

Efficacy of Kinesiotaping on Handgrip Strength in Nurses of Age Group 18 To 40 Years: A Randomized Controlled Trial

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ABSTRACT

Background: Kinesiotaping has increasingly become a common therapeutic tool in modern rehabilitation practice. Over the years, clinicians and therapists have relied on it for its potential to support muscles, enhance movement, and improve functional capacity. Research has indicated that when this taping method is applied correctly and with an appropriate level of tension, it may help boost muscular force and overall performance. Building on this understanding, the present study aimed to explore how applying Kinesiotape with 35% mechanical tension influences grip strength among nurses—both immediately after application and over a sustained period.

Objectives: The primary objective of this study was to assess and compare the acute effects of Kinesiotaping on handgrip strength in nurses aged 18 to 40 years. A handheld dynamometer was used to measure variations in grip strength, allowing for accurate and reliable comparisons across time points and between groups.

Methodology: A total of 38 nurses, aged between 18 and 40 years, volunteered to participate in this research. They were randomly assigned into two groups.

Intervention Group: Received Kinesiotape applied with 35% mechanical tension.

Control Group: Received the same taping pattern but with no tension applied.

Grip strength was assessed using a properly calibrated hand-held dynamometer. Measurements were taken at several important intervals:

1. Baseline—before the tape was applied
2. 30 minutes after application
3. 24 hours post-application
4. 48 hours post-application

The tape was kept intact for the full 48-hour duration to examine both short-term and extended effects.

Results: The statistical evaluation indicated that neither group showed significant improvements in grip strength when their own pre- and post-application readings were compared. However, when the groups were compared against each other, a meaningful difference emerged. After 48 hours, participants who received Kinesiotaping with 35% tension demonstrated significantly better grip strength than those in the no-tension control group, with results reaching statistical significance ($p < 0.05$).

Conclusion: Overall, the study concludes that applying Kinesiotape with 35% mechanical tension can lead to short-term enhancements in

handgrip strength among nurses. While the improvements may not be dramatic within each group individually, the tension-based taping clearly outperformed the no-tension method during extended comparison. These findings reinforce the idea that properly tensioned Kinesiotaping can serve as a beneficial, temporary strategy for increasing muscle strength in clinical or occupational settings.

Keywords: kinesiotaping, grip strength, handheld dynamometer

INTRODUCTION

Grip strength is widely recognized as a simple yet highly effective indicator of overall muscle strength. For this reason, its evaluation must be carried out using a well-validated dynamometer model, following standardized testing procedures, and with reference to appropriate population-based baseline values to ensure accuracy and reliability of measurements. ⁽²⁾ Traditionally, grip strength has been used to assess functional limitations in adults; however, its potential application as an indicator of work capacity has not been thoroughly explored in the available literature. Among the various physical fitness parameters, handgrip strength remains one of the most commonly used measures of upper-extremity muscular strength due to its simplicity and high reliability. ⁽³⁾ According to Long et al., there is a high prevalence of musculoskeletal disorders involving the upper quadrant among nursing professionals ⁽⁵⁾. Several studies have further shown that grip strength may be influenced by a range of factors such as age, gender, number of hours worked, years in the profession, consecutive work shifts, stress levels, exercise habits, and the physical demands inherent in clinical duties. ⁽⁴⁾ Handgrip strength is often used as an indirect marker of overall muscle strength and has been found to correlate with many health-related outcomes, including quality of life, the

ability to perform activities of daily living (ADLs), bone mineral density, and the risk of vertebral fractures. Additionally, it may influence hospitalization duration, psychological and social well-being, and the course and prognosis of certain diseases. ⁽⁶⁾ Grip strength is frequently measured using the handheld dynamometer, a tool known for providing simple, quick, and reliable readings of handgrip performance. ⁽⁷⁾ With advancements in modern therapeutic approaches, there has been a growing interest in innovative techniques to address musculoskeletal conditions without restricting functional movement. One such advancement is kinesiotaping, developed in 1973 by Dr. Kenzo Kase. Kinesiotape is designed to mimic the natural elasticity of human skin, allowing it to stretch 40–60% beyond its original length. This unique property enables full range of motion, distinguishing it from conventional rigid taping methods. The benefits of kinesiotaping vary depending on the amount of stretch applied and the placement of the tape, and may include correction of muscle function, improved fascial alignment, enhanced circulation, tissue healing support, increased proprioception, edema reduction through lymphatic facilitation, and improved joint positioning. ⁽⁸⁾ Reports have shown increased muscle activity following the application of kinesiology tape along the direction of the muscle from origin to insertion. Although the precise physiological mechanism behind the enhanced motor neuron recruitment remains unclear, the possibility that external tape application could improve muscle performance has prompted numerous studies. These investigations aim to determine whether the cutaneous stimulation produced by Kinesiotape can indeed enhance muscle strength. ⁽⁹⁾ Once the effects of kinesiotaping on healthy individuals are established, its application over the muscles responsible for gripping may serve as a complementary intervention for treating manual dysfunction.

(8) The human hand is one of the most intricate and essential components of the upper extremity. Its exceptional mobility and the sensitivity of surrounding tissues enable fine motor activities such as gripping, manipulating objects, and perceiving tactile information. In light of the increasing use of kinesiotape in clinical settings, further research is required to validate its proposed benefits and establish evidence-based guidelines for its application. Given the limited studies available on kinesiotaping and the crucial role of handgrip strength in everyday activities, the present study aimed to evaluate the effect of kinesiotaping on handgrip strength among nursing professionals. Grip strength was assessed using a handgrip dynamometer to ensure precise and objective measurements. (8) Handgrip strength is commonly measured using a manual hydraulic dynamometer in settings such as hospitals, workplaces, and rehabilitation centers. Different types of dynamometers may be used by occupational physicians, surgeons, and hand therapists, but all aim to measure a patient's palmar grip force objectively. These instruments support the thenar and hypothenar eminences against the back of the handle while allowing the remaining fingers to exert pressure on the front portion. Manual handheld dynamometers can typically measure grip strength ranging from 5 kg to 100 kg. With this background, the present study was conducted to observe the effects of kinesiotaping on handgrip strength.

NEED OF STUDY

Nursing professionals across the globe are exposed to a high risk of workplace injuries and musculoskeletal disorders, often resulting in pain, discomfort, and long-term functional limitations. Factors such as fatigue, varying physical capacity, demanding and irregular shifts, and inadequate upper-body strength significantly contribute to these injuries. Research indicates that nearly 75% of nurses experience an increased risk of

musculoskeletal problems due to the physically intensive and fast-paced nature of their work. Grip strength assessment plays an important role in identifying workers who may require early intervention. It offers a non-invasive, simple, and reliable method to evaluate muscular strength and detect individuals who may be at risk of reduced performance or future injury. Low grip strength among hospital inpatients has been linked to poor health outcomes, including higher levels of functional limitation and increased mortality. Previous studies also suggest that grip strength can be improved through targeted physical exercises, nutritional supplementation, and traditional finger-movement rehabilitation techniques. Additionally, structured finger-movement training and finger-weight lifting are widely accepted interventions for enhancing hand strength. Despite these well-established approaches, scientific evidence regarding the impact of Kinesiotaping on grip strength—especially its immediate effects and its influence after 48 hours—remains limited. Initial findings propose that Kinesiotaping may lead to improvements in grip strength among nurses, but comprehensive research in this area is still lacking. Recognizing the importance of grip strength in daily nursing tasks and overall health, this study aims to evaluate the efficacy of Kinesiotaping on handgrip strength in nurses aged 18 to 40 years, using the handheld dynamometer for accurate measurement.

Aim

The primary aim of this study is to determine the immediate or acute effects of Kinesiotaping on handgrip strength among nurses aged 18 to 40 years.

Objective

The objective is to assess and compare the acute impact of Kinesiotaping on handgrip

strength using a handheld dynamometer in nurses between 18 and 40 years of age.

Hypothesis-Null Hypothesis (H₀): Kinesiotaping does not produce any significant improvement in grip strength.

Alternative Hypothesis (H₁): Kinesiotaping results in a significant improvement in grip strength.

MATERIALS AND METHODOLOGY

Research Design-This study follows a randomized controlled placebo trial design, ensuring that participants are randomly allocated and comparisons between groups remain unbiased.

Sampling Procedure-Simple random sampling was used to recruit participants, giving each eligible subject an equal chance of being selected.

Study Population-The study involved individuals working in the nursing profession.

Sample Size-A total of 38 participants was included in the study.

Group Distribution

- Group A – Experimental Group (n=19): Received Kinesiotaping intervention
- Group B – Control Group (n=19): Received placebo Kinesiotaping

Study Setting-The study was conducted in tertiary care hospitals located in Jalgaon.

Study Duration-The research was carried out over a period of six months.

Blinding-A single-blind method was used, where the participants were unaware of whether they received the actual intervention or the placebo.

Inclusion Criteria

- Individuals working in the nursing profession
- Cooperative participants willing to follow instructions
- Age range between 18 and 40 years
- Both male and female participants
- Baseline grip strength below the following cut-off values:

- Females: < 32.9 kg
- Males: < 46.3 kg

Exclusion Criteria

1. History of hand trauma
2. Impaired or restricted hand function
3. Current pain or complaints in the hand region
4. Fragile or sensitive skin
5. Cardiopulmonary disorders
6. Hormonal or osteomyoarticular conditions
7. Bone or joint deformities
8. Congenital or acquired abnormalities in either upper limb
9. Central or peripheral neurological deficits
10. History of injury or surgery to the upper extremities within the past six months
11. Known skin allergies

Equipment-Handheld dynamometer

Outcome Measure-Grip strength was used as the primary outcome measure to evaluate the effectiveness of the intervention.

PROCEDURE

After obtaining ethical approval from the Institutional Ethical Committee, written informed consent was collected from all participants. Individuals who fulfilled the inclusion criteria underwent a detailed assessment, during which baseline information was recorded. A pre-intervention measurement of grip strength was taken using a handheld dynamometer for every participant. Following this initial assessment, the subjects were randomly assigned into two groups—Group A and Group B—using a simple random sampling method. Group A (n = 19) received Kinesiotaping, while Group B (n = 19) received placebo Kinesiotaping. Grip strength was evaluated at three different time intervals: immediately after application, after 24 hours, and again after 48 hours, allowing comparison of changes across time.

Procedure for Kinesiотaping

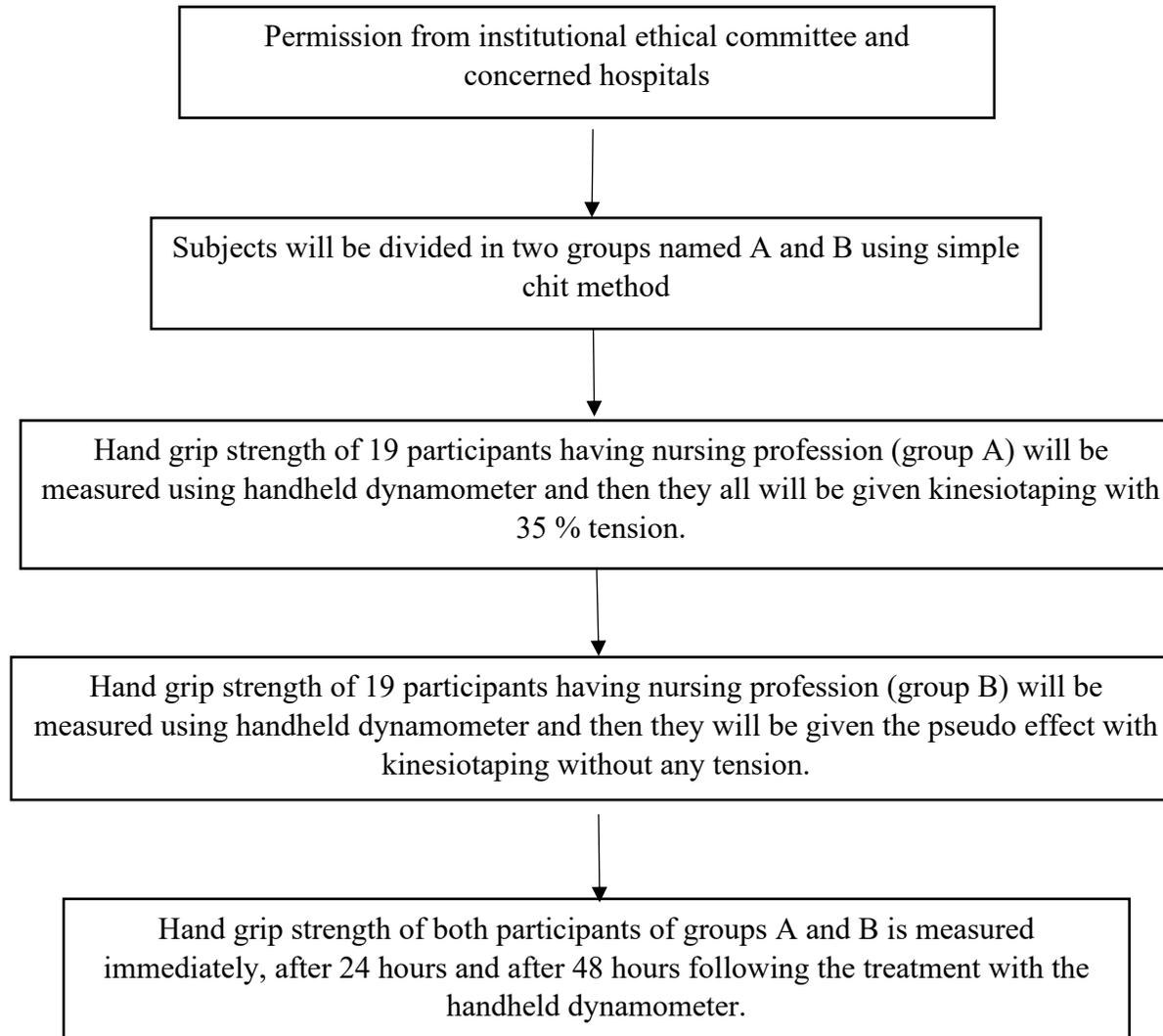
In the tension-applied taping group (Group A), Kinesiotape was applied to the extensor region of the forearm using 35% mechanical tension. In contrast, the control group (Group B) received the same tape placement technique but without any tension. The taping technique followed the procedure described by Mohammad et al., using an I-shaped tape configuration, and was consistent with the methodologies recommended by Kim and Kim as well as Waleed et al. Before the tape was applied, the skin over the dominant forearm's extensor surface was cleaned thoroughly with an alcohol swab to ensure proper adhesion. Participants were instructed to sit upright with

their back straight and feet flat on the floor. The tested arm was kept comfortably by the side of the body with the elbow flexed at 90 degrees, the forearm pronated, and the wrist positioned neutrally. To determine the appropriate tape length for Group A, the distance between a point 2 cm below the lateral epicondyle of the humerus and the radial styloid process was measured. The tape was then applied along this path with 35% tension. For Group B, the tape was applied along the same proximal-to-distal line but without any tension. All participants were instructed to leave the tape in place for the full duration of 48 hours, after which the final outcome measurements were taken.



Figure 1: kinesiотaping

Flow chart of general procedure



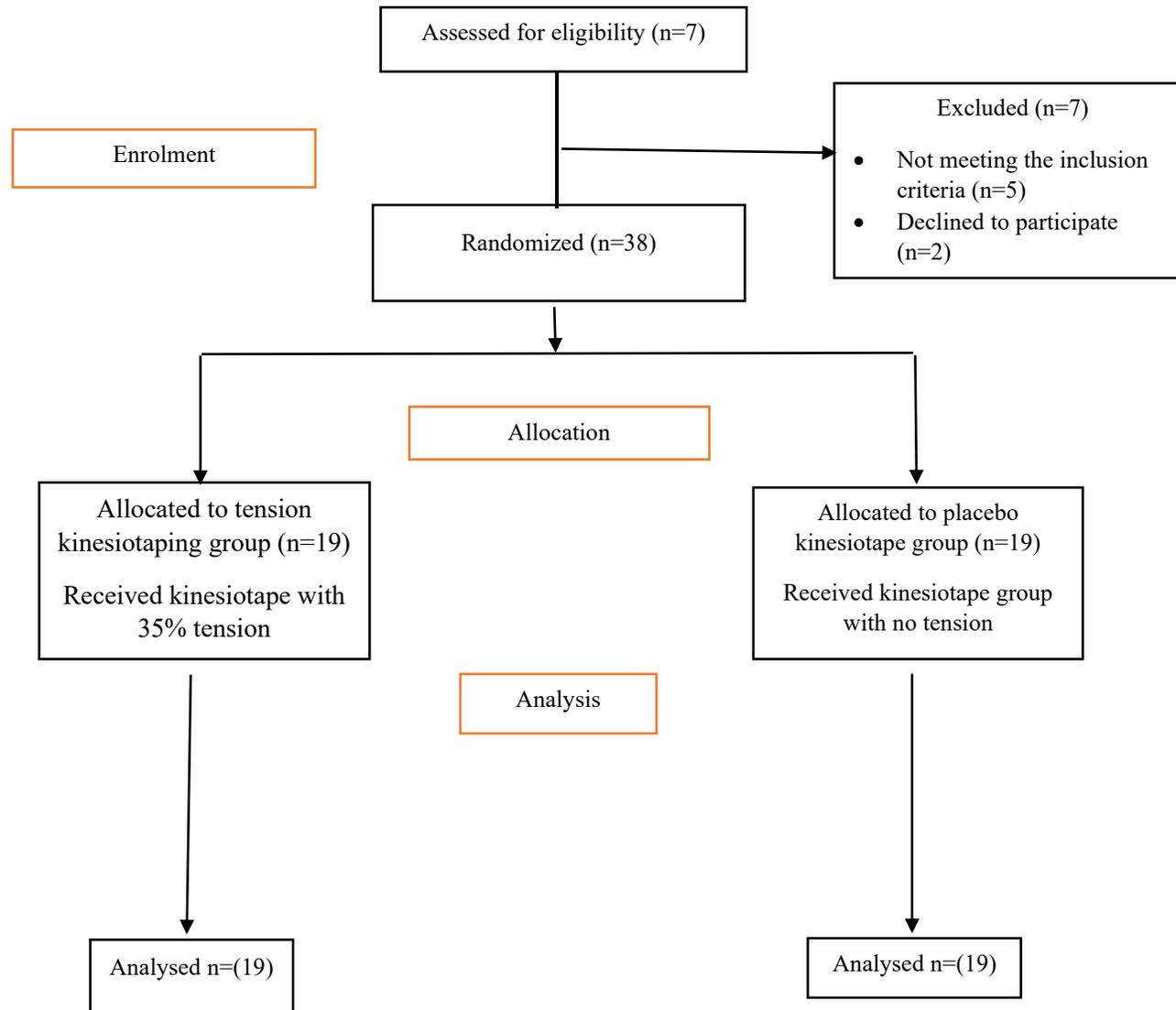


Figure 2: CONSORT chart

STATISTICAL ANALYSIS

Statistical analysis for the present study was carried out both manually and with the assistance of MS Excel and Minitab 17 to ensure accuracy and validation of the findings. The level of significance was set at 5%. All collected data were first entered into an Excel spreadsheet, after which the necessary calculations were performed and systematically organized into tables for further evaluation. For continuous variables, statistical measures such as the mean and standard deviation were computed to describe the data. Categorical variables, on the other hand, were summarized using percentages. Prior to conducting comparative tests, the normality of the data distribution was examined using the Kolmogorov–Smirnov test, which indicated a significant difference in distribution patterns. To compare the mean values or distribution differences between the two groups, an ANOVA test was applied. Additionally, an unpaired t-test was used to analyze within-group differences by comparing pre- and post-intervention measurements. All statistical tests were performed at each assessment interval—before the taping procedure and following all outcome measurements—to determine the effectiveness of the intervention.

RESULT

The study was conducted among nursing professionals working in tertiary care hospitals in Jalgaon. After collecting and organizing the data, the distribution of participants across different age groups was analyzed. In Group 1,

21.05% of participants were below 20 years of age, 63.16% were between 21–30 years, 10.53% were in the 31–40 age range, and 5.26% were between 41–50 years. In Group 2, 52.63% were below 20 years, 47.37% were between 21–30 years, and none of the participants fell within the 31–40 or 41–50 age ranges. Regarding gender distribution, Group A consisted of 12 female and 7 male participants, while Group B included 10 females and 9 males. Overall, the study comprised 22 female and 16 male subjects. Body Mass Index (BMI) was calculated for all participants using the standard formula of weight divided by height squared (kg/m^2). In Group 1, 15.79% had a BMI below 18.4, 57.89% were within the normal range of 18.5–24.9, and 26.32% fell into the 25.0–29.9 category. In Group 2, 10.53% were below 18.4, 89.47% had a normal BMI, and none were in the 25.0–29.9 range.

An unpaired t-test was applied to compare the mean grip strength scores between the two groups at baseline, 24 hours, and 48 hours. At the start of the study, both groups showed comparable results (Group 1: 19.60 ± 16.7 vs. Group 2: 19.90 ± 14.1 , $p=0.94$). After 24 hours, the difference remained statistically insignificant (Group 1: 25.90 ± 17.50 vs. Group 2: 21.10 ± 16.10 , $p=0.37$). However, at the 48-hour mark, Group 1 exhibited significantly higher grip strength compared to Group 2 (31.40 ± 15.7 vs. 19.80 ± 16.2 , $p=0.032$), indicating a meaningful difference at this time point.

Table 1: Comparison at baseline

Group	Size	Mean	S.D.	t value	P value
Group 1	19	19.60	16.7	0.07	0.94
Group 2	19	19.90	14.1		

Table 2: Comparison after 24 hours

Group	Size	Mean	S.D.	t value	P value
Group 1	19	25.90	17.50	0.90	0.37
Group 2	19	21.10	16.10		

Table 3: Comparison after 48 hours

Group	Size	Mean	S.D.	t value	P value
Group 1	19	31.40	15.7	2.23	0.032
Group 2	19	19.80	16.2		

Within-group analysis across the three-time intervals—baseline, 24 hours, and 48 hours—showed no statistically significant changes in mean values. Group 1 produced a p-value of 0.10, suggesting no significant variation over

time. Similarly, Group 2 showed stable results across all intervals (p=0.96), indicating that mean grip strength remained consistent throughout the study period within each group.

Table 4: Comparison within group A

Group	Size	Mean	S.D.	F value	P value
Baseline	19	19.58	16.70	2.40	0.10
after 24 hours	19	25.95	17.47		
after 48 hours	19	31.39	15.71		

Table 5: Comparison within group B

Group	Size	Mean	S.D.	F value	P value
Baseline	19	19.95	14.09	0.04	0.96
after 24 hours	19	21.05	16.07		
after 48 hours	19	19.84	16.20		

DISCUSSION

The present randomized controlled placebo trial was designed to evaluate the effectiveness of kinesiotaping compared to placebo kinesiotaping on handgrip strength, utilizing a handheld dynamometer for measurement. The statistical findings of this investigation support the alternative hypothesis, demonstrating that kinesiotaping produced a significant improvement in grip strength after 48 hours of application. All participants in this study belonged to the 18–40-year age range. Previous research carried out in 2023 on Indian nursing students and nursing staff reported a notable decline in grip strength within this age group. According to Singh et al., nearly 75% of nurses face an elevated risk of musculoskeletal disorders and workplace injuries due to the physically strenuous nature of their duties. Factors such as fatigue, reduced physical capacity, varying work shifts, and diminished upper-body strength were identified as major contributors to injury risk among nurses. ⁽³⁾ In the current study, a greater proportion of female participants exhibited

reduced grip strength in comparison to males. This observation is consistent with earlier findings indicating that grip strength tends to be naturally higher in males than females. Supporting evidence from a 2023 study that compared individuals above 21 years of age with normative values established by Walankar et al. (2016) revealed that fewer than one-fourth of participants met the expected grip strength standards for their age and sex. While male participants—especially those aged 21–40 years—occasionally exceeded the normative values, female participants consistently scored below them. ⁽³⁾ The handheld dynamometer used in this research demonstrated strong intra-rater and inter-rater reliability for assessing grip strength, confirming its suitability as a precise evaluative tool. ⁽¹⁵⁾ Although neither the kinesiotaping group nor the placebo taping group showed immediate improvement after initial application, a significant increase in grip strength was recorded in the kinesiotaping group at the 48-hour assessment. These results indicate that kinesiotaping may enhance

muscle performance over time, possibly through mechanisms involving neuromuscular facilitation. Despite the growing interest in Kinesio taping, research in this field is still relatively limited, particularly because its widespread international use has emerged mainly within the last decade. The primary aim of the present study was to explore how kinesiotaping influences grip strength by measuring outcomes at multiple time intervals: before taping, 30 minutes after application, and again at 24 and 48 hours. The statistically significant improvements detected at the 48-hour mark support Kenzo Kase's theoretical model suggesting that kinesiotaping may strengthen weakened muscles by enhancing muscle function and providing both mechanical and sensory reinforcement. ⁽⁶⁾ One of the key findings of this study was that applying tape over the forearm extensor region produced the most marked improvements in grip strength. Extensor muscles play a crucial stabilizing role during gripping activities. They balance flexor activity by maintaining an optimal length-tension relationship. Because these muscles are predominantly tonic in nature, containing a high proportion of type I fibers that respond effectively to low-threshold sensory stimulation, kinesiotaping may preferentially activate this muscle group. Additionally, the extensor surface of the forearm is generally hairier than the flexor side. The presence of more hair follicles enhances sensory input, which in turn may facilitate greater muscular activation. ⁽⁶⁾

Kinesiotape is designed to gently lift the skin, increasing the available space for underlying tissues to move more freely and improving proprioceptive feedback. This mechanical lifting effect may influence motor unit recruitment by stimulating cutaneous receptors, a mechanism supported by observed increases in muscle electrical activity following tape application. ⁽¹¹⁾ Interestingly, even taping without tension can stimulate mild activation or produce a placebo effect, as

cutaneous input can influence muscle spindle behavior. Therefore, even placebo taping—where the tape is applied without tension—may generate a sensory response contributing to small improvements in grip strength. However, for true muscle facilitation, kinesiotaping generally requires a tension level within the 25–35% range as recommended by the Kinesio Taping Association. In the control group of this study, the tape was applied without tension, providing only minimal mechanical influence during movement but still offering sensory cues, which explains the limited yet observable response in the placebo condition. ⁽¹¹⁾

CONCLUSION

This randomized controlled placebo trial demonstrates that kinesiotaping applied to the forearm extensor region can lead to a significant acute improvement in handgrip strength after 48 hours when compared with placebo kinesiotaping. The findings indicate that kinesiotaping may serve as an effective supportive technique for enhancing grip strength, particularly in individuals who are at risk of reduced muscle performance—such as nursing professionals and healthcare workers who frequently rely on upper-limb function for their daily tasks. These results highlight the potential of kinesiotaping as a simple, non-invasive, and clinically relevant adjunct to improve functional capacity in populations exposed to high physical strain.

LIMITATIONS

This study has certain limitations that should be acknowledged. The sample size was relatively small and consisted predominantly of female participants, which may restrict the generalizability of the results to wider populations. The follow-up period focused only on acute changes within a 48-hour window, without assessing whether the observed effects persist over longer durations. Additionally, minor variations in taping

technique or precise tension application may have influenced the outcomes. The possibility of a placebo effect—given that sensory stimulation occurs even with tape applied without tension—also complicates interpretation of the comparative effectiveness between the two groups.

FUTURE SCOPE

Future research could explore the long-term impact of kinesiotaping on grip strength as well as other functional parameters of the upper limb such as endurance, dexterity, and injury prevention. Comparative studies involving alternative taping techniques, physical therapy interventions, strengthening programs, or neuromuscular facilitation modalities may help determine the relative effectiveness of kinesiotaping. Additionally, developing standardized protocols for tape application—such as clearly defined tension levels, anatomical guidelines, and optimal duration of application—would improve reproducibility and optimize clinical outcomes.

Declaration by Authors

Ethical Approval: Ethical clearance for this study was obtained from the Institutional Ethics Committee. Informed consent was collected from all participants prior to their involvement and prior to publication of the findings.

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Conflict of Interest: None declared.

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