ISSN No: - 2456-2165 https://doi.org/10.38124/ijisrt/26sep446

Efficacy of Kinesiotaping for Pain, Disability, Posture and Pain Pressure Threshold in Cervicogenic Headache

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Publication Date: 2026/09/22

Abstract:

- ***Background and Need:***

Cervicogenic headache (CGH) is a secondary headache disorder associated with pain referred from cervical structures to the head and the face. It is frequently marked by unilateral headache, limited neck range of motion, postural abnormalities, and myofascial trigger points. Kinesiotaping (KT) has been proposed as a potential physiotherapy intervention for CGH due to its proposed effects on pain, muscle activity, soft tissue support and postural alignment.

- ***Objective:***

To examine the available evidence regarding the Efficacy of Kinesiotaping for Pain, Disability, Posture, and Pain Pressure Threshold in Cervicogenic Headache.

- ***Methods:***

A search for the literature on Pubmed and ScienceDirect. Articles published from 2014 to 2023 were screened using the keywords "cervicogenic headache," "kinesiotaping," "kinesiotape," "myofascial trigger points," "KT," and "athletic tape". Articles were selected based on predetermined inclusion and exclusion criteria. We identified a total of 501 records. Four studies fulfilled the eligibility criteria and were included in the review.

- ***Results:***

The studies investigated KT as a stand-alone intervention, or in combination with physiotherapy, exercise, low-level laser therapy and Mulligan mobilization. In general, the KT was related to reductions in the intensity of pain, the frequency and duration of headaches, and improvements in pain pressure threshold, neck disability, and forward head posture. Studies included all reported statistically significant improvements in the KT groups compared with their respective control or comparison interventions.

- ***Conclusion:***

The available literature suggests that kinesiotaping may be a beneficial adjunct or standalone physiotherapy intervention for reducing pain and improving selected clinical outcomes in individuals with cervicogenic headache. However, the limited number of available studies indicates a need for further high-quality research to establish its effectiveness and clinical applicability.

Keywords: *Cervicogenic Headache, Kinesiotaping, Kinesiotape, Myofascial Trigger Points, KT, KT-Taping, Atheletic Taping.*

How to Cite: N. M. Manish Sharma; Karthika Senthil Kumar; William Charles Pereira (2026). Efficacy of Kinesiotaping for Pain, Disability, Posture and Pain Pressure Threshold in Cervicogenic Headache. *International Journal of Innovative Science and Research Technology*, 11(9), 636-642. https://doi.org/10.38124/ijisrt/26sep446

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I. INTRODUCTION

Headache is one of the most common medical problems in the world and affects a large proportion of the population. Headaches can be classified into primary and secondary headache disorders broadly by international headache society (IHS).Cervicogenic headache (CGH) is a secondary headache disorder caused by dysfunction or pathology of structures in the cervical region.[1],[23],[4] Cervicogenic headache is classically described as unilateral, side-locked pain that originates in the neck and is referred to the head and/or face.[3–5] It has been related to cervical musculoskeletal dysfunction, restricted cervical motion, postural abnormalities and myofascial trigger points. It has been reported that CGH accounts for about 15-20% of chronic and recurrent headache . The reported prevalence of CGH in general population has varied from 0.4% to 2.5% .[6–8]

According to the International Classification of Headache Disorders, third edition (ICHD-3), CGH is classed as headache due to a condition of the neck.[10] The upper cervical nerves, especially C1-C3, mostly innervate the cervical spine and adjacent tissues. Thus, nociceptive input from cervical joints, intervertebral discs, muscles, ligaments and other cervical structures might contribute to pain reported in the occipital, frontal, temporal or orbital region of the head.[11],[17] The reason for neck pain referral to the head is the convergence of sensory input in the trigeminocervical complex. Cervical afferents from the upper cervical spinal nerves converge with trigeminal afferents and this may cause pain to be perceived in the areas of the head and face supplied by the trigeminal nerve.[17–19] .

Cervicogenic headaches are also thought to be significantly influenced by myofascial trigger points. A hyperirritable region inside a taut band of skeletal muscle that hurts when compressed and may result in a distinctive referred pain pattern is called a trigger point.The sternocleidomastoid, temporalis, suboccipital, and upper trapezius muscles have all been identified as trigger sites.[21], Persistent muscle contraction may increase peripheral nociceptive afferents' sensitivity by causing ischemia, decreased local circulation, and the release of neuroactive chemicals.[2]." The persistence and referral of CGH-related pain may be influenced by these mechanisms as well as convergence within the trigeminocervical system.

Clinically, CGH typically manifests as pain that starts in the occipital or posterior cervical region and spreads to the frontal or orbital regions on the same side. The pain is typically characterized as mild or varying in intensity, dull, and non-throbbing. External strain on delicate cervical tissues or cervical movements may exacerbate symptoms. The disease is often linked to decreased cervical range of motion. Some people may experience additional symptoms such phonophobia, impaired vision, dizziness, and other related issues.Instead of just treating headache symptoms, management of CGH typically focuses on treating the underlying cervical musculoskeletal dysfunction. Cervical mobilization, manipulation, myofascial procedures, sustained natural apophyseal glides (SNAGs), soft-tissue treatment, posture correction, electrotherapy, and therapeutic exercise are examples of conservative physiotherapy approaches.[2–32] These treatments primarily aim to reduce pain, improve cervical mobility, address muscular dysfunction, and restore appropriate postural and motor control.

In physiotherapy, kinesiotaping (KT) has become a new therapeutic strategy. Kenzo Kase created KT, an elastic therapeutic tape that can be stretched longitudinally while being applied directly to the skin.[33] Modification of soft-tissue movement, supply of positional or proprioceptive input, and mechanical and sensory stimulation of the skin and underlying tissues are among the suggested effects of KT.[3]." Because of these properties, it is used to treat a variety of musculoskeletal disorders.

KT has been administered to shoulder and cervical muscles, such as the deep cervical extensors and upper trapezius, in patients with cervicogenic headaches. Since postural dysfunction and myofascial trigger points are often linked to CGH, the suggested therapeutic effects may be especially pertinent to the condition. Therefore, by addressing pain, postural alignment, and muscular sensitivity, KT may offer an alternate or supplemental approach to traditional physiotherapy methods.

While a number of physiotherapy therapies have been studied for CGH, there is still a dearth of particular research on kinesiotaping. Pain intensity, pain pressure threshold, headache frequency and duration, neck impairment, and forward head posture are among the outcomes of the research that have examined KT as an independent intervention and in conjunction with other physiotherapy therapies. Therefore, it is necessary to synthesize the current literature in order to ascertain the potential clinical usefulness of KT in the treatment of CGH.

With a focus on pain, pain pressure threshold, neck disability, headache characteristics, and postural outcomes, the current literature review was conducted to assess the evidence regarding the efficacy and practical application of kinesiotaping in people with cervicogenic headache.

II. METHODOLOGY

- *Search Strategy*

A search for the literature on Pubmed and ScienceDirect. Articles published from 2014 to 2023 were screened using the keywords “cervicogenic headache,” “kinesiotaping,” “kinesiotape,” “myofascial trigger points,” “KT,” and “athletic tape”. Articles were selected based on predetermined inclusion and exclusion criteria. We identified a total of 501 records. Four studies fulfilled the eligibility criteria and were included in the review.

- *Study Selection*

Based on predetermined inclusion and exclusion criteria, studies were chosen. Full-text English-language publications from 2014 to 2023 were included in the review. Articles published more than ten years prior to the evaluation and studies involving animals were not included. Three steps

ISSN No: - 2456-2165 https://doi.org/10.38124/ijisrt/26sep446

comprised the selection process: full-text evaluation, abstract screening, and title screening.

➢ *Examined Variables*

The variables examined in the study were Pain intensity – assessed primarily using the Visual Analogue Scale (VAS).

- Pain pressure threshold (PPT) – assessed using an algometer/tenso-algometer/electronic algometer.
- Neck disability – assessed using the Neck Disability Index (NDI).
- Forward head posture – assessed using lateral cervical radiography in the relevant study.
- Headache frequency – assessed using a headache diary/subjective questionnaire.
- Headache duration – assessed using a subjective questionnaire/headache diary.

➢ *Search of Literature*

The search identified a total of 501 articles. The retrieved literature was screened according to the predefined eligibility criteria. Following title screening, abstract screening, and full-text assessment, 4 studies were considered eligible and included in the literature review. (Fig 1)

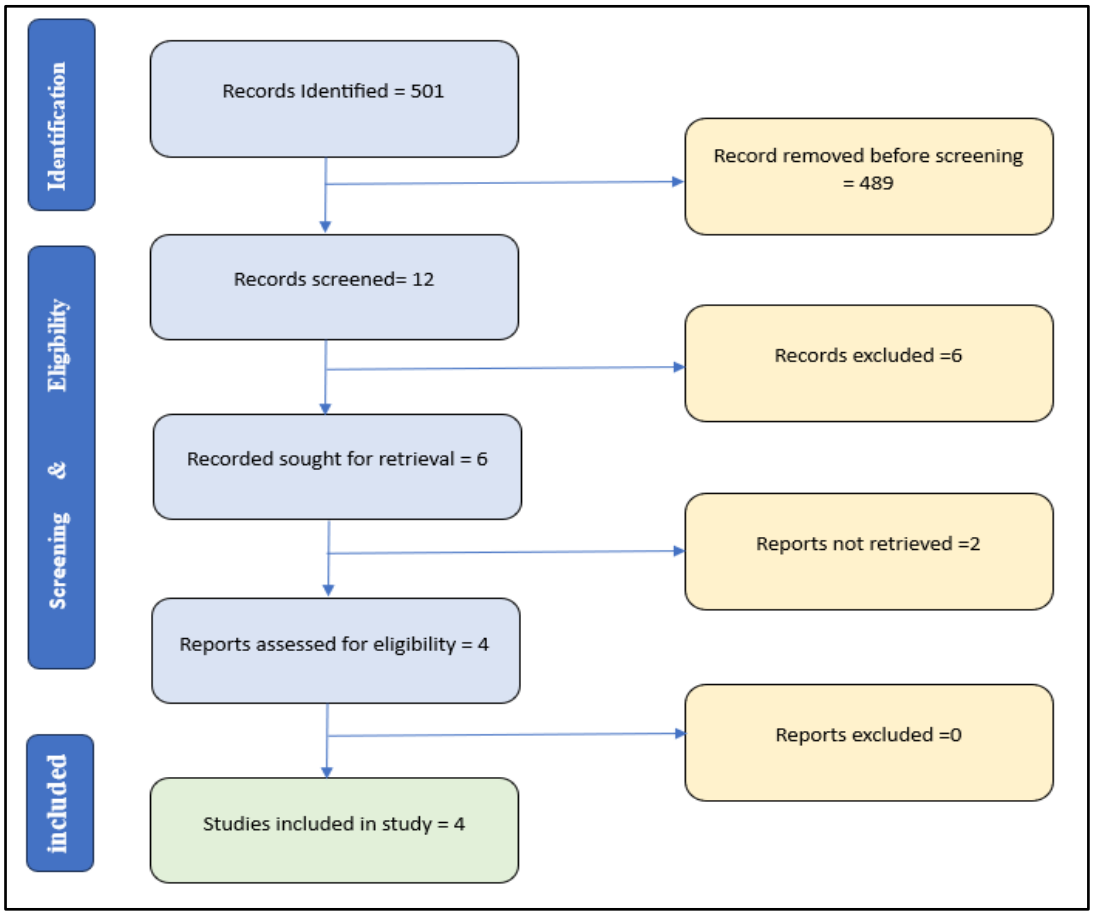

Fig 1 The Prisma Flow Diagram, Illustrating Each Step in the Process to Identify the Final Selection of Studies to be Reviewed.

III. RESULTS

➢ *Sample*

245 patients with cervicogenic headaches from four randomized controlled trials were included in the literature review: Alanzy et al. (2017) n = 45, Saleh et al. (2016) n = 45, Esin et al. (2018) n = 101 teenagers, and Neyaz et al. (2020) n = 54.

➢ *Methodological Quality of Trials*

The methodological quality of the included randomized controlled trials was assessed using the PEDro Scale. The four included studies obtained PEDro scores of 7/10 (Saleh et al., 2016), 10/10 (Esin et al., 2018), 4/10 (Alanzy et al., 2017), and 7/10 (Neyaz et al., 2020), respectively.

➢ *Interventions*

Kinesiotaping was examined in the included studies either as a stand-alone treatment or as a supplement to traditional physiotherapy treatments. The upper trapezius and deep cervical extensor muscles were the main targets of KT, albeit treatment duration and application techniques varied. KT was studied in conjunction with home exercises, Mulligan's sustained natural apophyseal glides (SNAGs), low-level laser therapy, posture correction, and physiotherapy exercises. Pain intensity, pain pressure threshold, frequency and duration of headaches, neck impairment, and forward head posture were among the outcomes evaluated. (Table 1).

ISSN No: - 2456-2165 https://doi.org/10.38124/ijisrt/26sep446

Table 1 Brief Description of Included Studies

No.	Author & Year	Sample Size	Intervention / Device	Duration, Frequency, Intensity of Intervention	Dependent Variables	Evaluation / Reassessment	Results
1	Saleh et al. (2016)	N = 45 Control = 15 LLLT = 15 KT = 15	Kinesiotaping with physiotherapy. KT applied to the upper trapezius and deep cervical extensors, with the base fixed at T4–T5 and anchored below the occiput.	Physiotherapy groups: 3 days/week for 6 weeks. KT was changed every 2 weeks. Intensity of KT application was not reported in the review.	Forward head posture; Neck Disability Index (NDI); Pain Pressure Threshold (PPT).	Pre-treatment and post-treatment assessment. PPT measured using electronic algometer; forward head posture assessed by lateral X-ray/radiograph; NDI used for disability.	Significant intra-group and inter-group improvement was observed in forward head posture, NDI and PPT. Overall improvement was more pronounced in the KT group.
2	Esin et al. (2018)	N = 101 KT = 34 Control = 34 Home exercise = 33	Kinesiotaping group compared with control and home-exercise groups. Home exercise was included as part of the post-treatment regimen.	3-month study period. A headache diary was maintained during the first pretreatment month. KT/home-exercise regimen was followed for 28 days, with 1-month follow-up for the KT and control groups; home-exercise group continued for 2 months.	Pain threshold; Pain intensity.	Pain threshold measured with Tenso Algometer and pain intensity with Visual Analogue Scale (VAS). Assessments were performed before and after treatment and after the home-exercise regimen (1 month after treatment).	The KT group showed statistically significant improvement in pain threshold and pain intensity compared with the control group.
3	Alanzy et al. (2017)	N = 45 Exercise = 15 LLLT = 15 KT + Exercise = 15	Kinesiotaping combined with exercise; comparison groups received exercise or low-level laser therapy.	6 weeks. Frequency/intensity was not specified in the review summary.	Pain Pressure Threshold (PPT); Neck Disability Index (NDI); Forward head posture.	Pre-intervention and post-intervention assessment.	The KT + exercise group demonstrated significant improvement compared with the exercise group in NDI, PPT and forward head posture.
4	Neyaz et al. (2020)	N = 54 KT + SNAGs = 27 SNAGs control = 27	Kinesiotaping combined with Mulligan's Sustained Natural Apophyseal Glides (SNAGs). KT was applied to the upper trapezius and deep cervical extensors.	3 sessions/week for 6 weeks. SNAGs were applied in the painful/restricted direction; 4 repetitions of each glide, maintained for 10 seconds at end range or until onset of pain.	Pain intensity; Headache frequency; Headache duration.	VAS for pain intensity and subjective questionnaire for headache frequency and duration. Assessed before and after intervention.	The KT + SNAGs group showed significant improvement compared with SNAGs alone, with reduced headache intensity, frequency and duration.

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IV. DISCUSSION

An overview of Kinesiotaping's (KT) practical practicality and efficacy as a cervicogenic headache (CGH) intervention was the goal of this review. Included were four randomized controlled trials examining how KT affected people with CGH. Several clinically significant outcomes, such as pain pressure threshold (PPT), pain intensity, frequency and duration of headaches, neck impairment, and forward head posture, were used to assess KT across the included trials.

➢ *Threshold for Pain Pressure*

The lowest pressure needed to cause pain is known as the pain pressure threshold (PPT), which is frequently used to evaluate discomfort.[1] The effects of KT on PPT in people with CGH were examined in three studies that were included of this review: Saleh et al., Esin et al., and Alanzy et al. While Esin et al. compared KT with placebo and postural-correction-based therapies, Saleh et al. and Alanzy et al. compared KT with physiotherapy-based interventions and low-level laser therapy. Following KT intervention, PPT improved statistically significantly in all three investigations. These results are in line with other studies by Mohan et al.[2] and Chao et al.[3], who found that KT application increased PPT in people with myofascial trigger points and low back pain, respectively. The suggested method might entail KT's lifting and supporting actions on the underlying tissues, which could lessen nociceptive and mechanical strain on the skin and subcutaneous tissues.Additionally, KT may affect sensory input and local circulation, which may lessen pain sensitivity and soreness. Additionally, prior research has indicated that combining KT with other therapies, including TENS or core stabilization exercises, may improve its effects.

➢ *Pain Intensity*

Another outcome that was frequently looked at in the included research was pain intensity, which was mainly measured using the Visual Analogue Scale (VAS). Following KT intervention, Saleh et al., Esin et al., Alanzy et al., and Neyaz et al. independently observed statistically significant decreases in pain intensity. These results are corroborated by Abdelfattah et al. ("), who reported similar results, and Chao et al. ("), who showed a considerable decrease in pain intensity after KT treatment.

The mechanical and sensory impacts of KT may contribute to the pain reduction. According to Jaro Rodríguez et al., KT's lifting effect may widen the gap between the skin and underlying tissues, which could lessen irritation of both deep and superficial sensory receptors and, as a result, lessen pain perception.

➢ *Forward Head Posture*

The development or maintenance of CGH may be influenced by forward head posture, which is thought to be a significant postural determinant linked to cervical musculoskeletal dysfunction. The effects of KT on forward head position were examined by Saleh et al. and Alanzy et al., who found notable improvements after intervention. These results imply that when KT is used in the treatment of CGH, it may be helpful in improving postural alignment.

The ability of KT to continuously deliver cutaneous and proprioceptive feedback, which promotes more optimal alignment and muscle activation, may be connected to the postural improvements that have been suggested. While Xiong et al. claimed that KT may help correct incorrect cervical posture and thus reduce discomfort, Muro et al. suggested that KT may help rectify joint misalignment.

V. CONCLUSION

The authors of the trials listed here have, to the greatest extent feasible, assessed the efficiency of KT in lowering CGH both subjectively and objectively. Neck disability index, head and neck radiography, pain pressure threshold, and visual analogue scale are some of these metrics. There were statistically significant variations between the measured values in all four studies when the pre- and post-treatment evaluation results of these measures were compared. These metrics directly demonstrate the improvement in patient outcomes, confirming that KT is a successful intervention in the management of CGH.

➢ *Declaration of Conflicting Interests*

The authors declare no conflicts of interest with respect to the authorship and/or publication of this article.

➢ *Funding*

The authors received no financial support for the research and/or authorship of this article.

➢ *Acknowledgement*

We would like to express our gratitude to the core team of the institutional department for their support and guidance.

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