

Therapeutic knee taping improved pain and disability in osteoarthritis of the knee

Hinman RS, Crossley KM, McConnell J, Bennell KL. Efficacy of knee tape in the management of osteoarthritis of the knee: blinded randomised controlled trial. *BMJ*. 2003;327:135-8.

QUESTION

In patients with osteoarthritis (OA) of the knee, does therapeutic knee taping (TKT) reduce pain and disability?

DESIGN

Randomized (allocation not concealed*), blinded (patients and outcome assessors)*, controlled trial with 3 weeks each of intervention and follow-up.

SETTING

Metropolitan private practices and a university laboratory in Melbourne, Victoria, Australia.

PATIENTS

87 patients (mean age 69 y, 66% women) who met the American College of Rheumatology criteria for OA of the knee. Exclusion criteria included allergy to tape, history of joint replacement, body mass index > 38 kg/m², and rheumatoid arthritis. Follow-up was 99%.

INTERVENTION

29 patients each were allocated to TKT, control tape, or no tape. The tape was worn for 3 weeks and reapplied weekly. TKT provided medial glide, medial tilt, and anteroposterior tilt to the patella. Control tape aimed to provide sensory input only. Patients in the no-tape group received no intervention.

COMMENTARY

Because no cure for OA exists, treatments focus on managing symptoms so that individuals can maintain reasonable functional capabilities. The overwhelming preponderance of treatments evaluated for OA are drugs (60% of treatment studies) or surgical procedures (26%), with a remarkable neglect of physical treatment methods (1).

The randomized controlled trial by Hinman and colleagues highlights the importance of the patellofemoral joint as a source of symptoms in knee OA. Although the American College of Rheumatology recommended taping osteoarthritic knees for years before this trial, evidence to show that it works in reducing pain has been minimal.

This study shows that TKT reduces pain and disability in patients with knee OA. The influence of the tape may "unload" the lateral patellofemoral joint, where pathology and resultant symptoms predominate. The beneficial effects were maintained 3 weeks after the treatment was stopped. The magnitude of the treatment effect of taping was similar to that of drug therapies and exercise programs (1).

The treatment was well tolerated and safe. 28% of patients in the TKT group compared with 1 patient (3%) in the control-tape group

MAIN OUTCOME MEASURES

Change from baseline in pain (0- to 10-cm visual analogue scale) assessed at 3 and 6 weeks, and patient-perceived rating of change (1 to 5 Likert scale) assessed at 3 weeks. Patients with a Likert scale score of 4 or 5 were classified as improved.

MAIN RESULTS

Analysis was by intention to treat. At 3 weeks, reduction in pain was greater in the TKT group than in the control or no-tape group (Table). More patients in the TKT group than in the no-tape group were classified as improved (Table). The TKT and control tape groups did not differ for number of patients classified as improved (Table). At 6 weeks, reduction in pain on most aggravating activity was greater in the TKT group

than in the no-tape and control groups ($P < 0.05$ for both), whereas reduction in pain on movement was greater in the TKT group than the no-tape group ($P < 0.05$) but not the control group.

CONCLUSION

In patients with osteoarthritis of the knee, therapeutic knee taping improved pain and disability.

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*See Glossary.

Therapeutic knee taping (TKT) vs control tape (CT) or no tape (NT) in osteoarthritis of the knee at 3 weeks†

| Outcomes | Comparisons | Mean scores | Difference between groups (95% CI)‡ |
|---|-------------|--------------|-------------------------------------|
| Change from baseline in pain on movement (VAS) | TKT vs NT | -2.1 vs 0.1 | 2.1 (1.2 to 3.0) |
| | TKT vs CT | -2.1 vs -0.7 | 1.3 (0.3 to 2.4) |
| Change from baseline in pain on most aggravating activity (VAS) | TKT vs NT | -2.5 vs -0.4 | 2.0 (1.0 to 3.1) |
| | TKT vs CT | -2.5 vs -1.1 | 1.5 (0.3 to 2.7) |
| Proportion of patients improved | TKT vs NT | 72% vs 10% | 600% (164 to 1960) |
| | TKT vs CT | 72% vs 48% | 50% (-1.7 to 140) |

†VAS = 0- to 10-cm visual analogue scale. Other abbreviations defined in Glossary; RBI, NNT, and CI calculated from data in article.

‡Significant differences favor TKT (round-off errors increase or decrease difference by 0.1).

reported minor skin irritation. Even so, all participants continued to wear the tape for 3 weeks.

Some study limitations exist. First, the TKT group had greater pain scores at baseline, raising concerns about imbalanced randomization of participants. Second, because the treating therapist could influence by verbal suggestion the subjective outcome of pain, blinding may not have been optimal. Third, a number of potential concerns with wider generalizability and application of the results exist. It should be noted that the tape was applied by physical therapists trained in assessment and application of this technique, and the Australian population studied was not as obese as many OA patient groups in the United States. However, TKT may offer a simple and effective self-management strategy for knee OA.

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Reference

1. Tallon D, Chard J, Dieppe P. Relation between agendas of the research community and the research consumer. *Lancet*. 2000;355:2037-40.