TIBBIYOT
TA'LIMI & INNOVATSIYALARI

O'ZBEKISTON RESPUBLIKASI
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TOSHKENT TIBBIYOT AKADEMIYASI

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- 14.00.00 - Tibbiyot fanlari;
- 14.00.01 - Akusherlik va ginekologiya;
- 14.00.02 - Morfologiya;
- 14.00.03 - Endokrinologiya;
- 14.00.04 - Otorinolaringologiya;
- 14.00.05 - Ichki kasalliklar;
- 14.00.06 - Kardiologiya;
- 14.00.07 - Gigiena;
- 14.00.08 - Oftal'mologiya;
- 14.00.09 - Pediatriya;
- 14.00.10 - Yuqumli kasalliklar;
- 14.00.11 - Dermatologiya va venerologiya;
- 14.00.12 - Tibbiy reabilitologiya;
- 14.00.13 - Nevrologiya;
- 14.00.14 - Onkologiya;
- 14.00.15 - Patologik anatomiya;
- 14.00.16 - Normal va patologik fiziologiya;
- 14.00.17 - Farmakologiya va klinik farmakologiya;
- 14.00.18 - Psixiatriya va narkologiya;
- 14.00.19 - Klinik radiologiya;
- 14.00.20 - Tibbiy genetika;
- 14.00.21 - Stomatologiya;
- 14.00.22 - Travmatologiya va ortopediya;
- 14.00.23 - Hamshiralik ishini tashkil etish;
- 14.00.24 - Sud tibbiyoti;
- 14.00.27 - Xirurgiya;
- 14.00.28 - Neyroxirurgiya;
- 14.00.41 - Xalq tabobati;
- 14.00.35 - Bolalar xirurgiyasi;
- 14.00.34 - Yurak-qon tomir xirurgiyasi

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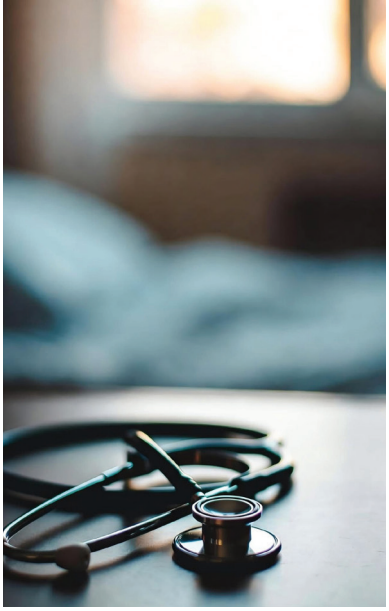
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MUNDARIJA

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Abstract. This article examines approaches to evaluating the effectiveness of complementary rehabilitation methods in patients with cervical osteochondrosis and myofascial pain syndrome. Kinesiotherapy, phytotherapy, acupuncture, and osteopathic manual techniques are discussed in relation to their potential effects on pain intensity, cervical range of motion, functional limitations, and activities of daily living. Clinical outcome assessment methods include the Visual Analogue Scale (VAS), Neck Disability Index (NDI), and cervical range of motion measurement (CROM); the osteopathic inhibition test and global activity test are discussed as procedures requiring standardization. The literature review highlights the importance of active rehabilitation and individualized treatment planning. Further clinical studies using standardized assessment protocols are required to establish the effectiveness and safety of these interventions and their combined application.

Keywords: cervical osteochondrosis, myofascial pain syndrome, rehabilitation, kinesiotherapy, phytotherapy, acupuncture, osteopathic assessment, inhibition test, global activity test, pain intensity, functional status.

Annotatsiya. Ushbu maqolada bo‘yin osteoxondrozi va miofassial og‘riq sindromi mavjud bemorlarni reabilitatsiya qilishda noan’anaviy davolash usullarining samaradorligini baholash masalalari yoritilgan. Kinezioterapiya, fitoterapiya, akupunktura va osteopatik manual usullarning og‘riq intensivligi, bo‘yin harakat amplitudasi, funksional cheklanishlar hamda bemorlarning kundalik faolligiga ta’siri tahlil qilingan. Klinik samaradorlikni baholashda vizual analog shkala (VAS), Bo‘yin funksiyasi buzilishi indeksi (NDI) va bo‘yin harakat amplitudasi (CROM)dan foydalanish yondashuvlari, shuningdek osteopatik ingibitsiya testi va global faoliyat testini standartlashtirish zarurati ko‘rib chiqilgan. Adabiyotlar tahlili faol reabilitatsiya va individual yondashuvning ahamiyatini ko‘rsatadi. Noan’anaviy usullarning samaradorligini aniq belgilash uchun standartlashtirilgan metodika asosida qo‘shimcha klinik tadqiqotlar o‘tkazish zarur.

Kalit so‘zlar: bo‘yin osteoxondrozi, miofassial og‘riq sindromi, reabilitatsiya, kinezioterapiya, fitoterapiya, akupunktura, osteopatik baholash, ingibitsiya testi, global faoliyat testi, og‘riq intensivligi, funksional holat.

Аннотация. В статье рассматриваются вопросы оценки эффективности нетрадиционных методов лечения и реабилитации пациентов с шейным остеохондрозом и миофасциальным болевым синдромом. Проанализированы подходы к применению кинезиотерапии, фитотерапии, акупунктуры и остеопатических мануальных техник, а также их потенциальное влияние на интенсивность боли, объём движений в шейном отделе позвоночника, функциональные ограничения и повседневную активность пациентов. Рассмотрены методы оценки клинических результатов с использованием визуальной аналоговой шкалы (ВАШ), индекса нарушения функции шеи (NDI) и измерения объёма движений в шейном отделе (CROM), а также необходимость стандартизации ингибиторного теста и теста глобальной активности. Анализ литературы подчёркивает значение активной реабилитации и индивидуального подхода. Для объективной оценки эффективности комплексного применения рассматриваемых методов необходимы дополнительные клинические исследования со стандартизированным протоколом.

Ключевые слова: шейный остеохондроз, миофасциальный болевой синдром, реабилитация, кинезиотерапия, фитотерапия, акупунктура, остеопатическое обследование, ингибиторный тест, тест глобальной активности, интенсивность боли, функциональное состояние.

INTRODUCTION

Neck pain is a common musculoskeletal problem and may be associated with reduced movement, impaired work capacity, sleep disturbance, and lower quality of life. The term “cervical osteochondrosis” is frequently used clinically for degenerative changes of the cervical intervertebral discs and adjacent structures; however, imaging abnormalities do not necessarily explain the severity of symptoms. Clinical decisions should integrate history, neurological examination, function, and screening for serious pathology [1,2]. Myofascial pain may coexist with cervical degenerative changes and can involve localized muscle tenderness, trigger points, protective muscle guarding, and referred pain.

A rehabilitation programme should therefore address pain and functional limitations rather than relying exclusively on imaging findings or passive procedures. Clinical practice guidelines support education, graded activity, exercise, and—in selected cases—multimodal care or manual therapy [1,2]. Complementary interventions are often requested by patients. Acupuncture has been evaluated in randomized trials and systematic reviews, with findings that depend on the comparator and outcome [4,5]. Evidence concerning herbal medicine is less certain and varies by formulation [6,7]. Osteopathic assessment techniques such as an inhibition test or global activity test should be described using reproducible operational definitions; their names alone do not establish diagnostic validity or therapeutic effectiveness.

LITERATURE REVIEW

Cervical degenerative changes and myofascial pain: clinical context.Cervical degenerative changes are frequently identified on imaging, particularly with increasing age, but radiological findings do not always correspond directly to pain intensity or functional limitation. Therefore, the term “cervical osteochondrosis” should not be treated as a complete explanation for every episode of neck pain. Clinical interpretation requires consideration of symptom distribution, neurological findings, movement-related aggravation, functional limitations, and the possibility of other causes. Clinical practice guidance for neck pain emphasizes classification, assessment of risk factors, education, and selection of interventions according to the patient’s presentation rather than imaging findings alone [1,2]. Myofascial pain may coexist with cervical degenerative changes and can involve taut muscle bands, hypersensitive trigger points, local or referred pain, protective muscle guarding, and reduced movement tolerance. These features may contribute to a cycle in which pain reduces activity, reduced activity lowers muscle endurance, and fear of movement reinforces disability.

However, myofascial pain should be assessed clinically and not inferred solely from an imaging report. A comprehensive rehabilitation assessment should distinguish musculoskeletal pain from progressive neurological symptoms and other warning signs requiring further medical evaluation [1,2]. This distinction is important when evaluating complementary methods. A treatment may reduce pain in the short term without changing structural degeneration, while improved strength, movement confidence, and activity tolerance may occur even when imaging findings remain unchanged. Accordingly, rehabilitation outcomes should prioritize patient-reported pain and disability alongside physical performance and safety, rather than using radiological change as the sole indicator of success. Exercise-based rehabilitation is a central component of care for many people with persistent or recurrent neck pain. Kinesiotherapy can include graded cervical mobility, deep neck-flexor and neck-extensor training, scapular and shoulder-girdle strengthening, endurance work, coordination exercises, stretching where indicated, and progressive return to everyday activity. Education about pacing, posture variation, self-management, and the value of regular movement may help patients sustain activity and reduce fear-avoidance behaviours. Exercise selection should be adapted to irritability, baseline capacity, comorbidities, neurological status, and the person's goals; one standard programme is unlikely to suit every patient [1,2]. Cho, Park, and Kim's systematic review and meta-analysis included 21 studies and found that exercise therapy was associated with improvements in pain and disability among people with chronic nonspecific neck pain. The pooled standardized mean difference was −1.47 for pain (95% CI −1.89 to −1.06) and −1.79 for disability (95% CI −2.31 to −1.27) [3]. These estimates indicate a potentially important benefit, but they should be interpreted cautiously because statistical heterogeneity was very high (I^2=94% for both outcomes). Differences in exercise type, programme duration, participant characteristics, comparison groups, and outcome measures may explain some of this variability. The review also noted that evidence was less conclusive for acute and subacute nonspecific neck pain [3].

Evidence also suggests that matching the intervention to the patient's clinical presentation may be preferable to providing an identical programme to everyone. A systematic review comparing matched and unmatched physical therapy interventions reported better short-term pain and disability outcomes when exercise was matched to clinical features, although benefits were not consistently maintained at intermediate follow-up [8]. This finding supports individualized progression and reassessment rather than rigidly applying a fixed exercise protocol. For research purposes, the exercise programme should be described in enough detail to allow replication, including exercise selection, intensity, frequency, duration, progression rules, supervision, adherence, and co-interventions. Acupuncture has been investigated as an adjunctive option for chronic neck pain. Proposed explanations include modulation of nociceptive processing and changes in pain-related sensory responses, but mechanisms should not be assumed to establish clinical effectiveness. Published studies differ in acupuncture points, needle technique, treatment dose, session frequency, practitioner experience, and the control intervention used. These differences complicate comparisons across trials and make it important to distinguish acupuncture added to usual care from acupuncture compared with sham procedures or other active treatments. Fang and colleagues reviewed 18 randomized controlled trials evaluating longer-term outcomes after acupuncture for chronic neck pain. When acupuncture was used as an adjunct, the review reported sustained pain relief at three months (SMD −0.79, 95% CI −1.13 to −0.46) and a benefit at six months on the measure reported by the authors. However, acupuncture did not show a statistically significant pain advantage over sham acupuncture in the relevant comparison, although some functional outcomes improved [4]. Reported adverse events were generally mild and transient. The comparator-dependent findings are clinically important: improvement after a treatment package does not by itself prove that the specific procedure is superior to a credible sham intervention.

A further systematic review published in 2025 included 26 trials and 3,520 participants. Compared with inert treatments, acupuncture was associated with lower pain intensity (MD −1.26, 95% CI −1.77 to −0.75) and improved disability scores in the pooled analysis [5]. Nevertheless, certainty, risk of bias, clinical heterogeneity, and the nature of comparison groups should be considered when interpreting these results. In practice, acupuncture is best evaluated as a possible adjunct to an active rehabilitation programme, not as a substitute for education, progressive exercise, or appropriate medical assessment. Studies should record treatment-related adverse events and use a clearly specified protocol. Phytotherapy is a broad category rather than a single reproducible intervention. Herbal products may differ by plant species, plant part, extraction process, active constituents, formulation, dose, route of administration, manufacturing quality, and contamination controls. Consequently, evidence for one preparation cannot automatically be generalized to another product or to herbal medicine as a whole. This is especially relevant in musculoskeletal conditions, where studies may combine oral preparations, topical products, or multi-ingredient formulas with different proposed mechanisms and safety profiles. Reviews of herbal medicine for cervical degenerative disorders and neck pain have identified studies of potential benefit, but the available evidence is difficult to interpret because of variation in preparations, study design, outcome measures, and comparator treatments [6,7]. Small samples, incomplete

reporting, short follow-up, and differences in the quality of the products can limit confidence in the estimated effect. A reported improvement in a particular trial should therefore be attributed to the preparation and protocol actually studied, rather than used to claim that all phytotherapy is effective. Safety is a core part of evaluating herbal interventions. Products may cause allergic reactions, gastrointestinal symptoms, or interactions with prescribed medicines; some products may also vary in strength or contain undeclared ingredients. A research protocol should identify the exact product, manufacturer, ingredients, dose, route, duration, quality-control procedures, contraindications, and adverse-event monitoring plan. Participants should be advised not to discontinue prescribed treatment or self-medicate with an unverified product. Until more consistent evidence is available, phytotherapy should not displace established rehabilitation components.

Manual therapy may include mobilization, soft-tissue techniques, and other hands-on procedures selected according to the clinical assessment. Osteopathic approaches often combine manual assessment and treatment with advice and movement-based strategies; however, techniques described under the same label may vary substantially. For that reason, research should name the actual procedures performed rather than use “osteopathic treatment” as an undefined package. Manual interventions are commonly considered within multimodal care, with exercise and self-management remaining important components. A 2025 Cochrane review concluded that manual therapy combined with exercise may improve function compared with placebo for primarily chronic neck pain, while pain reduction relative to placebo was not clearly demonstrated; comparisons with no treatment showed more favourable results for pain and function. The review also emphasized limitations in the evidence and incomplete reporting of adverse events and intervention details [9]. These findings suggest that manual therapy may be useful for selected patients, but the size and certainty of benefit depend on the comparator and the specific intervention. High-velocity cervical manipulation should not be assumed appropriate for every patient, particularly when red flags, vascular concerns, myelopathy, or progressive neurological deficits are suspected.The inhibition test and global activity test mentioned in the proposed assessment framework require explicit operational definitions before they can be used as research outcomes. The protocol should state the purpose of each test, patient and examiner position, the movement or force applied, positive and negative criteria, scoring method, number of repetitions, and assessor training. Reliability should be examined between assessors and, where appropriate, within the same assessor. Without these definitions, results may reflect examiner interpretation rather than a reproducible clinical change. Such tests should complement, not replace, validated measures of pain, disability, movement, and functional performance.

A meaningful evaluation of rehabilitation should use several complementary outcomes. Pain intensity may be recorded with a Visual Analogue Scale (VAS) or a consistent numerical rating scale (NRS) [11]. The Neck Disability Index (NDI) can quantify self-reported limitations in activities affected by neck pain [10]. Cervical range of motion may be assessed with a standardized instrument or consistent measurement procedure, while a functional assessment can document tolerance for work, sleep, driving, household tasks, and physical activity. The same methods, instructions, and assessment conditions should be used at baseline and follow-up to reduce measurement error. Pain intensity alone is not sufficient to characterize recovery. A participant may report less pain while continuing to avoid activity, or may improve function despite some residual symptoms. Therefore, pain, disability, movement, participation, adherence, medication use, patient global impression of change, and adverse events should be interpreted together. The timing of follow-up is also important: an immediate post-treatment effect may not persist after supervised sessions end. Assessments at baseline, at the end of treatment, and at a prespecified follow-up can help distinguish short-term response from more durable improvement. Cross-study comparisons require particular caution.

Standardized mean differences and raw mean differences are not interchangeable, and studies may use different scales, patient populations, baseline severity, and control conditions. A numerically larger estimate in one review does not necessarily mean that one treatment is superior to another when the estimates come from independent studies. High heterogeneity, risk of bias, small samples, publication bias, and incomplete adverse-event reporting should be considered alongside statistical significance. Where possible, studies should report effect sizes with 95% confidence intervals and explain whether the change is likely to be clinically meaningful. Overall, the most consistent foundation for rehabilitation is an individualized programme combining education, graded activity, and exercise, with treatment adapted to clinical findings and patient goals [1–3,8]. Acupuncture may provide additional benefit for some patients, although results vary according to the comparison group and the certainty of the evidence [4,5]. Evidence for phytotherapy is harder to generalize because products and methods differ [6,7]. Manual therapy may contribute to a multimodal programme, but its independent effect and optimal application remain uncertain in several comparisons [9]. None of these findings establishes that a single complementary method is universally effective for all patients with cervical degenerative changes and myofascial pain. A key gap is the limited ability to transfer findings from broad nonspecific neck-pain populations directly to people who have both documented cervical degenerative changes and clinically assessed myofascial pain syndrome. Future research should define the target population, distinguish structural

imaging findings from clinical symptoms, standardize the core rehabilitation programme, and evaluate any complementary intervention as a clearly specified addition. A controlled design should use validated outcome measures, prespecified follow-up, transparent reporting of adherence and co-interventions, and systematic adverse-event monitoring. This approach would allow the relative contribution of each component to be assessed more reliably.

Table 1.
Outcome Measures, Assessment Procedures, and Evaluation Criteria for Clinical Monitoring

Domain	Measure / procedure	Timing and interpretation
Pain	VAS or NRS, 0–10	Baseline, post-treatment, follow-up; lower score indicates less pain.
Disability	Neck Disability Index (NDI)	Baseline, post-treatment, follow-up; lower score indicates less disability.
Mobility	CROM in degrees	Record flexion, extension, rotation, and lateral flexion using the same protocol.
Function	Patient-Specific Functional Scale or validated global rating	Predefine activities and scoring instructions.
Myofascial findings	Standardized tenderness/trigger-point examination	Use consistent criteria and assess examiner reliability.
Safety	Adverse-event checklist and medication review	Record type, severity, timing, seriousness, and suspected relationship.

RESEARCH METHODOLOGY

Study type: narrative evidence review with a proposed clinical evaluation framework. This manuscript is not a completed clinical trial or a registered systematic review. It synthesizes clinical guidance and selected systematic reviews/meta-analyses concerning adult neck pain, exercise therapy, acupuncture, herbal medicine, and manual therapy. As a reproducible search log and formal risk-of-bias assessment were not available, the article does not claim to be exhaustive. Population of interest for future research: adults with neck pain and clinical features consistent with myofascial pain, with cervical degenerative findings documented where relevant.

Evidence from broad nonspecific neck-pain populations may not fully generalize to patients with a specifically defined combination of cervical osteochondrosis and myofascial pain syndrome. A future prospective controlled study could compare (A) standardized education and kinesiotherapy with (B) the same core programme plus one clearly specified adjunct. If a combined package is evaluated, the content and dose of every component must be documented. Randomization, allocation concealment, blinded outcome assessment where feasible, ethics approval, prospective registration, and sample-size calculation based on one primary outcome are recommended. No new sample size or original patient outcome is asserted in this article.

ANALYSIS AND RESULTS

A clinical study should screen for red flags such as suspected fracture, infection, malignancy, inflammatory disease, progressive neurological deficit, or signs of cervical myelopathy. Before acupuncture, review bleeding risk, anticoagulant use, skin infection, and other contraindications. Before phytotherapy, document the product and review allergies, drug interactions, pregnancy-related concerns, and hepatotoxicity/nephrotoxicity risks. New weakness, gait disturbance, loss of coordination, or rapidly worsening symptoms require medical assessment. For a controlled study, report baseline characteristics transparently and analyze participants according to a prespecified plan, preferably using intention-to-treat principles. Report between-group estimates with 95% confidence intervals rather than p-values alone. Address missing data, adherence, co-interventions, adverse events, and protocol deviations. Within-group improvement alone does not prove that an adjunct caused the change. The reviewed evidence supports exercise therapy as an important component of rehabilitation for chronic nonspecific neck pain. Although the 2023 meta-analysis reported sizeable pooled effects, very high heterogeneity limits precision and generalizability [3]. Differences in exercise dose, programme content, patient selection, and comparison treatment may explain some of this variability. For the target population, an individualized and progressive exercise programme with predefined functional goals is more defensible than a fixed one-size-fits-all protocol.

Acupuncture findings are promising but comparator-dependent. The 2024 review found sustained improvement when acupuncture was used as an adjunct, while not demonstrating a significant pain advantage over sham acupuncture [4]. The 2025 review reported benefits compared with inert controls but also noted very low certainty and heterogeneity [5]. Acupuncture may therefore be discussed as an optional adjunct with informed consent and realistic expectations, rather than as a replacement for active rehabilitation. Phytotherapy evidence is less consistent and cannot be generalized across all herbal products [6,7]. Its clinical evaluation requires a specific preparation, quality standard, dose, and safety-monitoring plan. Osteopathic assessment can contribute to a structured physical examination, but the inhibition test and global activity test require operational definitions and reliability data before they can be interpreted as research outcomes. A multimodal intervention can be pragmatic, yet it is difficult to identify which component caused improvement unless the study design supports that conclusion. The participant counts and effect estimates below are taken from published reviews and are not a newly recruited patient sample. The studies included heterogeneous neck-pain populations and do not prove that identical effects will occur in every patient with cervical osteochondrosis and myofascial pain syndrome.

Table 2.
Findings from selected published evidence

Evidence source	Evidence base	Reported result	Key limitation
Exercise meta-analysis, 2023 [3]	21 studies	Chronic neck pain: pain SMD −1.47; disability SMD −1.79	I^2=94%; high heterogeneity.
Acupuncture durability review, 2024 [4]	18 randomized trials	Adjunct at 3 months: pain SMD −0.79; no significant pain difference vs sham	Comparator-dependent effects.
Acupuncture review, 2025 [5]	26 trials; 3,520 participants	Vs inert treatment: pain MD −1.26; disability MD −6.52	Very low certainty; high heterogeneity.
Oral herbal medicine review, 2021 [7]	16 studies	Several herbal preparations evaluated	Intervention and design variation.
Matched physical therapy review, 2024 [8]	27 studies	Matched exercise improved short-term pain and disability vs unmatched exercise	Benefit not maintained at intermediate follow-up.
Manual therapy + exercise review, 2025 [9]	9 studies; 694 participants	Vs placebo: function improved, little or no pain reduction; vs no treatment: pain and function improved	Low certainty; adverse events rarely reported.

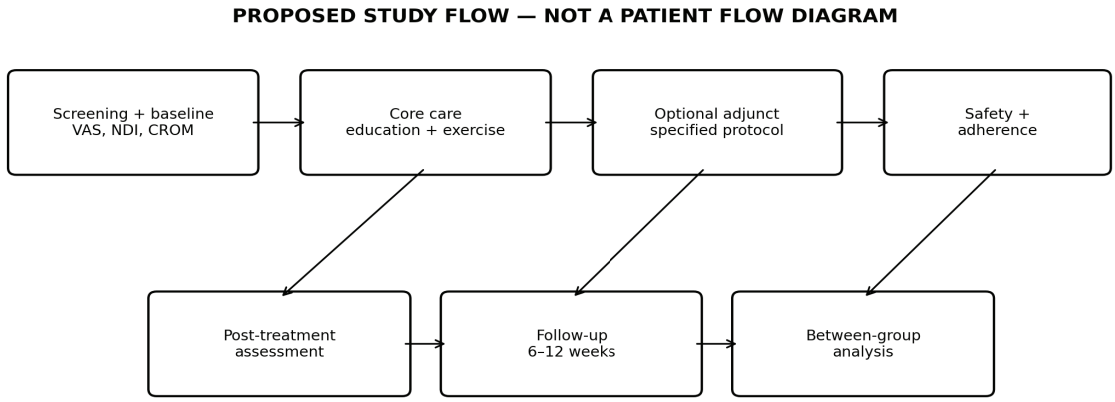


Figure 1. Proposed clinical evaluation pathway
Note: Th**is figure shows a proposed study workflow, not an actual participant flow diagram.**

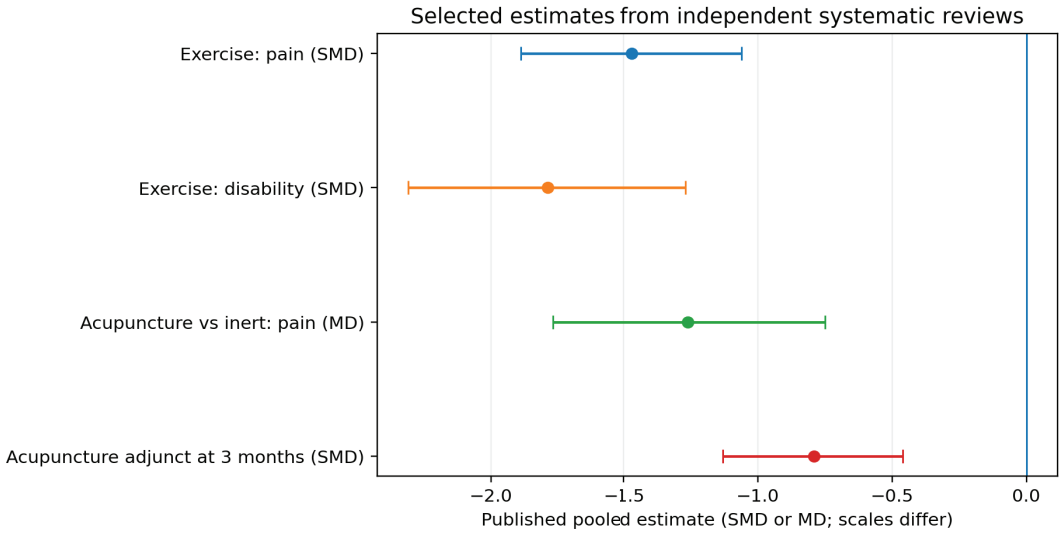


Figure 2. Selected pooled estimates from independent reviews

Note: Standardized mean differences (SMDs) and mean differences (MDs) use different scales, populations, and comparators. This descriptive figure is not a direct head-to-head ranking of interventions.

Table 3.
Proposed rehabilitation framework

Component	Potential role	Key safeguards
Kinesiotherapy	Core active intervention: mobility, strength, endurance, home practice	Individualize loading and monitor symptoms.
Acupuncture	Optional adjunct for selected patients	Qualified practitioner; sterile single-use needles; informed consent.
Phytotherapy	Optional only when product-specific rationale exists	Document formulation/dose; review interactions and contraindications.
Osteopathic/manual approach	Structured assessment; selected gentle techniques may complement exercise	Define tests; document reliability; screen red flags and manipulation risks.
Education/self-management	Support activity, pacing, adherence, and self-efficacy	Avoid fear-based advice and unnecessary activity restriction.

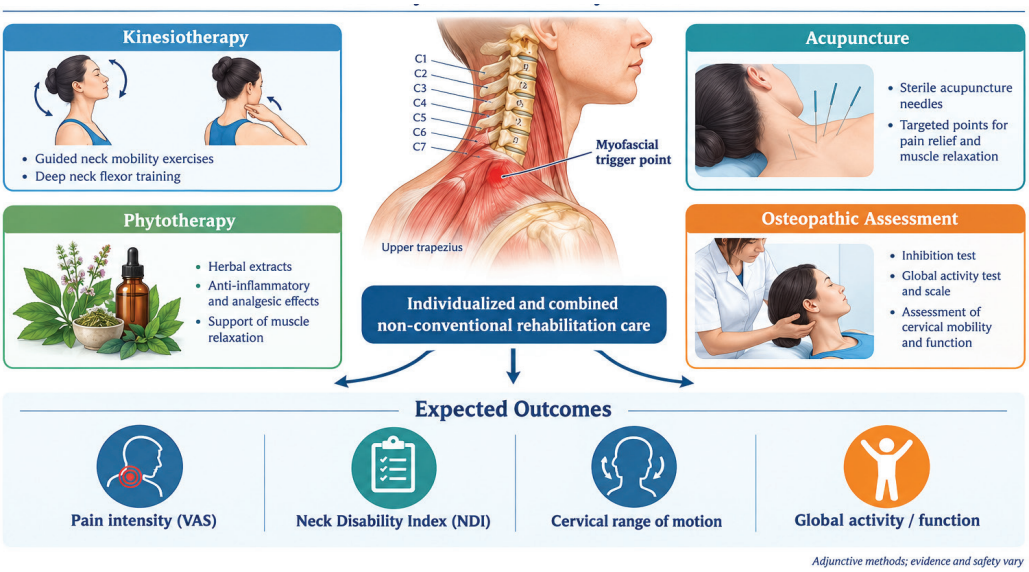


Figure 3. Integrated Approach to Non-Conventional Rehabilitation for Neck Pain: Kinesiotherapy, Acupuncture, Phytotherapy, and Osteopathic Assessment with Expected Clinical Outcomes

CONCLUSION

The reviewed evidence supports education and individualized kinesiotherapy as the foundation of rehabilitation for cervical degenerative disorders accompanied by myofascial pain. Acupuncture may provide additional benefit for selected patients, but estimates vary according to comparator and certainty of evidence. Phytotherapy cannot be considered a uniform intervention and requires product-specific assessment. Osteopathic tests should be standardized and their reliability established before use as outcome measures. Current literature does not establish the superiority of a combined package containing all these methods for the specific target population. Prioritize education, graded exercise, cervical mobility, and strengthening within an individualized rehabilitation plan.

Consider acupuncture only as an adjunct when clinically appropriate, with informed consent and a trained practitioner. Specify any phytotherapy product, dose, quality standard, contraindications, and potential drug interactions. Define the inhibition test and global activity test in a written protocol and assess inter-rater reliability before research use. Conduct a prospective controlled study with ethics approval, justified sample size, a prespecified primary outcome, follow-up, and systematic adverse-event reporting. Use VAS/NRS, NDI, CROM, functional measures, adherence, and safety outcomes at baseline, post-treatment, and follow-up; report effect estimates with 95% confidence intervals.

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