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Original Research Article

A PROSPECTIVE STUDY ON THE EFFICACY OF KINESIOTAPING IN LATERAL EPICONDYLITIS MANAGEMENT

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ABSTRACT

Background: Lateral epicondylitis (tennis elbow) is a common musculoskeletal disorder characterized by pain and tenderness over the lateral epicondyle, leading to impaired grip strength and functional disability. Conservative treatment remains the mainstay of management, and kinesiotaping has emerged as a non-invasive adjunct therapy aimed at reducing pain, improving proprioception, and enhancing functional recovery. The objective is to evaluate the clinical and functional efficacy of kinesiotaping in the management of lateral epicondylitis by assessing pain relief, functional outcomes, grip strength, complications, and overall patient recovery.

Materials and Methods: A prospective study was conducted on 50 patients diagnosed with lateral epicondylitis. All patients were treated with kinesiotaping in combination with a structured physiotherapy exercise program. Clinical and functional outcomes were assessed using the Visual Analogue Scale (VAS), Patient-Rated Tennis Elbow Evaluation (PRTEE) score, Disabilities of the Arm, Shoulder and Hand (DASH) score, and grip strength measurements. Evaluations were performed at baseline, 1 week, 4 weeks, and 8 weeks follow-up.

Results: Significant improvement was observed in all outcome parameters during follow-up. The mean VAS score decreased from 76.06 ± 6.99 at baseline to 36.84 ± 7.99 at 8 weeks. PRTEE scores improved from 73.31 ± 6.94 to 37.28 ± 8.45, while DASH scores improved from 62.35 ± 7.25 to 32.23 ± 7.93. Mean grip strength increased from 17.52 ± 2.91 kg to 27.13 ± 3.11 kg. Complications were minimal, with only minor skin irritation, itching, and transient redness reported. Final outcome assessment revealed excellent results in 8% of patients, good results in 32%, fair results in 60%, and no poor outcomes.

Conclusion: Kinesiotaping is a safe, effective, and non-invasive treatment modality for lateral epicondylitis. It provides significant pain relief, improves grip strength and upper limb function, and is associated with minimal complications. Kinesiotaping, when combined with physiotherapy exercises, serves as a valuable adjunct in the conservative management of lateral epicondylitis.

Keywords: Lateral epicondylitis, Tennis elbow, Kinesiotaping, PRTEE score, DASH score, Grip strength, Visual Analogue Scale.

INTRODUCTION

Lateral epicondylitis, commonly known as tennis elbow, is a painful musculoskeletal disorder affecting the common extensor tendon origin at the lateral epicondyle of the humerus. It is one of the most common causes of elbow pain, with an incidence of 1–3% in the general population, particularly affecting individuals between 35 and 55 years of age who perform repetitive wrist extension and forearm supination activities.[1,2]

The condition results in pain, reduced grip strength, and functional limitations that adversely affect occupational and daily activities. Although several treatment modalities such as rest, non-steroidal anti-inflammatory drugs, physiotherapy, corticosteroid

injections, and bracing have been utilized, no single treatment has been established as the gold standard.[3,4]

Kinesiotaping has emerged as a non-invasive therapeutic technique that aims to reduce pain, improve proprioception, enhance muscle function, and facilitate tissue healing without restricting joint movement. Recent studies have demonstrated promising results regarding pain reduction and functional improvement in patients with lateral epicondylitis.[5,6] Therefore, the present study was undertaken to evaluate the efficacy of kinesiotaping in the management of lateral epicondylitis with respect to pain relief, grip strength, and functional outcomes.

Objectives of the study

1. To assess the clinical and functional outcome of kinesiotaping in the management of lateral epicondylitis by using PRTEE score and DASH scores.
2. To study the improvement in pain by using VAS score over the course of followup of the study.
3. To assess the improvement in grip strength over the course of follow-up of the study.
4. To record any complications and evaluate the final outcome by calculating percentage improvement of DASH score and grade it as excellent/good/fair/poor.

MATERIALS AND METHODS

This is a prospective study to assess the eficacy of kinesiotaping in the management of lateral epicondylitis. The study is conducted in the department of Orthopaedics, of Narayana medical college, Nellore, between January-2024 and december-2025. 50 patients, presenting to the department of Orthopaedics with lateral epicondylitis, treated by kinesiotaping and physiotherapy, satisfying our inclusion criteria are included in the study.

Inclusion Criteria

1. Age between 18 and 65 years who are clinically diagnosed with unilateral
2. lateral epicondylitis characterized by pain over lateral epicondyle and tenderness at the common extensor origin.
3. Positive clinical tests including cozens test and mills test.
4. Symptom duration of at least 6 weeks to 3 months
5. Subjects who are willing to participate in the study and are willing to give the needed written consent form.
6. Pain intensity of more than or equal to 4

Exclusion Criteria

1. Fracture Cervical radiculopathy, neurological deficits or peripheral neuropathy affecting upper limb.
2. Corticosteroid injection within the previous 3 to 6 months.
3. Systemic conditions including rheumatoid arthritis or other autoimmune or metabolic disorders.
4. Skin allergy, infection, or open wounds at the site of tape application.
5. Inability to understand instructions or comply with the study protocol.

Clinical Evaluation

Every patient's detailed medical history was obtained. The history included the duration of symptoms, dominant hand involvement, occupational and recreational activities, previous treatments received, and associated medical comorbidities. Particular attention was given to repetitive wrist extension and forearm supination activities, which are known risk factors for lateral epicondylitis.

Clinical examination was performed to assess tenderness over the lateral epicondyle, pain during resisted wrist extension and middle finger extension, grip strength, and range of motion of the elbow and wrist joints. Provocative tests such as Cozen's test, Mill's test, and Maudsley's test were carried out to confirm the diagnosis.

The severity of pain and functional disability was assessed using the Visual Analogue Scale (VAS), Patient-Rated Tennis Elbow Evaluation (PRTEE) score, and Disabilities of the Arm, Shoulder and Hand (DASH) score. Grip strength was measured using a hand dynamometer and compared during subsequent follow-up visits.

Additionally, other causes of lateral elbow pain such as radial tunnel syndrome, cervical radiculopathy, inflammatory arthritis, elbow instability, and intra-articular pathology were ruled out before initiating treatment.

Radiographic Evaluation

Pain severity, functional improvement, grip strength, and treatment response were evaluated during each follow-up visit. Comparisons were made between baseline and subsequent assessments at 1 week, 4 weeks, and 8 weeks following application of kinesiotaping.

Clinical evaluation was performed using the Visual Analogue Scale (VAS) for pain assessment, the Patient-Rated Tennis Elbow Evaluation (PRTEE) score for elbow-specific disability, and the Disabilities of the Arm, Shoulder and Hand (DASH) score for upper limb function. Grip strength was measured using a hand dynamometer and compared with previous recordings to assess functional recovery.

Special clinical tests including Cozen's test, Mill's test, and Maudsley's test were performed at each follow-up to evaluate tenderness and symptom improvement. Elbow and wrist range of motion were also assessed to identify any restriction of movement or residual disability.

Ultrasonography and/or Magnetic Resonance Imaging (MRI) were performed in selected patients to evaluate tendon pathology, extensor carpi radialis brevis (ECRB) degeneration, partial tendon tears, and associated soft tissue abnormalities. Imaging findings

were correlated with clinical outcomes wherever indicated.

Any complications related to treatment, including skin irritation, itching, redness, allergic reactions, persistence of symptoms, or recurrence of pain, were documented and analyzed throughout the study period.

Kinesiotaping In Lateral Epicondylitis

1. Principle: Kinesiotaping is based on the principle of providing support to injured muscles and tendons without restricting the normal range of motion. The elastic properties of the tape gently lift the skin, increasing the interstitial space, improving blood and lymphatic circulation, reducing pain, enhancing proprioception, and facilitating the healing process. It also helps redistribute mechanical stress away from the affected extensor tendon origin.

2. Indications: Kinesiotaping is indicated in patients with lateral epicondylitis presenting with pain over the lateral epicondyle, reduced grip strength, tenderness over the common extensor origin, pain during resisted wrist extension, and functional limitation of the upper limb. It may be used as a primary conservative treatment or as an adjunct to physiotherapy and rehabilitation exercises.

3. Advantages: Kinesiotaping is a non-invasive, inexpensive, and easily applicable treatment modality. It allows unrestricted joint movement while providing therapeutic support. It reduces pain, improves grip strength, enhances proprioception, facilitates early return to daily activities, and has minimal adverse effects. It can be combined effectively with physiotherapy exercises.

4. Disadvantages: The effectiveness of kinesiotaping depends on proper application technique and patient compliance. The benefits may be temporary and require repeated applications. Some patients may develop mild skin irritation, itching, redness, or allergic reactions to the adhesive material.

5. Characteristics: Kinesio tape is an elastic cotton tape with acrylic adhesive that can stretch up to 140–160% of its original length. It closely mimics the elasticity of human skin, allowing comfortable movement while providing continuous therapeutic effects. Different taping patterns and tensions can be applied depending on the clinical objectives such as pain reduction, muscle facilitation, or tendon unloading.

6. Treatment Procedure

a. Patients were clinically evaluated using VAS, PRTEE, DASH scores, and grip strength measurements before initiation of treatment. Written informed consent was obtained.

b. The affected upper limb was positioned comfortably with the elbow extended, forearm pronated, and wrist flexed to place the extensor muscles under stretch.

c. The skin over the lateral aspect of the elbow and proximal forearm was cleaned and dried. Excess hair was removed whenever necessary to ensure proper adhesion.

d. A Y-strip of kinesio tape was applied along the wrist extensor muscle group from its origin near the lateral epicondyle to the distal forearm with appropriate tension.

e. An additional I-strip was applied transversely over the lateral epicondyle to provide decompression and pain relief at the site of maximal tenderness.

f. The tape was gently rubbed after application to activate the adhesive and ensure proper fixation.

g. Patients were instructed to keep the tape in place for the recommended duration and to report any discomfort, itching, or skin irritation.

h. A structured physiotherapy exercise program consisting of stretching and strengthening exercises for the wrist extensors was simultaneously initiated.

i. Follow-up assessments were performed at 1 week, 4 weeks, and 8 weeks. Pain, grip strength, and functional outcomes were recorded during each visit. Any complications such as skin irritation, redness, or recurrence of symptoms were documented.

A. Materials Required

- Kinesio tape rolls
- Scissors
- Measuring tape
- Skin preparation materials

B. Patient Positioning and Skin Preparation

- Comfortable sitting position
- Elbow extension and wrist flexion
- Cleaning and drying of the skin

C. Application of Kinesiotape

- Y-strip application along wrist extensors
- I-strip application over lateral epicondyle
- Appropriate tape tension and fixation

D. Follow-up Assessment

- VAS score evaluation
- PRTEE and DASH score assessment
- Grip strength measurement using dynamometer
- Documentation of complications and patient satisfaction

Outcome Measures

1) Pain Assessment

a) Visual Analogue Scale (VAS): A validated pain assessment tool ranging from 0 to 100, where 0 indicates no pain and 100 indicates the worst imaginable pain. VAS scores were recorded at

baseline, 1 week, 4 weeks, and 8 weeks following treatment.

2) Functional Assessment

a) Patient-Rated Tennis Elbow Evaluation (PRTEE): A disease-specific questionnaire assessing pain and functional disability associated with lateral epicondylitis. The score ranges from 0 to 100, with higher scores indicating greater pain and disability.

b) Disabilities of the Arm, Shoulder and Hand (DASH) Score: A standardized outcome measure evaluating upper limb function and symptoms. Scores range from 0 to 100, where lower scores indicate better functional status and less disability.

3) Grip Strength Assessment

a) Hand Grip Strength: Measured using a calibrated hand dynamometer at baseline, 1 week, 4 weeks, and 8 weeks. Grip strength was recorded in kilograms (kg), with higher values indicating improved functional recovery and muscle performance.

4) Clinical Assessment

a) Tenderness over Lateral Epicondyle: Assessed clinically during each follow-up visit to evaluate reduction in local pain and inflammation.

b) Provocative Tests: Cozen's test, Mill's test, and Maudsley's test were performed at each follow-up to assess symptom severity and treatment response.

c) Range of Motion (ROM): Elbow and wrist joint range of motion were assessed clinically to identify any restriction of movement and to monitor functional improvement during follow-up.

5) Complications Assessment

a) Local Skin Reactions: Patients were monitored for skin irritation, itching, redness, allergic reactions, or discomfort related to kinesiotape application.

b) Recurrence or Persistence of Symptoms: Any recurrence of pain, persistent functional limitation, or need for additional intervention was documented throughout the study period.

RESULTS

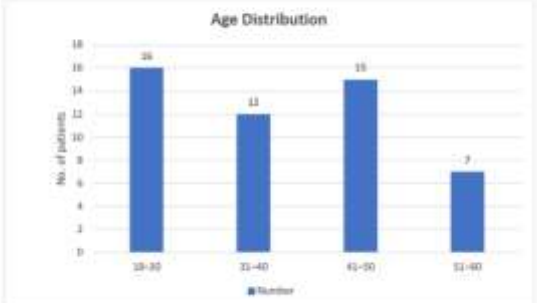
AGE DISTRIBUTION:

The majority of patients in our group were of age between 41-50 years, making up to 36.66% of total study population (11 patients). The distribution of age among both the groups in our study is as following.

Table 1: AGE DISTRIBUTION

Age Category	Number	Percentage (%)
18–30	16	32.0
31–40	12	24.0
41–50	15	30.0
51–60	7	14.0
Total	50	100

The majority of patients belonged to the middle-aged population, with most cases occurring in the 31–50-year age group (54% of the total study population). This suggests that lateral epicondylitis predominantly affects the active working population.



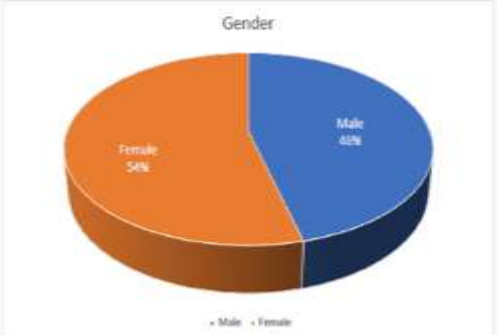
Graph 1: AGE DISTRIBUTION

GENDER DISTRIBUTION:

Table 2: GENDER DISTRIBUTION

Gender	Number (n)	Percentage (%)
Male	23	46%
Female	27	54%
Total	50	100%

The distribution shows a slight predominance of female gender in the study population (54% of the total study population). However, both males and females were substantially represented, indicating that the condition affects both genders relatively commonly.



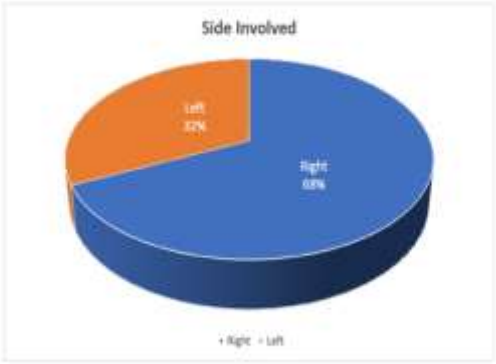
Graph 2: GENDER DISTRIBUTION

SIDE INVOLVED

Table 3: SIDE INVOLVED

SIDE INVOLVED	NUMBER	PERCENTAGE (%)
Right	34	68%
Left	16	32%
Total	50	100

The right side was more commonly affected accounting for 68% of the total study population (34 patients) compared to the left side. This trend may be related to greater functional use and repetitive strain on the dominant upper limb.



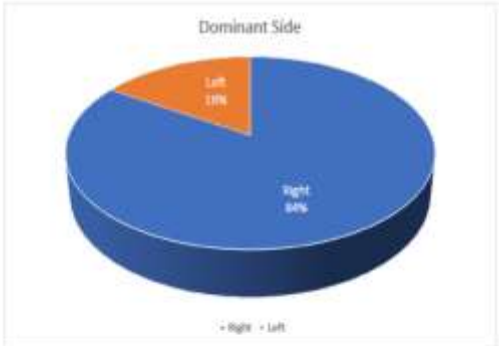
Graph 3: DISTRIBUTION OF SIDE INVOLVED

DISTRIBUTION OF DOMINANT SIDE

Table 4: DISTRIBUTION OF DOMINANT SIDE INVOLVED

Dominant Side	Number (n)	Percentage (%)
Right	42	84%
Left	8	16%
Total	**50**	**100%**

Most participants were right-hand dominant, accounting for 84% of the study population (42 patients) which reflects the general population trend. Dominant limb overuse is considered an important contributing factor in the development of lateral epicondylitis.



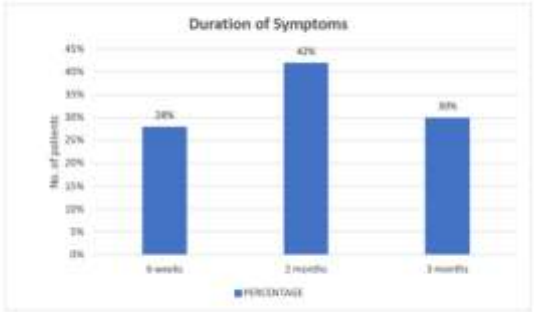
Graph 4: DISTRIBUTION OF DOMINANT SIDE

DURATION OF SYMPTOMS:

Table 5: DISTRIBUTION OF DURATION OF SYMPTOMS

DURATION	NUMBER	PERCENTAGE (%)
6 weeks	14	28%
2 months	21	42%
3 months	15	30%

Most patients presented with symptoms of 6 weeks – 3 months duration before treatment. This indicates that many patients seek medical care after failure of initial conservative medical management.

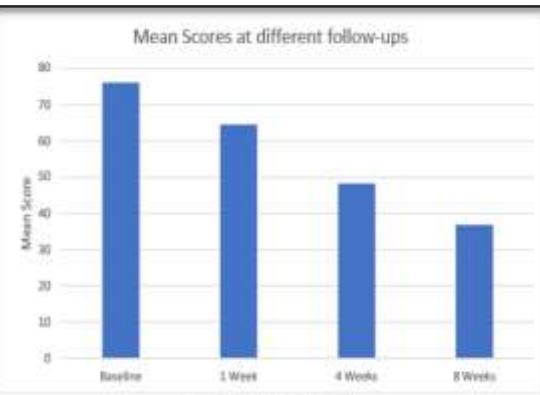


Graph 5: DISTRIBUTION OF DURATION OF SYMPTOMS

VAS SCORE:

Table 6: VAS SCORE

	MEAN ± SD	P VALUE (VSPre procedure)
Baseline	76.06 ± 6.99	—
1 Week	64.48 ± 7.27	<0.0001
4 Weeks	48.18 ± 7.92	<0.0001
8 Weeks	36.84 ± 7.99	<0.0001



Graph 6: VAS SCORE

PRTEE SCORE:

Table 7: PRTEE SCORE

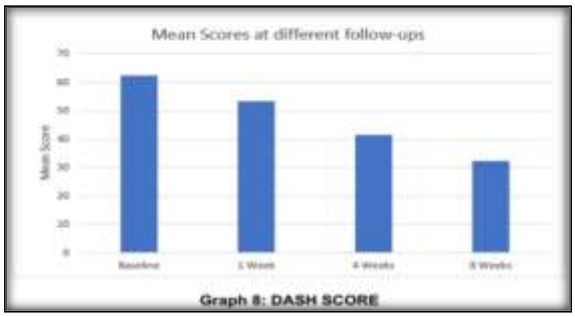
FOLLOW-UP	MEAN ± SD	P VALUE (VSBASELINE)
Baseline	73.31 ± 6.94	—
1 Week	62.29 ± 7.65	<0.0001
4 Weeks	48.50 ± 7.78	<0.0001
8 Weeks	37.28 ± 8.45	<0.0001

Graph 7: PRTEE SCORE

DASH SCORE:

Table 8: DASH SCORES

FOLLOW-UP	MEAN ± SD	P VALUE (VSBASELINE)
Baseline	62.35 ± 7.26	—
1 Week	53.38 ± 7.53	<0.0001
4 Weeks	41.43 ± 7.73	<0.0001
8 Weeks	32.23 ± 7.93	<0.0001

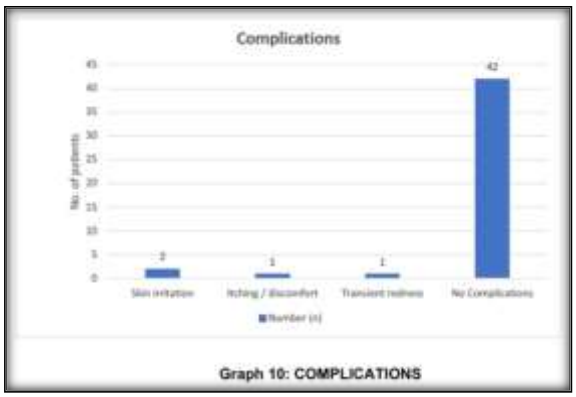


Graph 8: DASH SCORE

COMPLICATIONS

Table 10: COMPLICATIONS

Complication	Number (n)	Percentage (%)
Skin irritation	2	4%
Itching / discomfort	1	2%
Transient redness	1	2%
No Complications	42	96%
Total	**50**	**100%**



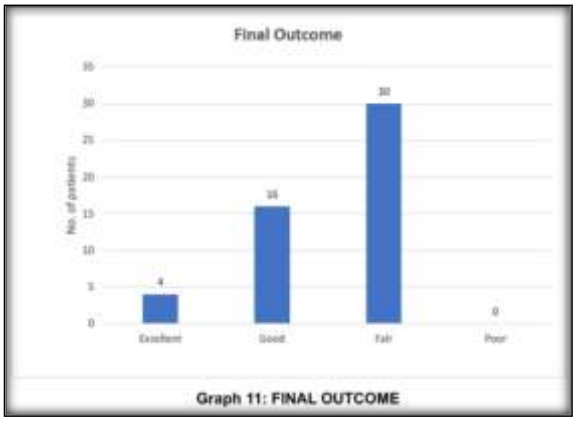
Graph 10: COMPLICATIONS

FINAL OUTCOME:

The final outcomes have been graded as excellent, good, fair and poor based on the percentage improvement of DASH score at the final follow-up, compared to the baseline DASH score.

Table 11: FINAL OUTCOME

OUTCOME	NUMBER	PERCENTAGE (%)
Excellent	4	8.0
Good	16	32.0
Fair	30	60.0
Poor	0	0.0



Graph 11: FINAL OUTCOME

Case Illustration

Case – 1: Pre procedure clinical Photograph

Clinical Photograph showing kinesiotaping for left elbow

Case – 2: Pre procedure clinical Photograph

Clinical Photograph showing kinesiotaping for right elbow

DISCUSSION

The clinical and functional outcomes of patients with lateral epicondylitis treated with kinesiotaping were evaluated in the present study.

Kinesiotaping has gained popularity as a conservative treatment modality because of its ability to provide continuous sensory stimulation, reduce pain, improve proprioception, and support the extensor musculature without restricting joint movement. The elastic properties of the tape help decrease mechanical stress at the common extensor tendon origin and facilitate participation in rehabilitation exercises. Previous studies by Kachanathu et al., Shakeri et al., and Cho et al. have reported significant improvements in pain and functional outcomes following kinesiotaping in patients with lateral epicondylitis.[8-10]

Distribution by Age: In the present study, the majority of patients belonged to the 31–50 year age group. The mean age distribution was comparable to previously published studies, indicating that lateral epicondylitis commonly affects individuals during their active working years due to repetitive use of the wrist extensor muscles. Similar observations have been reported by Nirschl and Ashman, Verhaar, and Kraushaar et al.[1,2,5]

Distribution by Gender: The study population demonstrated a slight female predominance, although both genders were substantially represented. The higher prevalence among females may be related to repetitive domestic and occupational activities involving gripping, lifting, and wrist extension. Similar findings have been reported by Walker-Bone et al. and Shiri et al.[6,7]

Side Involved and Dominant Limb: The right elbow was affected more frequently than the left. Most patients were right-hand dominant, supporting the concept that repetitive use of the dominant upper limb contributes significantly to the development of lateral epicondylitis. Repetitive mechanical loading results in microtrauma and degenerative changes at the extensor carpi radialis brevis tendon origin, as described by Kraushaar and Nirschl.[1]

Duration of Symptoms: Most patients presented with symptoms ranging from 6 weeks to 3 months before seeking medical care. This suggests that patients commonly seek treatment after initial self-management measures fail to provide adequate relief. Similar trends have been observed in previous studies evaluating conservative treatment strategies for tennis elbow.[3,4]

Pain Assessment (VAS Score): The mean Visual Analogue Scale (VAS) score demonstrated a progressive and statistically significant reduction from baseline through the follow-up period. The mean score decreased from 76.06 ± 6.99 at baseline to 36.84 ± 7.99 at 8 weeks, indicating substantial pain relief following treatment. These findings are consistent with studies by Kachanathu et al., Shakeri et al., Zhong et al., and Balevi et al., who reported significant reductions in pain following kinesiotaping.[8,9,12,15]

Functional Outcome Based on PRTEE Score: The Patient-Rated Tennis Elbow Evaluation (PRTEE) score showed continuous improvement during follow-up. The mean PRTEE score decreased from 73.31 ± 6.94 at baseline to 37.28 ± 8.45 at 8 weeks, indicating improvement in both pain and disease-specific functional activities involving the elbow and forearm. Similar improvements in functional outcomes have been reported by Cho et al., Li et al., and Zhong et al.[10,12,16]

Functional Outcome Based on DASH Score: The Disabilities of the Arm, Shoulder and Hand (DASH) score demonstrated a steady decline from baseline to the final follow-up. The mean DASH score improved from 62.35 ± 7.25 to 32.23 ± 7.93, reflecting reduction in disability and improvement in overall upper limb function. Comparable results have been documented by Shakeri et al., Cho et al., and Altas et al.[9,10,14]

Grip Strength: Grip strength measurements showed progressive improvement throughout the study period. Mean grip strength increased from 17.52 ±

2.91 kg at baseline to 27.13 ± 3.11 kg at 8 weeks, indicating restoration of muscular performance and functional hand use. Similar gains in grip strength following kinesiotaping have been reported by Kachanathu et al., Zhong et al., Li et al., and Balevi et al.[8,12,15,16]

Final Outcome: The final outcome assessment demonstrated favorable clinical results in the majority of patients. Excellent outcomes were observed in 8% of patients, good outcomes in 32%, and fair outcomes in 60%. No patient demonstrated a poor outcome, indicating overall effectiveness of the intervention. These findings support the role of kinesiotaping as a useful adjunctive modality in the conservative management of lateral epicondylitis.[4,9,16]

Complications: The incidence of complications was low. Only minor adverse effects such as skin irritation, itching, and transient redness were observed. No major complications, severe allergic reactions, or treatment discontinuations occurred during the study period, confirming the safety and tolerability of kinesiotaping. Similar safety profiles have been reported by Zhong et al., Altas et al., and Hoseini et al.[12,14,17]

Summary

1. Kinesiotaping provided significant pain reduction during the follow-up period.[8,9,12]
2. Disease-specific functional outcomes measured by PRTEE improved progressively.[10,12]
3. DASH scores demonstrated improvement in overall upper limb function.[9,14]
4. Grip strength increased significantly during follow-up.[8,12,16]
5. The majority of patients achieved good or fair clinical outcomes.
6. No patient demonstrated poor outcomes following treatment.
7. Complications were minimal and limited to minor skin reactions.[12,17]
8. Kinesiotaping proved to be a safe, non-invasive, and effective adjunct in the conservative management of lateral epicondylitis.[4,16,18]

CONCLUSION

The present prospective study was conducted to evaluate the efficacy of kinesiotaping in the management of lateral epicondylitis. Fifty patients with clinically diagnosed lateral epicondylitis were treated with kinesiotaping and followed for eight weeks. Clinical and functional outcomes were assessed using the Visual Analogue Scale (VAS), Patient-Rated Tennis Elbow Evaluation (PRTEE) score, Disabilities of the Arm, Shoulder and Hand (DASH) score, and grip strength measurements.

The study demonstrated significant improvement in pain relief, functional recovery, and grip strength throughout the follow-up period. The incidence of complications was minimal, and patient satisfaction was high. Based on these findings, kinesiotaping appears to be a safe, cost-effective, and useful adjunctive treatment modality in the conservative management of lateral epicondylitis.[8,9,12,16,18]

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