



DOSSIER · THERAPY

Respiratory Therapy and Breathwork

The database records a substantial number of studies on **respiratory therapy** and **breathwork**, the majority of which are conducted in humans. Controlled studies focus on **fatigue**, **cognition**, and the **musculoskeletal system**. The most notable finding: most applications are based on **observational studies** or **mechanistic models**, whereas controlled evidence of efficacy is lacking for many popular indications.

1,223

STUDIES IN
TOTAL

931

IN HUMANS

440

OF WHICH
CONTROLLED

3

IN ANIMALS

0

IN THE LAB

Figures from the IHR study database · Last updated 2026-10-04

How to Read This Dossier

ESTABLISHED

measured in humans, with a comparison group

PLAUSIBLE

supported by mechanism, animal studies or observation

HYPOTHESIS

a likely connection that still needs to be tested

Respiratory Therapy and Breathwork at a Glance

RESPIRATORY THERAPY

encompasses clinically guided techniques for breath regulation, such as physiotherapeutic breath training or diaphragmatic breathing. **Breathwork** refers to self-directed techniques like slow breathing rates or rhythmic breath cycles, often derived from yogic or contemplative traditions. Both aim to modulate the autonomic nervous system, for example, via heart rate variability or baroreflex sensitivity.

1,223 evaluated studies · 440 controlled human trials · 491 observational studies · 60 review articles · 3 animal studies · 0 cell culture studies

MUSCULOSKELETAL SYSTEM AND CHRONIC LUNG DISEASES

Randomised controlled trials demonstrate significant improvements in dyspnoea, walking distance (6-minute walk test), and quality of life in COPD patients following a 3-month pulmonary rehabilitation programme with breath training. Effects persisted for up to 24 months, and exacerbations decreased.

Cognition, mental health, and stress regulation Meta-analyses confirm significant reductions in subjective stress (effect size $g = -0.35$), anxiety ($g = -0.32$), and depressive symptoms ($g = -0.40$) through breathing exercises such as slow or coherent breathing. Studies show increased heart rate variability (HRV) and improved psychological well-being. · **Heart and circulation** Slow breathing techniques (6 breaths/min) significantly reduced blood pressure in patients with essential hypertension and improved autonomic regulation. Synchronisation of breathing and baroreflex led to increased baroreflex sensitivity.

Inflammatory processes and autonomic regulation A 10-day training programme with cyclic hyperventilation and breath retention in healthy participants enhanced anti-inflammatory immune responses (increased IL-10, reduced pro-inflammatory cytokines) following endotoxin administration. · **Fatigue and stress** Systematic reviews indicate that slow breathing increases HRV, reduces sympathetic activity, and modulates respiratory sinus arrhythmia. Studies suggest short-term physiological effects on fatigue-related parameters, though long-term clinical impacts on fatigue syndromes remain unclear.

Controlled efficacy evidence for many popular indications, such as chronic conditions (asthma, hypertension) or specific fatigue syndromes (ME/CFS), remains an open research question. The evidence base often relies on observational studies or mechanistic models. · Heterogeneity in interventions (breathing patterns, duration, guidance) and the absence of standardised terminology complicate meta-analyses and direct comparisons between techniques. · Biofeedback studies frequently show short-term physiological changes without correlation to clinical improvements. Many studies have small sample sizes, lack blinding, or involve short intervention durations.

Respiratory therapy and breathwork are well-supported methods for modulating the autonomic nervous system, with demonstrated effects on respiratory function, stress reduction, and cardiovascular regulation. However, their efficacy in chronic diseases requires further systematic research.

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1. What Respiratory Therapy and Breathwork Are

Both approaches aim to **modulate the autonomic nervous system**, for example, via **baroreflex sensitivity** or **heart rate variability (HRV)**. Implementation varies from **single biofeedback sessions** to **multi-week rehabilitation programmes**.

Diversity of measurement parameters is critical: breathing techniques are assessed via **subjective scales** (e.g., dyspnoea, stress), **physiological markers** (HRV, blood pressure, oxygen saturation), or **functional tests** (6-minute walk test, cognitive performance). Many studies use **biofeedback** as a control condition, which complicates the isolation of specific effects. Additionally, a **standardised terminology** is lacking—terms like *pursed-lip breathing*, *slow breathing*, or *yogic breathing* overlap despite describing distinct **breathing patterns** (frequency, depth, nasal/mouth breathing). **Intervention duration** ranges from **single sessions** to **multi-month programmes**, limiting direct comparisons.

2. What the Studies Show in Detail

The foundational human studies and key reviews are organised by application, including population, duration, preparation, outcome measures, and results as reported in the original publications. Numbers are included only where explicitly stated in the source.

Distribution of **controlled human studies** by field of application — the figures cannot be summed as a single study may be assigned to multiple fields:

FIELD OF APPLICATION	CONTROLLED STUDIES
Fatigue and stress	156
Cognition and mental health	150
Musculoskeletal system	137
Safety and tolerability	84
Cardiovascular system	74
Oncology	27
Metabolism	23
Gut and microbiome	22

Musculoskeletal System and Respiratory Function in Chronic Lung Diseases

A randomised controlled trial involving 60 patients (mean age 65 ± 7 years, FEV_1 $35 \pm 14\%$) with moderate to severe COPD assessed an outpatient pulmonary rehabilitation programme over 3 months. The intervention group received breathing training, chest physiotherapy, daily supervised exercise (3 months) and weekly breathing exercises (6 months). The control group received standard care. Outcomes measured included dyspnoea (Chronic Respiratory Questionnaire, CRQ), 6-minute walk test (6MWT) distance, and hospitalisation rate. The intervention group demonstrated significant improvements in dyspnoea ($p < 0.0001$), walking distance ($p < 0.0001$), and CRQ subscales for daily dyspnoea, fatigue, and emotional function ($p < 0.01$). Effects persisted with slightly reduced magnitude over 24 months. Exacerbations decreased significantly ($p < 0.0001$), though hospitalisations did not. Limitations included the lack of participant blinding and the small sample size, which precluded subgroup analyses ¹.

A multicentre, randomised controlled crossover trial examined a 3-month rehabilitation programme (breathing training, mucus clearance, relaxation, and exercise training) in asthma and COPD patients (sample size not explicitly stated). After 3 months, significant improvements were observed in endurance time (421 s), heart rate (6 beats/min), 6MWT distance (39 m), and total CRQ score (17 points) compared with the control group (medication only). Effects were sustained at 6 months. Asthma and COPD patients benefited similarly, except for walking distance (greater effect in asthma). Limitations included the lack of blinding and unclear group sample sizes ².

A pilot study involving 29 stable COPD patients (mean age 69.9 ± 9.5 years, FEV_1 $47.7 \pm 15.6\%$; 21 women) compared 12 weeks of yoga (twice weekly, including asanas and *visama vritti pranayama*) with standard care. Primary endpoints were dyspnoea intensity (DI) and dyspnoea distress (DD) during ergometry and the 6-minute walk test (6MWT). Secondary endpoints included physical performance, psychological well-being, and quality of life. Yoga was safe and feasible, reducing DD after the 6MWT (effect size 0.34), but not DI. Limitations included the small sample size and the absence of an active control group ⁴.

A Cochrane Review (2012) analysed randomised studies on breathing exercises in COPD. Primary endpoints were dyspnoea, exercise capacity, and quality of life. The meta-analysis showed inconsistent effects: some studies reported improvements in dyspnoea and exercise capacity, while others did not. The quality of evidence was low, as many studies had small sample sizes, short intervention durations (typically < 3 months), and heterogeneous breathing techniques. Systematic comparisons between techniques (e.g., pursed-lip breathing vs. diaphragmatic breathing) were lacking ⁷.

HYPOTHESIS The studies suggest that breathing therapy in COPD and asthma may primarily act through optimisation of respiratory mechanics (e.g., reduction of dynamic hyperinflation) and improved exercise tolerance. Long-term efficacy could be mediated by a reduction in exacerbations and enhanced body awareness. However, which specific techniques work at which disease severity, and how their efficacy differs, remains to be clarified.

Inflammatory Processes and Autonomic Regulation

A randomised controlled trial involving 24 healthy participants examined the effects of a 10-day training programme (meditation, cyclic hyperventilation with breath retention, cold exposure) on cytokine levels following intravenous administration of *E. coli* endotoxin (2 ng/kg). The intervention group showed a faster and more pronounced increase in the anti-inflammatory cytokine IL-10, correlating with elevated adrenaline levels. Pro-inflammatory cytokines (TNF- α , IL-6, IL-8) were significantly reduced. The technique induced intermittent respiratory alkalosis and hypoxia. Limitations included the small sample size and lack of blinding.

In the study, the primary endpoint was asthma-specific quality of life (AQLQ), a patient-reported outcome measured via questionnaire. Effects on this measure were no longer significant after 12 months, indicating no sustained improvement in asthma-related quality of life. Limitations included the lack of blinding and a high dropout rate (30%) ⁶.

HYPOTHESIS The data suggest that a combined programme of meditation, breathing exercises, and cold exposure may exert anti-inflammatory effects through modulation of the autonomic nervous system (e.g., increased parasympathetic activity). Short-term improvements in quality of life in asthma could be explained by reduced dyspnoea and enhanced self-efficacy. However, studies directly investigating these mechanisms in patients with chronic inflammatory conditions have yet to be conducted.

Cognition, Psyche, and Stress Regulation

A randomised controlled trial involving 126 participants compared three stress-reduction interventions—physical activity (PA), mindfulness meditation (MM), and heart rate variability biofeedback (HRV-BF), which includes breathwork components—on stress, anxiety, depressive symptoms, and psychological well-being. All interventions, including the breathwork-based HRV-BF, led to significant improvements ($p < 0.05$), with no differences between groups. The study does not isolate the effects of breathwork alone.

A randomised controlled trial involving 46 musicians examined the effect of a 30-minute HRV-BF session (slow breathing with/without biofeedback) on performance anxiety (STAI-S) and HRV. The intervention groups showed significant increases in high-frequency HRV ($\eta^2 = 0.122$) and reductions in the LF/HF ratio ($\eta^2 = 0.116$) during the anticipation phase. Performance anxiety did not decrease significantly. Limitations included the short intervention duration and the lack of follow-up measurements.

A meta-analysis (2023) involving 785 participants from 12 randomised studies demonstrated that breathing exercises (e.g., slow breathing, coherent breathing) significantly reduced subjective stress (effect size $g = -0.35$; $p = 0.0009$). Similar effects were observed for anxiety ($g = -0.32$) and depressive symptoms ($g = -0.40$). Heterogeneity was moderate ($I^2 = 42\%$). Limitations included variability in breathing techniques and the lack of differentiation by duration or intensity ⁵.

The intervention group showed significant improvements in the MBHI subscales for introverted, assertive, and sensitive personality styles ($p \leq 0.05$), as well as in the SCL-90-R scales for depression, hostility, and global symptom severity ($p \leq 0.01$), suggesting potential psychometric effects. Clinical validation of these findings is still pending.

HYPOTHESIS The data indicate that breathing techniques may reduce stress through synchronisation of respiration and autonomic regulation (e.g., increased HRV). Effects on cognition and psyche could be mediated by improved interoceptive awareness and reduced sympathetic overactivation. However, studies directly investigating these mechanisms using neuroimaging (e.g., fMRI) or neurophysiological markers (e.g., EEG) are still pending.

Fatigue and Stress

Primary endpoints were walking distance (6MWT), quality of life, and dyspnoea (Mahler Index). After 6 weeks, no significant differences were observed. After 6 months, the Mahler Transition Index showed an improvement in the intervention group ($p < 0.05$), providing an initial indication that requires further investigation.

Primary endpoints were health-related quality of life (HRQoL) and mental health (PHQ-9, GAD-7).

A systematic review (2018) analysed psychophysiological correlates of slow breathing (< 10 breaths/min). Slow breathing increased HRV and respiratory sinus arrhythmia, reduced sympathetic activity, and modulated EEG activity (increase in alpha waves, decrease in theta waves). Limitations included study heterogeneity and the lack of long-term data ¹².

HYPOTHESIS The data suggest that breathing techniques may alleviate fatigue and stress through improved autonomic regulation (e.g., increased HRV) and reduced hyperventilation. Effects in Long-COVID could be mediated by enhanced body awareness and reduced dyspnoea. However, whether these mechanisms operate in specific fatigue syndromes (e.g., ME/CFS) remains an open question.

Heart and Circulation

A randomised controlled trial involving 60 patients with essential hypertension (stage 1) compared 3 months of slow (6 breaths/min) and fast (12 breaths/min) breathing exercises with a control group. Primary endpoints were blood pressure (BP) and autonomic function tests (e.g., Valsalva manoeuvre, E/I ratio). Slow breathing significantly reduced BP ($p < 0.05$) and improved autonomic regulation. Fast breathing showed smaller effects. Limitations included the lack of blinding and the short intervention duration ⁹.

A study involving 23 healthy adults examined the effects of rosary prayer (6 breaths/min) and yoga mantras on cardiovascular rhythms. Both techniques led to synchronous increases in cardiovascular oscillations and a significant enhancement of baroreflex sensitivity (from 9.5 ± 4.6 to 11.5 ± 4.9 ms/mmHg; $p < 0.05$), a surrogate marker for autonomic regulation. Limitations included the lack of a control group and the small sample size ¹³.

HYPOTHESIS The data suggest that slow breathing techniques may improve cardiovascular regulation through synchronisation of respiration and the baroreflex. Effects on blood pressure could be mediated by reduced sympathetic activity and improved vascular regulation. However, whether these mechanisms operate in patients with cardiovascular diseases (e.g., heart failure) remains an open question.

Oncology

A randomised controlled pilot study involving 16 cancer patients undergoing chemotherapy examined pranayama (4 breathing techniques, weekly sessions + home practice) for potential effects on fatigue, sleep disturbances, anxiety, and quality of life. The study provides initial insights; whether these effects translate into clinical outcomes remains to be examined.

HYPOTHESIS The data suggest that breathing techniques in cancer patients may act through a reduction in stress responses and improved body awareness. However, studies with larger sample sizes and longer follow-up periods are needed to assess the clinical relevance of these effects.

Overall Picture

The available studies consistently demonstrate that respiratory therapy and breathwork have positive effects on both physical and psychological parameters across a range of indications. Improvements in respiratory function and exercise capacity in COPD, reductions in stress and anxiety, and modulation of autonomic regulation (e.g., increased heart rate variability, HRV) are particularly well documented in preclinical models. Early clinical settings suggest similar effects, but these findings require further investigation to confirm their translation to sustained clinical benefits in humans. These effects appear to be mediated through several mechanisms: optimisation of respiratory mechanics (e.g., reduction of dynamic hyperinflation), synchronisation of breathing and cardiovascular regulation (e.g., baroreflex sensitivity), and enhanced interoceptive awareness and self-efficacy.

However, evidence for some applications (e.g., oncology, immune modulation) remains limited, and study quality is often constrained by small sample sizes, lack of blinding, and short intervention durations. Furthermore, systematic comparisons between different breathing techniques (e.g., diaphragmatic breathing vs. pursed-lip breathing) and their differential efficacy in specific patient groups are lacking. Long-term data on the sustainability of effects are also scarce.

Methodology of the evidence base

Some studies on respiratory therapy and breathwork are randomised controlled trials (RCTs) with parallel or crossover designs, while observational and mechanistic studies are also present. Typical intervention durations range from 4 to 12 weeks, with some studies conducting follow-up measurements for up to 24 months. Primary endpoints frequently include subjective parameters (e.g., dyspnoea, quality of life, stress) and functional tests (e.g., 6-minute walk test, HRV). Objective physiological markers (e.g., cytokine levels, baroreflex sensitivity) are less commonly assessed. Additionally, active control groups are often lacking, which makes it difficult to distinguish the specific efficacy of breathing techniques from non-specific effects (e.g., social support). Studies employing neurophysiological or imaging methods (e.g., fMRI, EEG) are rare and would help to better understand the underlying mechanisms.

Breathwork as a panacea? The limits of the evidence

BREATHWORK

is often marketed as a **universally effective method** for stress reduction, performance enhancement, or pain relief. However, the evidence base shows that **controlled studies** are primarily available for **specific indications**: **COPD rehabilitation** and **asthma management** benefit from **physiotherapeutic breathing training**, while **slow breathing rates** have been used in **biofeedback studies** to investigate **heart rate variability**; the results are inconsistent. For **mental**

health conditions (e.g., anxiety, depression) or **chronic pain**, however, **equally robust evidence is lacking**. Many studies rely on **subjective scales** (e.g., perceived stress) rather than **hard clinical endpoints**, which does not rule out **placebo effects** or **expectation biases**.

MECHANISTIC MODELS

(e.g., **vagal stimulation**, **baroreflex sensitivity**) may explain **physiological changes**, but they provide little insight into **clinical relevance**. For instance, **increased HRV** in the studies reviewed has been associated with **stress resilience**, yet whether this has a **long-term** impact on conditions such as **hypertension** or **inflammatory markers** remains unclear. Furthermore, **systematic investigations** into the **optimal breathing rate**, **duration**, or **frequency** for most applications are lacking. Even for **established methods** such as **nasal high-flow therapy**, it remains uncertain whether the effects stem from **respiratory mechanics**, **oxygen delivery**, or **psychological factors**.

3. How Robust the Research Is

The **efficacy studies** cover **fatigue**, **cognition**, and the **musculoskeletal system**, followed by **safety**, **cardiovascular health**, and **oncology**. The most frequently cited studies originate from **pulmonary rehabilitation** (COPD) and **stress research**, where **biofeedback** and **slow breathing rates** are considered established methods. **Review articles** on various interventions, including breathwork among others, dominate **mechanistic research**, such as studies on **vagal stimulation** or **baroreflex modulation**. **Observational studies** prevail in the investigation of **psychophysiological correlates** (e.g., HRV and emotions), while **controlled efficacy studies** for **chronic conditions** (e.g., asthma, hypertension) are less common.

The **methodological robustness** varies significantly: **pulmonary rehabilitation** and **stress reduction** benefit from **large, randomised studies** with **clinical endpoints** (e.g., quality of life, hospitalisation rates). However, for **cognitive effects** or **chronic pain**, **long-term follow-ups** are lacking. **Biofeedback studies** often demonstrate **short-term physiological changes** without correlating these with **clinical improvements**. **Breathwork** is frequently studied in **non-clinical populations** (e.g., musicians, athletes), which limits **generalizability to patients**. Critically, the **heterogeneity of interventions**—even among similar breathing techniques—differs in **frequency**, **duration**, and **instruction**, complicating **meta-analyses**.

4. Common Claims—and What the Data Actually Show

CLAIM	EVIDENCE BASE
Respiratory therapy for Long COVID	The evidence base is still developing : only a few controlled studies examine breathing techniques for Long-COVID symptoms such as fatigue or dyspnoea. Th
Breathwork for depression	Controlled studies are almost entirely lacking. The few available works show short-term effects on mood scales, but no long-term clinical improvements . Mec
Breathing techniques for performance enhancement in sports	The evidence is limited to small, heterogeneous studies with subjective endpoints (e.g., perceived exertion). Physiological markers (e.g., lactate, VO ₂ max) shc
Long-term effects on the immune system	Although acute immunomodulation (e.g., following a single breathing exercise) has been demonstrated in studies, long-term, controlled evidence is lacking. E

5. The Most Robust Studies

Ranked by evidential strength, not by prominence. The full evaluation includes many more studies; only the most reliable are listed here.

Controlled Human Studies

- ¹ Long-term effects of outpatient rehabilitation of COPD: A randomised trial (2000)
- Voluntary activation of the sympathetic nervous system and attenuation of the innate immune response in humans (2014)
- ² The effects of a community-based pulmonary rehabilitation programme on exercise tolerance and quality of life: a randomised controlled trial (1997)
- Physical activity, mindfulness meditation, or heart rate variability biofeedback for stress reduction: a randomised controlled trial (2015)
- Mechanisms of nasal high flow on ventilation during wakefulness and sleep (2013)
- ³ Breathing retraining for dysfunctional breathing in asthma: a randomised controlled trial (2003)
- Matter over mind: a randomised-controlled trial of single-session biofeedback training on performance anxiety and heart rate variability in musicians (2012)

- Yoga as a Therapeutic Intervention: A Bibliometric Analysis of Published Research Studies from 1967 to 2013 (2015)
- ⁴ Yoga therapy decreases dyspnoea-related distress and improves functional performance in people with chronic obstructive pulmonary disease: a pilot study (2009)
- ⁵ Effect of breathwork on stress and mental health: A meta-analysis of randomised-controlled trials (2023)
- Yoga breathing for cancer chemotherapy-associated symptoms and quality of life: results of a pilot randomised controlled trial (2012)
- ⁶ Physiotherapy breathing retraining for asthma: a randomised controlled trial (2018)
- ⁷ Breathing exercises for chronic obstructive pulmonary disease (2012)
- ⁸ Impact of pulmonary rehabilitation on psychosocial morbidity in patients with severe COPD (2006)
- Treatment of dyspnoea in COPD. A controlled clinical trial of dyspnoea management strategies (1995)
- ⁹ Effect of slow- and fast-breathing exercises on autonomic functions in patients with essential hypertension (2009)
- ¹⁰ Effects of Diaphragmatic Breathing on Health: A Narrative Review (2020)
- ¹¹ An online breathing and wellbeing programme (ENO Breathe) for people with persistent symptoms following COVID-19: a parallel-group, single-blind, randomised controlled trial (2022)
- Mechanistic Pathways of Mindfulness Meditation in Combat Veterans With Posttraumatic Stress Disorder (2016)
- Short-Term Effects of a Respiratory Telerehabilitation Programme in Confined COVID-19 Patients in the Acute Phase: A Pilot Study (2021)
- Graded blood pressure reduction in hypertensive outpatients associated with use of a device to assist with slow breathing (2004)
- The Role of Heart Rate Variability in Mindfulness-Based Pain Relief (2020)
- Effects of Preoperative Breathing Exercise on Postoperative Outcomes for Patients With Lung Cancer Undergoing Curative Intent Lung Resection: A Meta-Analysis (2021)
- Aerobic and breathing exercises improve dyspnoea, exercise capacity and quality of life in idiopathic pulmonary fibrosis patients: systematic review and meta-analysis (2020)

6. Summary

The available studies consistently demonstrate positive effects of breathing therapy and breathwork on physical and psychological parameters, particularly in COPD (respiratory function, exercise capacity), stress and anxiety reduction, and modulation of autonomic regulation (e.g., increased HRV). Mechanisms include optimisation of breathing mechanics, synchronisation of respiration and cardiovascular regulation, and improved interoceptive awareness. Pulmonary rehabilitation and stress research are particularly well-studied, with large, randomised trials featuring clinical endpoints. However, evidence remains limited for some applications, such as oncology or immunomodulation, and methodological quality is often constrained by small sample sizes or lack of long-term data.

In chronic conditions such as asthma or hypertension, long-term effects could be explained by reductions in dyspnoea, improved self-efficacy, and optimised vascular regulation. Short-term cognitive and psychological effects may stem from synchronisation of breathing and autonomic regulation, as well as reduced sympathetic overactivation. Furthermore, efficacy may vary across disease severities, necessitating systematic comparisons between breathing techniques.

Future studies should clarify which specific breathing techniques (e.g., diaphragmatic breathing vs. pursed-lip breathing) are most effective for which indications and patient groups. Long-term follow-up is needed to assess the clinical relevance and sustainability of effects in chronic diseases. Additionally, mechanisms such as autonomic regulation or anti-inflammatory effects should be directly investigated using imaging techniques (fMRI) or neurophysiological markers (EEG). Standardised terminology and intervention protocols would facilitate meta-analyses and comparisons between studies. Finally, data on differential efficacy in subgroups, such as by disease severity or comorbidities, are lacking.

7. Unresolved Questions

- **Standardisation:** Is there an **optimal respiratory rate** or **duration** for specific indications, or are effects **highly individual**?
- **Long-term effects:** Do breathing techniques have a **sustained** impact on **chronic conditions** (e.g., hypertension, diabetes), or are the effects **short-term**?
- **Combination therapies:** Can breathing techniques be used synergistically with **medication** or **physiotherapy**, or are there **interactions**?

Frequently Asked Questions

Is breathwork suitable as a standalone therapy for anxiety disorders?

The evidence is **limited**: controlled studies demonstrate **short-term effects** on **subjective anxiety scales**, but no **long-term clinical improvements**. Breathing techniques are primarily investigated as an **adjunctive method** in **multimodal therapeutic approaches** (e.g., cognitive behavioural therapy). **Standalone use is not evidence-based.**

How reliable are biofeedback-assisted breathing exercises?

Biofeedback has been used to assess physiological parameters such as **heart rate variability** or **blood pressure**; the results are inconsistent. Studies show **heterogeneous outcomes**, as effects depend on **instruction, duration, and indication**. **Long-term evidence is lacking** for **chronic conditions**.

Can respiratory therapy reduce medication use in COPD?

In **pulmonary rehabilitation**, respiratory therapy improves **quality of life** and **exercise capacity**, but it **does not replace pharmacological therapy**. Controlled studies show **no significant reduction** in **exacerbations** or **hospitalisations** through breathing techniques alone. It is recommended as a **complementary measure**.

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Research, put in context. Every statement leads to the original paper; the decision in the individual case rests with the treating professional.
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