Table II - *Clinical characteristics of the studies selected for this review.*

References	Objective	Sample and Assessment	Intervention	Results
Trevisan *et al.* (2010)	To verify the effectiveness of respiratory muscle and quadriceps training on the functional performance of individuals with COPD.	9 individuals with COPD aged between 49 and 76 years. **Assessment:** MIP, MEP, 1RM of lower limbs, 6MWT and quality of life SF-36.	TMR e MMII.	Improvement in all evaluated variables, with significant difference in MIP.
Fernandes *et al.* (2011)	To investigate the effects of diaphragmatic breathing on ventilation and breathing pattern, seeking to identify predictors of its effectiveness in patients with COPD.	44 volunteers, distributed in CG = 15 healthy patients, 7 men and age (60 + 7), moderate COPD group = 14, 11 men and age (63 + 7) and Severe COPD group = 1, with 14 men and age (60 + 8). **Assessment:** PV, MIP, MEP, spirometry and MD.	Diaphragmatic breathing.	Improvement of breathing pattern and ventilatory efficiency without causing dyspnea in patients whose respiratory muscle system has been preserved.
Wellington *et al.* (2012)	To investigate the effects of a training program in diaphragmatic breathing on thoracoabdominal movement and on the functional capacity of patients with COPD.	30 patients randomly allocated to GT = 15) and CG = 15 patients all with COPD. **Assessment:** CR/ABD ratio, diaphragmatic mobility, 6MWT and health-related quality of life.	Training program of diaphragmatic breathing	Increased mobility diaphragm, improvement in the 6MWT and quality of life in the TG. Greater participation of the diaphragm during natural breathing and improved functional capacity.
Nohama *et al.* (2012)	To assess qualitative and quantitative effects of transcutaneous synchronous diaphragmatic stimulation in patients with COPD.	06 volunteers with COPD, of both sexes, aged between 56 and 71 years. **Assessment:** MIP, MEP, pulmonary function test and application of the SGRQ-C quality of life questionnaire.	Electrical stimulation controlled by the respiratory signal.	Increased inspiratory muscle strength, improved quality of life and decreased symptoms.
Cancelliero *et al.* (2013)	To evaluate the effect of transcutaneous electrical diaphragmatic stimulation on the strength and respiratory muscle endurance, thoracoabdominal expandability and spirometric variables.	8 COPD patients, aged (68.5 ± 6.2), 6 men. **Assessment:** MIP, MEP, axillary, xiphoid and abdominal cirtometry and spirometry.	Transcutaneous electrical diaphragmatic stimulation.	Improvement in respiratory muscle strength and thoracoabdominal expandability.
Cancelliero *et al.* (2014)	To compare ventilatory parameters during Diaphragmatic Breathing and Pilates Breathing in COPD patients and healthy adults.	EG = 15 patients with moderate to severe COPD, 8 men and CG = 15 healthy male and female patients aged between 40 and 80 years. **Assessment:** Time, volume and thoracoabdominal coordination.	Diaphragmatic Breathing and Pilates Breathing.	DB increased PV, breathing movements, SpO_2 and decreased RF. PB increased PV in healthy patients and increased SpO_2 in both groups.
Abdelaal *et al.* (2015)	To explore the responses of VF and FC to diaphragmatic or costal manipulation or both in patients with COPD	195 male patients randomly divided into a diaphragmatic manipulation group (group A; n = 46), rib group (group B; n = 53),	Diaphragm and ribs manipulation	Increase in VF and HR.

		both procedures (group C; n = 50) and control group (group D; n = 46). **Assessment:** FVC, FEV1, FC, 6MWT.		
Beaumont *et al.* (2015)	To demonstrate the effectiveness of IMT in dyspnea using the Borg scale and the multidimensional dyspnea profile questionnaire at the end of a 6MWT in COPD patients with PImax = 85cm H_2O (95% of the predicted value (predicted.	32 randomized patients with COPD without inspiratory muscle weakness (MIP> 60cmH2O) **Assessment:** Dyspnea, Borg. MDP, 6MWT and MIP.	IMT and standardized pulmonary rehabilitation program.	Improvement in the sensory intensity of dyspnea in all patients and MDP in patients with FEV1 <50%.
Elmorsi *et al.* (2015)	To evaluate the effectiveness of inspiratory muscle training as part of physical training in COPD patients	60 male patients, equally divided into 3 groups, GA: Training of lower limbs + IMT, GB: Training of lower limbs and CG: without training. **Assessment:** MIP, MEP, dyspnea, 6MWT, BODE index and SGRQ-C.	IMT and peripheral muscle training.	IMT + PMT improves MIP, MEP and distance covered on the 6MWT when compared to isolated TMP. Both improve dyspnea, BODE index and SGRQ-C.
Rocha *et al.* (2015)	To evaluate whether the Manual Diaphragm Release Technique improves diaphragmatic mobility after a single treatment or cumulatively and whether it improves exercise capacity, MRP and the kinematics of the chest wall and abdomen.	20 patients with stable COPD, aged over 60 years, randomly assigned to EG = 10 patients (Manual diaphragm release technique and CG = 10 patients (simulated treatments **Assessment:** diaphragmatic mobility, 6MWT, MIP, MEP, abdominal and chest wall kinematics.	Diaphragm manual release	Improves diaphragmatic mobility, exercise capacity and inspiratory capacity.
Martinelli *et al.* (2016)	To identify the changes after transcutaneous electrical diaphragmatic stimulation by the Russian current.	13 patients with COPD grade III and IV, 11 of whom were male, white, aged 68.46 ± 11.11 years **Assessment:** Anthropometric, respiratory and functional measurements.	Transcutaneous diaphragmatic electrical stimulation by the Russian current.	Improves respiratory and functional.
Nair *et al.* (2019)	To compare the effects of diaphragmatic stretching and manual diaphragm release technique on diaphragmatic excursion in patients with COPD.	20 patients with mild and moderate COPD, allocated to group A or group B by randomization. **Assessment:** excursion of diaphragmatic expansion	Diaphragmatic stretching technique and manual diaphragm release technique	Improvement in diaphragmatic excursion before and after treatment.

COPD = Chronic Obstructive Pulmonary Disease; CG = Control Group; GT = WG = Training Group; GDM = Moderate COPD Group; GDG = DPOC Grave Group; TMR = Respiratory Muscle Training; PMT = Peripheral Muscle Training; LL = Muscles of the Lower Limbs; 6MWT = 6-minute walk test; 1RM = 1 Maximum repetition; MIP = Maximum Inspiratory Pressure; MEP = Maximum Expiratory Pressure; PRM = Maximum Respiratory Pressures; BODE Index = Body Mass-Index; Airflow Obstruction; Dyspnea and Exercise Capacity; SGRQ-C = St George's Respiratory Questionnaire for COPD Patients; SF-36 = Short Form-36 Questionnaire; FEV1 = Forced Expiratory Volume in the first second; RD = Diaphragmatic Breathing; RP = Pilates breathing; MD = Diaphragmatic Mobility; PV = Lung Volume; PV = Ventilatory Functions; CF = Functional Capacity; FVC = Forced Vital Capacity; SpO_2 = Peripheral Oxygen Saturation; FR = Respiratory Rate; HR = Heart Rate; PD = multidimensional profile of dyspnea; RC / ABD = Relationship between the rib cage and abdominal movement.