):**

**Study title:** Kinesio taping compared to physical therapy modalities for the treatment of should impingement
The purpose of this study was to determine and compare the efficacy of kinesio tape and physical therapy modalities in patients with shoulder impingement syndrome.

Conclusion: There was no significant difference between the two groups with respect to baseline measures. Pain and disability measures, as a result of taping, were not different between groups in our study.

Study title: Kinesio taping on short term change in shoulder strength: Randomized control trial.

Purpose: Up until now there has been no study that has examined the use of Kinesio tape used at the same time with any other strengthening intervention to ascertain its influence on strength. The purpose of this study was to determine if the claims of Kinesio tape would be supported in its role in strength enhancing properties.

Conclusion: There was no statistical difference between the 2 groups by the end of the study.


Purpose: The purpose of the study was to compare the effects of using therapeutic KT application compared to using sham KT application.

Conclusion: There was a difference between the two groups in regards to pain after one day; the KT group showed pain-free abduction ROM. No other significant differences between the two groups were found.

Sports performance (6):

Study title: Kinesio taping in treatment and prevention of sports injuries: A meta-analysis of the evidence for its effectiveness.

Purpose: The aim of the review was to evaluate, using a meta-analysis, the effectiveness of KT in the treatment and prevention of sports injuries.

Conclusion: Kinesio tape may have a small effect on strength, force sense error, and active range of motion on an injured area, but further clarification is needed. There was no substantial evidence to support the use of KT for improvements in other musculoskeletal outcomes (pain, ankle proprioception or muscle activity). Future research should focus on the efficacy of KT in the treatment of injuries in sporting cohorts. Appropriate blinding of subjects and assessors, as well as the presence of a placebo taping group, is required to ensure methodological quality.

Study title: Immediate effect of forearm Kinesio taping on maximal grip strength and force sense in healthy collegiate athletes.

Purpose: Kase, inventor of KT, claims it will increase muscle strength. The purpose of the study was to determine immediate effects on maximal grip strength and force sense in healthy collegiate athletes after application of forearm Kinesio taping.

Conclusion: No improvement in muscle tension for either sham or KT application.

Study title: The effect of kinesio taping on lower trunk range of motions.

Purpose: To investigate the effectiveness of kinesio taping on lower trunk ROM. The study explores the effect of taping on ROM in health subjects with no previous history of injury.

Conclusion: Results provide promising option of KT being effective for back pain in rehabilitation. However, further studies are needed. This is only an initial study to explore the possibilities. Significant results only found for active trunk flexion.

Study title: Effect of Kinesio Tape to muscle activity and vertical jump performance in health inactive people.

Purpose: The purpose of the study was to investigate the effect of KT application on triceps surae during vertical jump. It used health inactive people as participants which can relate to typical person in rehabilitation.

Conclusion: The findings indicate an increase in muscle activity of the medial gastrocneius during maximal vertical jump immediately following KT use. Jump height was not increased using KT application. KT might facilitate the muscle contraction capacity of the triceps surae during vertical jump.

Study title: Does kinesiotaping increase knee muscle strength and functional performance?

Purpose: To determine which application, knee brace, kinesiotaping (KT), or both is more effective regarding muscular strength and functional performance.

Conclusion: The study found that application of KT alone was slightly more effective in terms of strength and jump performance than the use of a brace alone, KT and a brace, or a bare leg.


Purpose: The purpose of the study was to determine the acute effects of kinesio taping on pain, strength,
joint position sense, and balance in patients with patellofemoral pain syndrome.

**Conclusion:** The findings suggest that there is no significant difference between KT and PKT regarding proprioception, pain, balance, and muscle strength in patients with PFPS. Applying KT is not an effective treatment method for decreasing pain or increasing joint position sense related to patellofemoral pain syndrome.

**CLINICAL BOTTOM LINE**

Kinesio Tape has not been proven to be effective or ineffective in a therapeutic setting.

**Important note on the limitation of this CAT:** This critically appraised topic has been peer-reviewed by one professor.

**SEARCH STRATEGY**

**Terms used to guide the search strategy**

**Patient/Client Group:** Clients in a therapeutic setting  
**Intervention (or Assessment):** Use of Kinesio Tape  
**Comparison:** Use of static athletic tape, other modalities, and bracing/casting  
**Outcome(s):** Effective therapeutic outcomes of Kinesio Taping

<table>
<thead>
<tr>
<th>Databases and Sites Searched</th>
<th>Search Terms</th>
<th>Limits Used</th>
</tr>
</thead>
</table>
| Kinesiotaping.com           | Search: “athletes”  
Search: “kinesiotape”  
Search: “kinesio tape” | No limits used for any studies |
| MEDLINE                      |              |             |
| Rehabilitation Reference Center |          |             |
| HaPI                         |              |             |
| Google                       |              |             |
| Journal of Orthopedic Sports Physical Therapy |          |             |
| Cinahl                       |              |             |

**INCLUSION and EXCLUSION CRITERIA**

**Inclusion Criteria**  
The terms “Kinesio Tape” or “Kinesio Taping” or “Kinesiotape” (as one word).

**Exclusion Criteria**
We excluded studies that were published prior to 2006.
We limited the search to "English language" articles.
We excluded studies that were not accessible in full text.

RESULTS OF SEARCH

A total of 15 relevant studies were located.

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Level (Tomlin)</th>
<th>Number Located</th>
<th>Author (Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meta-Analysis</td>
<td>I</td>
<td>1</td>
<td>Williams et al. (2012)</td>
</tr>
<tr>
<td>Randomized control trial (RCT)</td>
<td>I</td>
<td>7</td>
<td>Kaya et al. (2011)</td>
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<td></td>
<td></td>
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<td>Chang et al. (2010)</td>
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<td></td>
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<td>Callegari et al. (2012)</td>
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<td>Irion et al. (2010)</td>
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<td>Aytara et al. (2011)</td>
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<td>Saavedra-Hernandez et al. (2012)</td>
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<td></td>
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<td></td>
<td>Thelan et al. (2008)</td>
</tr>
<tr>
<td>Before and After</td>
<td>III</td>
<td>5</td>
<td>Huang et al. (2011)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yasukawa et al. (2006)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Cortesi et al. (2011)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Aktas, G. &amp; Baltaci, G. (2011)</td>
</tr>
<tr>
<td>Case Study</td>
<td>V</td>
<td>2</td>
<td>Anandkumar, S. (2012)</td>
</tr>
</tbody>
</table>

BEST EVIDENCE


This study was chosen because it had large sample size, it was a randomized control trial and it used Kinesio Tape in the treatment group as well as in the sham taping group.

SUMMARY OF BEST EVIDENCE

**Aim/Objective of the Study/Systematic Review:**

The purpose of the study was to compare the effects of using a therapeutic Kinesio Tape application compared to using a sham Kinesio Tape application.

**Study Design**

This was a randomized controlled trial that was double-blind. The primary author is a certified Kinesio Tape practitioner and applied all the taping procedures. The second author, was blind to the group assignments and measured outcomes. The following 3 outcome measures were used: Shoulder Pain and Disability Index (SPADI), Pain-free Active Range of Motion, and 100-mm Visual Analogue Scale (VAS). All measures were obtained at baseline and immediately after taping except the SPADI, 3 days and 6 days after tape application. The SPADI is a 13-item questionnaire that consists of 2 sub-scales for pain and disability, which are scored by taking an average of the 2 sub-scales.

The groups were assigned using a random-number generator and allocation was concealed. The treatment group received a standardized therapeutic KT application. The sham group received a standardized neutral KT application.

**Setting**

Cadet Physical Therapy Clinic at the United States Military Academy (Or Keller Army Community Hospital) in West Point, New York.
Participants

N = 42

Eligibility criteria consisted of a clinical diagnosis of rotator cuff tendonitis/impingement. Subjects were required to meet 5 inclusion requirements and exclusion criteria based on diagnosis. Inclusion criteria included (1) Pain onset prior to 150 degree of active shoulder elevation in any plane. (2) Positive empty can test indicating possible external impingement. (3) Positive Hawkins-Kennedy test indicating possible external impingement. (4) Subject complaint of difficulty performing ADLs. (5) Being aged 18-50. Exclusion criteria were shoulder girdle fracture, glenohumeral dislocation/subluxation, acromioclavicular sprain, concomitant cervical spine symptoms, a history of shoulder surgery within the previous 12 weeks, or shoulder pain for longer than 6 months. This was a purposive sample

Recruited subjects were college students enrolled in the United States Military Academy. All patients were being seen at Cadet Physical Therapy or Keller Army Community Hospital at West Point, NY. These participants were aged from 18-24 years.

There were 7 drop-outs from the study, 3 from the treatment group and 4 from the sham group. These participants failed to return for day six re-evaluation. These subjects reported that they did not return for follow up because their shoulder pain improved or they had busy class schedules.

Intervention Investigated

All patients who presented to the Cadet Physical Therapy Clinic at the United States Military Academy (Keller Army Community Hospital) in West Point, New York between the dates of September 2006 and September 2007 who had a main complaint of shoulder pain were considered to partake in the study.

There were certain exclusion and inclusion criteria that had to be met and enrollments were only made by the primary author who made sure each subject met all five inclusion criteria.

The primary author provided treatment. She is a certified KT practitioner and applied all of the taping procedures. The second author was blinded to the group assignment to avoid bias and measured outcomes.

Subjects were assigned to 1-2 groups using random-number generators and allocation was concealed. The treatment group received a standardized therapeutic KT application. The general application guidelines were consistent with the protocol for rotator cuff tendonitis/impingement suggested by Kase et al. Standard 2-in (5 cm) beige Kinesio Tex tape was used for all applications in both groups.

The intervention was applied three different times (Day 1, Day 3 & Day 6).

At each taping, the participants were instructed to wear the tape for an additional 4-72 hours before removal and to allow 12-24 hours before returning to the clinic for reassessment.

Control

The sham KT group received a standardized, neutral KT application. The sham taping consisted of two 4-in (10 cm) I-strips applied with no tension. 1 was placed over the acromioclavicular joint in the sagittal plain and one on the distal deltoid in the transverse plane. ( During the study when they attempted to apply the KT in this manner, two test subjects complained of a very minor sensation of skin shear discomfort at higher ranges of shoulder elevation and rotation. Consequently, they developed the alternative sham taping application used that they were more confident and provided the desired neutral treatment effects.

Experimental

The first strip was a Y-strip representative of the supraspinatus, which was applied from the muscle insertion to origin with paper-off tension. The first strip was applied with the subject in a position combining cervical side bending to the contralateral side and the arm reaching behind the back as if reaching into the contralateral back pocket.

The second strip was a Y-strip representative of the deltoid, also applied from insertion to origin with paper-off tension. The second strip was applied with the first tail to the anterior deltoid while the arm was externally rotated and horizontally abducted. The tail for the posterior deltoid was applied with the arm horizontally adducted and internally rotated as if reaching to the outside of the contralateral hip.

The third strip, approximately 20 cm in length, was either an I-strip or a Y strip depending on the shoulder contour. It was applied to the region of the coracoid process around to the posterior deltoid with a mechanical correction at the region of perceived pain or tenderness. The upper extremity was then moved
Outcome Measures

3 primary outcome measures were used.

1. The Shoulder Pain and Disability Index (SPADI): The SPADI is a 13-item questionnaire that consists of 2 subscales for pain (5 items) and disability (8 items), which is scored by obtaining an average of the 2 subscales. Scores range from 1 to 100, with higher scores indicating greater pain and disability. The SPADI has been studied extensively and determined to be a valid and reliable instrument that is responsive to change. The minimal clinically important change has been defined as greater than a 10-point decrease in score. The article used a 10-point change by day 6 to define success.

2. Pain-free Active Range of Motion (ROM): Shoulder ROM measurements of forward flexion, abduction, and scapular plane elevation were taken using a standard goniometer. Pain-free active ROM was designated as the ROM attained at the "point of first onset of pain".

3. 100-mm Visual Analogue Scale (VAS): Used to assess pain intensity at the endpoint of pain-free active shoulder ROM. Meaningful change was defined as a subject that showed a 15 degree increase in pain-free active ROM. A 2-point reduction on the 11-point numerical pain rating scale has been shown to be of clinical importance. The authors established that a 20-mm decrease of the AS by day 6 would be considered a meaningful change in this study.

All measures were obtained in the clinic at baseline, immediately after taping (Except the SPADI), 3 days and 6 days after tape application. The SPADI was only measured once at the time of the initial visit, as the score would not be expected to change immediately after taping. All measurements were taken by the second author, J. Dauber, in order to help ensure blindness of the study.

Main Findings

**TABLE 1**

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>BASELINE CHARACTERISTICS OF SUBJECTS*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sham KT Group (n = 21)</td>
</tr>
<tr>
<td>Duration (d)</td>
<td>8 (5-30)</td>
</tr>
<tr>
<td>Age (y)</td>
<td>13.8 (1.5)</td>
</tr>
<tr>
<td>Males (n)</td>
<td>17</td>
</tr>
<tr>
<td>Females (n)</td>
<td>4</td>
</tr>
<tr>
<td>NSAIDs*</td>
<td>8</td>
</tr>
<tr>
<td>SPADI pain subscale</td>
<td>43.7 (14.0)</td>
</tr>
<tr>
<td>SPADI disability subscale</td>
<td>24.2 (17.9)</td>
</tr>
<tr>
<td>SPADI total score</td>
<td>34.0 (13.9)</td>
</tr>
<tr>
<td>VAS (mm)</td>
<td>43.9 (17.2)</td>
</tr>
<tr>
<td>ABD (*)</td>
<td>110.1 (31.4)</td>
</tr>
<tr>
<td>FF (*)</td>
<td>114.7 (23.0)</td>
</tr>
<tr>
<td>SCAP (*)</td>
<td>118.9 (29.0)</td>
</tr>
</tbody>
</table>

*Abbreviations: ABD, pain-free abduction; FF, pain-free forward flexion; KT, Kinesio Tape; NSAIDs, nonsteroidal anti-inflammatory drugs; SCAP, pain-free scapular plane elevation; SPADI, Shoulder Pain and Disability Index; VAS, visual analogue scale (based on 100-mm scale).

* Data are mean ± SD, except for duration, which is presented as median (interquartile range), and gender and NSAIDs, which are count.

* Subjects taking prescribed NSAIDs at the start of the study.
### Table 2: Change Scores Compared to Day 1 Pretape Application

<table>
<thead>
<tr>
<th>Time</th>
<th>Sham KT (n = 21)*</th>
<th>Treatment KT (n = 21)*</th>
<th>Mean Difference (99% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 ABD</td>
<td>-2.2 (15.3)</td>
<td>169 (23.2)†</td>
<td>191 (1,736.5)</td>
</tr>
<tr>
<td>Day 3 ABD</td>
<td>9.4 (23.4)</td>
<td>260 (27.7)†</td>
<td>166 (-41, 387)</td>
</tr>
<tr>
<td>Day 6 ABD</td>
<td>25.7 (23.1)†</td>
<td>360 (33.9)†</td>
<td>10.3 (-13, 34.5)</td>
</tr>
<tr>
<td>Day 1 FF</td>
<td>0.9 (14.1)</td>
<td>76 (10.9)</td>
<td>68 (-37, 73)</td>
</tr>
<tr>
<td>Day 3 FF</td>
<td>11.6 (15.3)</td>
<td>172 (192)</td>
<td>56 (-88, 201)</td>
</tr>
<tr>
<td>Day 6 FF</td>
<td>20.3 (15.3)†</td>
<td>292 (26.3)†</td>
<td>89 (-91, 268)</td>
</tr>
<tr>
<td>Day 1 SCAP</td>
<td>0.7 (2.0)</td>
<td>87 (177)</td>
<td>80 (-46, 206)</td>
</tr>
<tr>
<td>Day 3 SCAP</td>
<td>9.9 (15.2)</td>
<td>202 (26.4)†</td>
<td>103 (-75, 283)</td>
</tr>
<tr>
<td>Day 6 SCAP</td>
<td>20.4 (21.9)†</td>
<td>259 (28.1)†</td>
<td>54 (-15.6, 26.5)</td>
</tr>
<tr>
<td>Day 1 VAS</td>
<td>-2.9 (6.4)</td>
<td>-91 (130)</td>
<td>-61 (-14.2, 24)</td>
</tr>
<tr>
<td>Day 3 VAS</td>
<td>-13.8 (15.3)</td>
<td>-160 (21.1)</td>
<td>-38 (-11.6, 19.2)</td>
</tr>
<tr>
<td>Day 6 VAS</td>
<td>-271 (18.1)‡</td>
<td>-237 (22.8)‡</td>
<td>33 (13.8, 20.5)</td>
</tr>
<tr>
<td>Day 3 SPADI total score</td>
<td>-12.2 (12.1)</td>
<td>-131 (139)</td>
<td>-99 (99, 11.8)</td>
</tr>
<tr>
<td>Day 6 SPADI total score</td>
<td>-18.8 (13.8)</td>
<td>-210 (16.2)†</td>
<td>-22 (-147, 10.4)</td>
</tr>
</tbody>
</table>

**Abbreviations:** ABD, pain-free abduction; CI, confidence interval; FF, pain-free forward flexion; KT, Kinesio Tape; SCAP, pain-free scapular plane elevation; SPADI, Shoulder Pain and Disability Index; VAS, visual analogue scale (based on 100-mm scale).

* Data presented as mean (SD).

† Calculated as treatment group minus sham group.

‡ Indicates a statistically significant difference between groups (P < .01).

§ Indicates that the measure exceeded predetermined meaningful clinical change.

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**Figure 1:** Flow diagram showing the progress of subjects at each stage of the clinical trial.
Original Authors’ Conclusions
The authors state that when Kinesio Tape is applied to a young, active population with a diagnosis of rotator cuff tendonitis/impingement, it may assist in improving pain-free shoulder abduction range of motion. Over time, Kinesio Tape is not any more effective than the sham tape in decreasing shoulder pain intensity or shoulder disability.

CRITICAL APPRAISAL

Validity
This study was a prospective, randomized double blinded, clinical trials using repeated-measures design. Subjects were randomized using a random-number generator. This type of study is Level 1B of Tomlin’s Research Pyramid. Bias included that all subjects were young, athletic individuals in the United States Military Academy.

PEDro Score: 9/10 based on Eligibility Criteria: Yes; Random Allocation: Yes; Concealed Allocation: Yes; Baseline Comparison: Yes; Blind Subjects: Yes; Blind Therapist: Yes; Blind Assessors: No; Adequate Follow-up: Yes; Intention-to-treat analysis: Yes; Between Group Comparison: Yes; Point Estimates and Variability: Yes.

Researchers were blinded as best of possible; due to the nature of the taping, in our opinion, it was difficult to remain blinded. Assessors would likely have known who was in which group based on tape.

Interpretation of Results
The day one MANOVA showed a significant effect p=.049. Using univariate ANOVA to find where the difference existed, it was discovered that the change score for pain-free shoulder abduction ROM in the treatment group showed a significant improvement when compared to the sham group p=.005 on day 1. A repeated-measures MANOVA was calculated for day 3 and day 6 data. This MANOVA also included the SPADI (shoulder pain and disability index) data. Both groups demonstrated significant improvement in all outcome measures, exceeding the predetermined criteria for success. Which contributed to the “change over time” category (p being less than or equal to .001). No main effect for group or group-by-time effect was observed.

There was not significant difference between the groups, both the “sham KT” group and the KT group showed improvement with treatment. The only difference reported was on day 1, which was improved “pain-free shoulder abduction” with the KT group. This result was not present at day 3 and day 6.

Due to the study design, statistics and lack of a control group, it is hard to identify a significant treatment effect in this study. The clinical significance is also difficult to interpret because this research was performed on young, healthy subjects. A rash was noted in two subjects which resolved 48 hours after tape removal. No other adverse effects were noted. The results seem to show a neutral effect, which is something to note. This means that, although we cannot prove the effectiveness of taping, it does not appear to cause any harm during treatment.

Summary/Conclusion
This is a treatment technique that is currently resting solely on testimonials, there is no substantial research evidence to support its use. There are several studies that show potential for effectiveness, but they are neither statistically significant nor conclusive. More research needs to be done. Testimonials are not to be completely discounted, as they are effective for some individual clients. In a clinical setting testimonial/clinical experience can be very valuable in determining the continued use of this technique, but there should also be a press to find stronger evidence as to the legitimacy of the product.

IMPLICATIONS FOR PRACTICE, EDUCATION and FUTURE RESEARCH
We concluded that additional testing and research needs to be done on a larger scale in order to generalize outcomes to a large population. Studies were limited to specific, small populations that do not have a clinical relevance on a larger scale. Future research needs to occur at a higher level. Randomized control trials on larger populations would yield more useful results that would have a better chance of being clinically significant. Several studies need to be conducted on similar populations so that data can be easily generalizable.

The Kinesio Taping Association International (KTAI) has designed a certification process that will allow dedicated practitioners to earn their designation as a Certified Kinesio Taping Practitioner (CKTP®). This training is not required, but available.
Dr. Kenzo Kase also prepared a training manual, “Clinical Therapeutic Applications of the Kinesio Taping Method” which gives a detailed explanation of application of Kinesio Tape.


