Review Article

Kinesiology Taping as an Adjunct for Pain Management: A Review of Literature and Evidence

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Abstract

Current evidence-based practice guidelines for the management of nonacute persistent and recurring musculoskeletal-related pain have emphasized the use of holistic multidisciplinary approaches including nonpharmacological therapies. Kinesiology taping is a simple, economical, easy-to-apply, nondrug therapeutic technique that is used by health-care professionals for managing and rehabilitating musculoskeletal injuries. High-quality research on kinesiology taping is limited, although recent evidence suggests that kinesiology taping may have a small effect in mitigating pain and may be associated with mild cutaneous side effects. We present a review of the principles of kinesiology taping and an evaluation of research on its efficacy to catalyze discussion among clinicians about the merits of kinesiology taping as an adjunct for pain management.

Key words: Elastic therapeutic taping, nonpharmacological adjunct, pain management

INTRODUCTION

Universal health coverage in India continues to remain poor despite a significant growth in the economy.[1,2] India spends only 4% of its total gross domestic product on its public health system, lower than other emerging economies such as Brazil, Russia, China, and South Africa.[3] India was ranked in the lowest quintile of 166 countries on health outcomes and spending,[4] and this places a reliance on private delivery of health care and subsequent inequalities for access to health-care services.[1,2] It is, therefore, necessary to explore effective yet economic alternatives for treatment purposes.

Unrelieved chronic pain is a global health-care problem with prevalence of mean SD 30.3% ± 11.7%.[5] A cross-sectional telephone survey in eight Indian cities estimated the overall point prevalence of chronic pain to be 13%.[6] and this places a reliance on private delivery of health care and subsequent inequalities for access to health-care services.[1,2] It is, therefore, necessary to explore effective yet economic alternatives for treatment purposes.

In 2004, the International Association for the Study of Pain stated that the management of pain need not involve advanced costly interventions but low-cost therapies that are effective and available to the health-care professionals, patients, and their families.[10]

Pharmacotherapy is often the primary treatment for the pain of recent onset, and many people obtain nonprescription analgesic medication.[6] However, long-term use of analgesic medication is not desirable because of adverse effects. Exercise, manual therapy, patient education, and self-management are recommended as primary interventions for many musculoskeletal conditions including nonspecific persistent low back pain and chronic pain associated with knee osteoarthritis.[11,12] Moreover, nonpharmacological interventions are used as adjuncts to core treatment within a biopsychosocial model of care to improve the activities of daily living and quality of life (QoL).[13,14] The World Health Organization advocates the use of patient education and

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Kinesiology taping is an inexpensive, easy-to-administer technique that involves the application of elastic adhesive tape on the skin. The technique has become popular because of its use by high-profile sports persons for injury prevention and rehabilitation. Kinesiology taping is also used to manage cancer-related lymphedema and neuromuscular-related spasticity in conditions that include stroke, cerebral palsy, and multiple sclerosis. Kinesiology taping was developed in the 1970s to facilitate healing of musculoskeletal-related injuries, and at present, it is being used by nurses, physiotherapists, chiropractors, osteopaths, and sports therapists. The purpose of this review is to discuss the potential value of kinesiology taping for the management of pain.

**KINESIOLOGY TAPING**

The use of taping techniques for the rehabilitation of musculoskeletal-related injuries spans decades. These techniques involve the application of nonelastic cotton zinc oxide-based adhesive tape to joints to provide structural support, biomechanical alignment, restriction of movement, and compression for the management of injuries.

Kinesiology taping differs from these traditional taping techniques. Kinesiology taping uses a latex-free cotton-based tape with polymer elastic strands woven throughout containing heat-sensitive acrylic adhesive. The elastic properties of the tape mean that it can be longitudinally stretched up to 55–60% of its resting length, and this gives the treatment its unique identity because kinesiology tape can support tissues and joints without restricting the movements of structures around the joint. An advantage over standard taping techniques is that kinesiology tape can be applied where rigid tapes cannot be conveniently applied, for example, head and neck, breast, underarm, and abdomen, resulting in better tolerated and fewer adverse effects. Precautions include open wounds, dermatological diseases, and vascular diseases such as deep vein thrombosis, allergy to adhesive tape, and frail skin susceptible to irritation and damage as seen in the elderly.

In India, kinesiology tape is available without prescription and over-the-counter for approximately ₹1000 for a 5 m strip of 5 cm wide tape. Proprietary names for kinesiology tape include Kinesio® Tex Tape, Rocktape, and Tiger K Tape®. There appears to be minor variations in the physical characteristics of different brands of kinesiology tape. Kinesiology tape is available in a variety of shapes, sizes, colors, and patterns, which give the tape its distinctive appearance. Some manufacturers have claimed that the colors of the tape influence treatment outcome although there is no evidence in support. Kinesiology tape is resistant to water, so it can be worn while showering, bathing, swimming, and during physical activity. The duration of a course of kinesiology taping treatment varies according to the condition being treated, although generally, kinesiology tape is replaced for every 3–5 days. From a clinician's perspective, it appears that kinesiology taping is tailored according to the need (s) of the patient using a trial and error approach based on previous clinical experience.

**PRINCIPLES OF KINESIOLOGY TAPING PRACTICE**

A wide variety of techniques have been described by the developer, manufacturers, and educators of kinesiology taping including techniques for pain relief, musculoskeletal rehabilitation, lymphatic drainage, postural correction and sports performance. Kinesiology taping techniques include neuromuscular taping, kinesiologic taping, and lymph taping. In general, kinesiology tape is applied to produce traction on the skin to produce skin convolutions (wrinkles) caused by the recoil of the tape due to its elastic properties. This is achieved by either stretching the tape during application while tissue is not stretched (i.e., in a neutral position) or positioning the body part to stretch tissue (e.g., in a flexed position) and applying tape without stretch. Opinion leaders claim that which technique is used depends on clinical assessment and the purpose of the treatment.

Often, kinesiology taping is used to relieve musculoskeletal pain, and the goal of treatment is to provide support to an injured or overused muscle. In this instance, the tape is removed from its paper backing and applied with a very light stretch from insertion to origin of the muscle along its direction of orientation; the skin, fascia and muscles are placed in stretched position during the kinesiology tape application. It is claimed that this will produce an eccentric pull in the fascia and muscle which will inhibit muscle contraction, thereby promoting healing and relief from pain. Where increased muscle contraction with full range of motion is
desired, kinesiology tape is applied from the origin to insertion of the muscle with a moderate stretch (25–50% approximately); this is theorized to produce concentric pull on the fascia and underlying muscles,[26,31] For the purpose of rehabilitation following ligament or tendon injury, kinesiology tape is applied with medium to full stretch (50–75% approximately) while the individual maintains a functional joint position during application to target the stimulation of mechanoreceptors for improving proprioception.[26] Other common techniques of kinesiology taping include fascial movement taping, sports, and power taping.[32]

Scissors can be used to cut kinesiology tape into various shapes. For example, fan shapes are used to reduce edema and are applied with light stretch (0–15% approximately) directed toward lymph ducts to promote drainage [Figure 2c]. It is believed that fan shapes optimize the areas of low pressure underneath the epidermis and that this assists drainage of the interstitial fluids and reduces pressure on the nociceptors, thereby reducing swelling and pain.[26]

Application of kinesiology tape involves prior preparation of the skin (e.g., removal of dirt, oil, cream, etc.) and the tape itself (e.g., rounding the edges of tape and avoiding touching the adhesive). It is suggested that the skin should be cleaned, the hairs must be trimmed, and the tape must be applied without any tension at its ends for better adherence on to the skin and for easier peeling of the tape afterward.[26] Notwithstanding, complete shaving should be avoided as it is desirable to have some lengths of hair (in mm) for the tape to stick to and stimulate skin mechanoreceptors by pulling on the hairs. After use, it is suggested that the tape should be carefully removed from top to down in the direction of body hairs to avoid hair pulling and skin irritation.[26] Moisturizer may be used if the skin becomes red and tender.

There is, however, a paucity of scientific evidence on the effect of design and technique variations on outcome. A critique of the fundamental physiological principles and mechanisms proposed for kinesiology tape is needed.

**Mechanisms of Action**

A variety of mechanisms of action have been proposed for the putative actions of kinesiology taping [Table 1]. These mechanisms are largely speculative, and theories are yet to be tested empirically.

The elastic nature of kinesiology tape means that it may generate convolutions (wrinkles) of the skin when applied to certain regions of the body. It is claimed that this causes microscopic lifting of the skin from the underlying tissue and that this improves microcirculation of the blood and lymph assisting in the drainage of analgesic substances and edema.[26] Studies evaluating the effect of kinesiology taping on microcirculation of blood and lymph are limited, conflicting, and inconclusive.[40-43]

It has been suggested that the elastic nature of kinesiology tape causes stretching and recoiling of the skin during movement, and that this stimulates low-threshold cutaneous mechanoreceptors, Golgi tendon organs, and muscle spindles.[26] Resultant activity in low-threshold afferents could cause central inhibition of nociceptive transmission and a reduction in pain in line with the Gate Control Theory of Pain,[44] and alter proprioception and postural awareness.[18,19,31,35,37,39,45,46] Mechanical forces produced by kinesiology tape may reduce stiffness in fascia occurring, for example, during acute inflammation and when the fascia tightens and loses flexibility.[30,47] Fascia consists of viscoelastic connective tissue matrix throughout the body and it is richly innervated with mechanosensitive receptors that signal forces from other soft tissues and structures.[48-56]

It is proposed that kinesiology taping over hypothesized myofascial meridians[57] can help mitigate pain and improve muscle performance, range of motion, and posture.[58] At present, there is a paucity of research evidence to support the notion that kinesiology taping influences fascia.

It seems likely that in some instances kinesiology taping effects are being mediated as an “elastic splint” by providing structural support to unload incumbent forces on soft tissues and joints, for example, shoulder impingement syndrome.[33] Kinesiology taping is also being used to apply correctional forces in cases such as patellofemoral pain syndrome.[25,26] It is likely that there is a large psychological effect associated with kinesiology taping including an expectation of benefit from being given a treatment.[39]
Clinical Efficacy

We have conducted an evaluation of research on clinical efficacy of kinesiology taping for pain and related musculoskeletal outcomes. Systematic reviews with or without meta-analysis with or without meta-analysis on kinesiology taping for clinical outcomes, primarily pain relief, were sought by searching the following in January 2016: MEDLINE, CENTRAL, EMBASE, CINAHL, AMED, SPORTDiscus, PEDro, OTseeker, Web of Science, Scopus, and Google Scholar. Keywords used were Kinesio* tap*, k-tap*, kinesthetic tap*, lymph taping, and elastic therapeutic tap*. Titles and abstracts of studies published in English or translated into English were screened by GB, and full reports were obtained.

The search identified 19 systematic reviews and 1 pooled analysis [Table 2]. In total there were 90 studies with 3081 participants that predominantly evaluated the efficacy of kinesiology taping for improving pain and function in musculoskeletal conditions in noncancer populations. In general, reviewers report insufficient evidence to judge the outcome because of a limited number of randomized controlled trials (RCTs) and those that exist have small sample sizes. A systematic review with meta-analysis on the effect of kinesiology taping on skeletal muscle strength noted that studies of lower methodological quality tended to report positive outcomes. Evidence in more recent systematic reviews suggest that kinesiology taping may have a small effect in reducing musculoskeletal-related pain and may not be superior to other treatments when used as standalone. Kinesiology taping, however, could be a useful adjunct to mainline therapies for pain management in conditions that include patellofemoral pain syndrome, rotator cuff tendinopathy, and lateral ankle sprain.

Kinesiology taping may also enhance proprioception which is suggestive of its role in the prevention and rehabilitation of sports-related soft tissue injuries.

An evaluation of the research against the Grade Practice Recommendations suggests that there is only level C evidence for clinical efficacy because of inconsistent findings from the systematic reviews and lack of high quality robust RCTs.

Kinesiology taping is also used to alleviate lymphedema and associated outcome measures in cancer patients. We have reported the initial findings of a systematic review that found positive outcomes for kinesiology taping for breast cancer-related lymphedema and associated outcomes including limb movability and QoL in 5/7 studies with controlled groups and in all studies without a comparison group.

Conclusion

Kinesiology taping is a simple low-cost treatment option that has the potential to be useful in the management of a variety of painful conditions. At present, kinesiology taping is not a part of mainstream physiotherapy or nursing pain management practice because there is a lack of consistent evidence for efficacy. Nevertheless, kinesiology taping may have a role as an adjunct as adverse effects appear to be few. Further research appears necessary.

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Conflicts of interest
There are no conflicts of interest.
Insufficient evidence to judge the treatment efficacy of KT and support its use in MSK chronic pain and disability, KT seems to have a positive effect on wrist extension, grip strength, function, MSK pain, KT may have limited potential to reduce pain but may not be clinically significant. Current evidence does not support the use of KT over other modalities. Moderate evidence to support the use of KT for immediate pain reduction but not for long-term pain relief. No or inconclusive evidence for improvements in muscle strength, ROM, stroke-related spasticity and cancer-related lymphedema. Moderate and limited evidence that KT is clinically more effective than sham or usual care tape/brandage. Insufficient evidence to support the use of the KT over other modalities. KT may have limited potential to reduce pain but may not be clinically meaningful. KT is not superior to other treatment modalities for reducing pain, and may be used in conjunction with more traditional therapies. KT produced similar or slightly superior short-term pain relief compared with other active physical therapy interventions. KT can be considered as an adjunct to other therapies. KT has no or only negligible effects on muscle strength. The strength-enhancing effects of KT are not muscle group-dependent. The immediate effect of KT on reducing low back pain and disability is insignificant. KT has a positive but small effect on reducing whiplash associated or specific neck pain, which may not be clinically relevant. Insufficient evidence to support the use of KT in patellofemoral pain syndrome. KT is superior to minimal intervention for pain relief, but is not superior to other treatment approaches for reducing pain and disability. KT has positive effects on proprioception, muscle endurance, and activity performance and so may be used for preventing and managing lateral ankle injuries. Adverse effect of KT is unlikely. KT technique used for muscles can relieve pain but unlike McConnell taping, KT cannot change patellar alignment. Both techniques of patellar taping can substantially improve muscle activity, motor function, and QoL. KT significantly improved pain-free range of motion; however, there is insufficient evidence to formally conclude on the efficacy of KT in rotator cuff tendinopathy as a stand-alone treatment or as an adjunct. Exercise and other therapies such as KT are ideal treatments in the early stage of shoulder impingement syndrome. Inconclusive evidence to support the use of taping for improving pain intensity, ROM, muscle tone, strength, or function.

### Table 2: Summary of systematic reviews and pooled analysis

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Outcomes, number of studies</th>
<th>Findings/authors’ conclusion</th>
</tr>
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<tbody>
<tr>
<td>Bassett et al., 2010[33]</td>
<td>MSK pain, muscle performance, n=3</td>
<td>Insufficient evidence to judge the treatment efficacy of KT and support its use in MSK chronic pain and disability, KT seems to have a positive effect on wrist extension, grip strength, function, MSK pain, KT may have limited potential to reduce pain but may not be clinically significant. Current evidence does not support the use of KT over other modalities. Moderate evidence to support the use of KT for immediate pain reduction but not for long-term pain relief. No or inconclusive evidence for improvements in muscle strength, ROM, stroke-related spasticity and cancer-related lymphedema. Moderate and limited evidence that KT is clinically more effective than sham or usual care tape/brandage. Insufficient evidence to support the use of the KT over other modalities. KT may have limited potential to reduce pain but may not be clinically meaningful. KT is not superior to other treatment modalities for reducing pain, and may be used in conjunction with more traditional therapies. KT produced similar or slightly superior short-term pain relief compared with other active physical therapy interventions. KT can be considered as an adjunct to other therapies. KT has positive effects on proprioception, muscle endurance, and activity performance and so may be used for preventing and managing lateral ankle injuries. Adverse effect of KT is unlikely. KT technique used for muscles can relieve pain but unlike McConnell taping, KT cannot change patellar alignment. Both techniques of patellar taping can substantially improve muscle activity, motor function, and QoL. KT significantly improved pain-free range of motion; however, there is insufficient evidence to formally conclude on the efficacy of KT in rotator cuff tendinopathy as a stand-alone treatment or as an adjunct. Exercise and other therapies such as KT are ideal treatments in the early stage of shoulder impingement syndrome. Inconclusive evidence to support the use of taping for improving pain intensity, ROM, muscle tone, strength, or function.</td>
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<tr>
<td>Mostafavifar et al., 2012[34]</td>
<td>MSK pain, function, strength, performance, n=6</td>
<td>Insufficient evidence for or against the use of KT to improve pain, function, performance, and return to play. KT is a safe modality</td>
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<tr>
<td>Williams et al., 2012[35]</td>
<td>Sports-related MSK pain, ROM, proprioception, muscle strength, kinematics in healthy individuals, n=10</td>
<td>Small beneficial effect of KT on strength, force sense error, and active ROM. Insufficient evidence for improvements in pain, ankle proprioception, or muscle activity</td>
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<tr>
<td>Kalron and Bar-Sela, 2013[36]</td>
<td>MSK pain, muscle strength, ROM, n=9; cancer-related lymphedema and edema, n=2; stroke-related spasticity, n=1</td>
<td>Moderate evidence to support the use of KT for immediate pain reduction but not for long-term pain relief. No or inconclusive evidence for improvements in muscle strength, ROM, stroke-related spasticity and cancer-related lymphedema</td>
</tr>
<tr>
<td>Morris et al., 2013[37]</td>
<td>MSK pain, ROM, disability, function, n=6; cancer-related lymphedema, n=1; stroke-related spasticity, n=1</td>
<td>Moderate and limited evidence that KT is clinically more effective than sham or usual care tape/brandage. Insufficient evidence to support the use of the KT over other modalities. Moderate evidence to support the use of KT for immediate pain reduction but not for long-term pain relief. No or inconclusive evidence for improvements in muscle strength, ROM, stroke-related spasticity and cancer-related lymphedema</td>
</tr>
<tr>
<td>Montalvo et al., 2014[38]</td>
<td>MSK pain, n=13</td>
<td>KT may have limited potential to reduce pain but may not be clinically meaningful. KT is not superior to other treatment modalities for reducing pain, and may be used in conjunction with more traditional therapies. KT produced similar or slightly superior short-term pain relief compared with other active physical therapy interventions. KT can be considered as an adjunct to other therapies. KT has positive effects on proprioception, muscle endurance, and activity performance and so may be used for preventing and managing lateral ankle injuries. Adverse effect of KT is unlikely. KT technique used for muscles can relieve pain but unlike McConnell taping, KT cannot change patellar alignment. Both techniques of patellar taping can substantially improve muscle activity, motor function, and QoL. KT significantly improved pain-free range of motion; however, there is insufficient evidence to formally conclude on the efficacy of KT in rotator cuff tendinopathy as a stand-alone treatment or as an adjunct. Exercise and other therapies such as KT are ideal treatments in the early stage of shoulder impingement syndrome. Inconclusive evidence to support the use of taping for improving pain intensity, ROM, muscle tone, strength, or function.</td>
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<tr>
<td>Parreira et al., 2014[39]</td>
<td>MSK pain, disability, QoL, return to work, global impression of recovery, n=12</td>
<td>KT was not superior to active therapies, sham taping, or placebo. In studies where beneficial effects were observed, the effect sizes were too small to have clinical significance. Current evidence does not support its clinical use</td>
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<tr>
<td>Csapo and Alegre, 2014[40]</td>
<td>Muscle strength in healthy population, n=19</td>
<td>KT has no or only negligible effects on muscle strength. The strength-enhancing effects of KT are not muscle group-dependent</td>
</tr>
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<td>Vanti et al., 2014[41]</td>
<td>Spinal pain and disability, n (NET + KT)=8; n=KT=6</td>
<td>The immediate effect of KT on reducing low back pain and disability is insignificant. KT has a positive but small effect on reducing whiplash associated or specific neck pain, which may not be clinically relevant</td>
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<tr>
<td>Méndez-Rebolledo et al., 2014[42]</td>
<td>Patellofemoral pain syndrome, n=6</td>
<td>Insufficient evidence to support the use of KT in patellofemoral pain syndrome.</td>
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<tr>
<td>Artioli and Bertolini, 2014[43]</td>
<td>Pain, n=10</td>
<td>KT produced similar or slightly superior short-term pain relief compared with other active physical therapy interventions. KT can be considered as an adjunct to other therapies.</td>
</tr>
<tr>
<td>Hanneshin Bebhanani et al., 2014[44]</td>
<td>Lateral epicondyritis, n=11</td>
<td>KT seems to have a positive effect on wrist extension, grip strength, function, and pain. Strong evidence is, however, not available</td>
</tr>
<tr>
<td>Ristow et al., 2014[45]</td>
<td>Postoperative maxillofacial surgery management, n=3</td>
<td>KT significantly reduced postoperative morbidity of OMF surgery, i.e., pain, trismus, and swelling. KT is a simple economical approach that is free from systemic adverse effects for improving patients’ QoL following OMF surgery</td>
</tr>
<tr>
<td>Lim and Tay, 2015[46]</td>
<td>MSK chronic pain and disability, n=17</td>
<td>KT is superior to minimal intervention for pain relief, but is not superior to other treatment approaches for reducing pain and disability. KT has positive effects on proprioception, muscle endurance, and activity performance and so may be used for preventing and managing lateral ankle injuries. Adverse effect of KT is unlikely.</td>
</tr>
<tr>
<td>Wilson and Bialocerkowski, 2015[47]</td>
<td>Lateral ankle sprain, n=8</td>
<td>KT has positive effects on proprioception, muscle endurance, and activity performance and so may be used for preventing and managing lateral ankle injuries. Adverse effect of KT is unlikely.</td>
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<tr>
<td>Beatriz and Rafael, 2015[48]</td>
<td>Patellofemoral pain syndrome, n=12</td>
<td>There is insufficient evidence to support the use of KT in patellofemoral pain syndrome. KT is an insensitive technique that has no side effects and can be used alongside other therapies.</td>
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<tr>
<td>Chang et al., 2015[49]</td>
<td>Patellofemoral pain syndrome, n (NET + KT)=11; n=KT=5</td>
<td>KT technique used for muscles can relieve pain but unlike McConnell taping, KT cannot change patellar alignment. Both techniques of patellar taping can substantially improve muscle activity, motor function, and QoL.</td>
</tr>
<tr>
<td>Desjardins-Charbonneau et al., 2015[50]</td>
<td>Rotator cuff tendinopathy, n (NET + KT)=10; n=KT=6</td>
<td>KT significantly improved pain-free range of motion; however, there is insufficient evidence to formally conclude on the efficacy of KT in rotator cuff tendinopathy as a stand-alone treatment or as an adjunct.</td>
</tr>
<tr>
<td>Dong et al., 2015[51]</td>
<td>Shoulder impingement syndrome, n (total interventions + KT)=33; n=KT=1</td>
<td>Exercise and other therapies such as KT are ideal treatments in the early stage of shoulder impingement syndrome</td>
</tr>
<tr>
<td>Grampurohit et al., 2015[52]</td>
<td>Poststroke outcomes, n (NET + KT)=15; n=KT=2</td>
<td>Inconclusive evidence to support the use of taping for improving pain intensity, ROM, muscle tone, strength, or function</td>
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</table>

*Studies evaluating the effectiveness of taping in general which includes kinesiology (elastic) taping and NET (nonelastic taping), †Studies evaluating the effectiveness of interventions for shoulder impingement syndrome that include kinesiology taping, pharmacotherapy, and surgery, ‡Study is a pooled analysis.

**KT:** Kinesiology taping, **MSK:** Musculoskeletal, **NET:** Nonelastic taping, **QoL:** Quality of life, **ROM:** Range of motion, **OMF:** Oral and maxillofacial surgery.

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