

Research Journal of Pharmaceutical, Biological and Chemical Sciences

Efficacy of Heartfulness Meditation on Improving Outcomes in COPD Patients.

Raja Amarnath^{1*}, Ghanshyam Verma,²Sugirtha Jenitha, and ³Jaya Prasanthi⁴.

¹Department of Pulmonary Medicine, Director - Critical Care Services, Sree Balaji Medical college and Hospital, Chrompet, Chennai-44 Consultant, Pulmonary medicine, Apollo Hospitals, Chennai.

²Department of Pulmonary Medicine, Incharge of critical care services, Sree Balaji Medical college and Hospital, Chrompet, Chennai-44. Consultant, pulmonary medicine, Apollo Hospitals, Chennai.

³Clinical researcher, Critical Care Unit, Sree Balaji Medical college and Hospital, Chrompet, Chennai-44

⁴Diabetologist.

ABSTRACT

Chronic obstructive pulmonary disease (COPD) is a debilitating and life-threatening lung disease, characterized by chronic irreversible limitation of airflow in the small airways of the lung. In 2015, World Health Organization estimated COPD as the 5th biggest killer worldwide with a global prevalence of 11.7 % (8.4%–15.0%). Every hour, COPD is estimated to kill over 250 people across the globe. In India, majority of older adults are affected with COPD and spend 70 percent of their costs on treating it during hospitalization. Recent research has found that weak adherence to the treatment plan and suboptimal rehabilitation are the most important factors contributing to the impairment in quality of life in these patients. Anxiety and emotional stress worsen symptoms in these patients and make them prone to exacerbations. Meditation relieves anxiety and depression, improves positive thinking and produces a sense of well being, contributing to a better response to treatment and optimal rehabilitation, thereby improves the symptoms of COPD, reduces the frequency of exacerbations and enhances PQLI (Physical Quality of Life Index).

Keywords: Chronic Obstructive Pulmonary Diseases, Heartfulness, Meditation, Anxiety, Emotional stress.

*Corresponding author

INTRODUCTION

A connection exists between breath and the mind. Whenever there is turbulence in the mind, breathing becomes heavy. Finding the beauty of one's inner self by plunging deep inside through meditation relieves the burden on the mind and eases the breath' ~ **Unknown**

Emotional stress is the wear and tear of our minds and bodies experienced as we attempt to cope with our continually changing emotional environment. How we experience these changes, whether the situation makes us feel stimulated or threatened, encouraged or discouraged, happy or sad, depends to a large extent, on how we perceive these things. Strangely, most of this emotional stress that we experience is self-generated[1]. Emotional stress produces a variety of physiological responses in the body, mediated mostly through autonomic nervous system and hormones. A stress response classically produces increase in heart rate, respiratory rate, blood pressure, and overall metabolic rate, and thus increases the demand on cardio pulmonary system[2]. Although, physiologically, sympathetic activity produces broncho dilatation, the overall burden on the respiratory system outweighs this positive influence and finally precipitates deconditioning in patients with an already compromised cardiopulmonary system. On the contrary, a classic relaxation response, like the one produced after a deep meditation, lowers heart rate, respiratory rate, blood pressure and overall metabolic rate and thus lowers the baseline demand on the cardio pulmonary system [3].

Fundamentals of Meditation:

Meditation is defined as "inner observation in silence", which has got a positive influence on both mind and the body. For millennia, Raja yoga meditation has proved its efficacy in producing calmness and peace, improving emotional stability, managing chronic ailments, enhancing health status and quality of life. Integrating Rajayoga system as the core component, Patanjali described Ashtanga yoga system which has become the main source of many different methods of meditation/yoga available in the present times. Ashtanga yoga consists of eight steps, namely, Yama (self-restraint), Niyama (observance), Asana (postures), Pranayama (control of breathing), Pratyahara (abstraction), Dharana (concentration), Dhyana (meditation) and Samadhi (Super conscious state/ Living dead state) [4-6]. As it is not very easy for the common man of the current times to follow this method with all its rigorousness, many simplified methods have emerged with subtle modifications to suit the current lifestyles.eg Heartfulness Meditation, Transcendental meditation, Kundalini yoga, Sudarshan kriya yoga etc.

Most of these methods of meditation have four elements in common: a quiet vicinity with as few distractions as viable(Ashrams/Meditation centers); a selected, relaxed posture (mostly sitting); a focal point of attention (a word or set of words, an item, breath or the heart); and an open attitude (letting distractions come and move certainly without judging them).

In recent years, increasing inquest is being made on the efficacy of Raja yoga meditation on improving mental and physical health in both clinical and non-clinical settings.

The following definitions of 'Heartfulness' are provided by the Oxford Dictionary- The fact or quality of being heartfelt; sincerity or warmth of feeling or expression[7]. According to Hindu tradition and Sanskrit scriptures this concept can be defined as: "the realization of the inner self of its eternal connection with the higher self inside one's own heart and seeking its guidance from within- so as to be free from the burden of the results of one's own thoughts and actions." This produces a state of "Dependence on the guidance from within" - in all the aspects of day to day living resulting in a well-balanced thinking and approach to life[8]. It is the unregulated mind, which is the main culprit of all the mental stress and its associated ill effects on the person[9].

Respiratory dynamics- Stress vs Meditation:

In the state of emotional stress, sympathetic nervous system triggers the body's historic fight-or-flight response - making the respiration rapid and shallow and abdominal muscles become tight, as are other muscles of the body. A surge of hormones consisting of cortisol and epinephrine is setoff, which booms blood pressure and heart rate and raises the metabolic rate, increasing overall oxygen consumption and CO₂ production in the body. This increases demand on the pulmonary system to cope up with the body's elevated

metabolic demand in such situations. But in COPD patients, who already have a high airway resistance and a weak diaphragm, this rapid shallow breathing actually results in inadequate emptying of the lungs with a further increase in the demand on the subsequent breaths. This triggers a vicious cycle with increased work of breathing finally compromising the entire pulmonary system.

Meditation, on the other hand, produces a deep and relaxed state, where the respiration becomes slower and deeper, and all the muscles of the body are relaxed. There is a dominance of parasympathetic nervous system and a reduced metabolic rate [10]. This reduces the demand on the pulmonary system. Further, slow and deep respirations allow lungs to fill and empty completely. Lung capacity increases, work of breathing decreases and thus the quality of breathing improves in these patients.

Deep and slow respiration, by itself, directly creates a perception of calmness in thoughts and the body. It activates the parasympathetic nervous system, which reverses the stress reaction- by slowing the heart rate, reducing blood pressure and harmonizing the neuroendocrine activity [11]. Similarly, with deep breathing, the abdominal muscles and diaphragm work instead of the muscle of upper chest and neck. Additionally, it reduces tension on the muscles of the neck and upper chest allowing these muscles to loosen up, permitting an overall better oxygenation and ventilation [12].

Thus meditation improves the efficiency of respiratory apparatus by minimizing the workload and maximizing the productivity.

Effects of meditation on COPD patients:

COPD patients suffer mainly due to dyspnea and frequent attacks of air hunger. One of the most important factors that compromises quality of life in these patients is air hunger [13]. Whenever a COPD patient suffers anxiety/emotional stress, it triggers hyperventilation and a sensation of air hunger. Thus, these patients frequently have dyspnea and anxiety occurring together [14]. This is a bad combination as each one will eventually trigger the other culminating in a self-perpetuating vicious cycle that eventually compromises the pulmonary system. Anxiety disorders are more common in COPD patients compared to general population [15]. Anxiety has a negative impact on the symptomatology of COPD and on rehabilitation programs [16,17]. COPD patients suffering from anxiety, when practice meditation, show improvement in their mental acuity and actively engage in their self care activities of daily living and show improved compliance with rehabilitation programs [18-20].

Studies reveal that higher levels of anxiety and depression lead to isolation of COPD patients from their support systems increasing their risk of hospitalization and death [21, 22]. Meditation enhances wellbeing in COPD patients by reducing emotional stress, anxiety and depression and thus making these patients actively engage in rehabilitation programs [23, 24]. Recent research has shown that meditation improves the perception of interoceptive information [25] by lowering chemosensitivity to CO₂ and providing faster recovery after sensory processing, thus accurately assessing the respiratory load [26]. This improved mental acuity towards pulmonary system, ability to respond quickly to the changing ventilatory needs allows better participation and performance of COPD patients in self care management programs and activities of daily living [27, 28].

Acute exacerbations of COPD requiring hospitalization accounts for more than 75 % of total COPD treatment costs and plays an enormous burden on psychological and physical health of these patients [29, 30]. Failure to quit smoking, infections, poor adherence to treatment plans, episodes of anxiety and depression are some of the major factors contributing to the acute COPD exacerbations [31-33]. Meditation aids in treating tobacco dependence [34], improves immunity, controls anxiety and depression, promotes adherence to treatment plans and rehabilitation programs [35, 36], thus helps in reducing the frequency of exacerbations.

Regular practice of meditation has shown beneficial effects in patients with chronic inflammatory conditions like psoriasis [37], rheumatism [38], which can also have same beneficial effects on the chronic airway inflammation in COPD patients as well. Similarly, the enhancement of the immunity in regular meditators [39] may be applicable in preventing exacerbations in COPD patients as well, if they could practice meditation systematically.

Beneficial effects of meditation on the comorbidities commonly exist with COPD

Very often, COPD patients have multiple comorbidities like cardiovascular diseases, diabetes, osteoporosis, skeletal muscle dysfunction, malnutrition, depression, metabolic syndrome, lung cancer etc which also influence their quality of life [40]. Not uncommonly, exacerbation of symptoms in a stable COPD patient may be due to the worsening of a comorbid condition [41, 42]. 60% of mortality in COPD is attributed to these comorbidities rather than by COPD itself [43, 44]. More than 50 % of COPD patients have more than three comorbidities [45]. Research has revealed that, in COPD patients, there is an increased activity of pro inflammatory cytokines- especially Tumor Necrosis Factor-alpha (TNF- α), and there is increased endothelial inflammation which has been shown to aggravate the development of atherosclerosis, diabetes, muscle wasting and kidney disease [46-51]. COPD patients with more than three comorbidities are likely to die prematurely than those without any comorbidities [52]. Of all the comorbidities in these patients, anxiety and depression are difficult to diagnose and treat, because they often overlap with the COPD symptoms and cause a substantial burden on the disease management [53-56]. Meditation has been shown to control hypertension [57], reduce blood sugars [58] and cholesterol [59, 60], lowers the severity of anxiety and depression, thus renders a holistic regulation of all these factors and enhances the quality of life in COPD patients.

It is estimated that 21% of those with a primary COPD diagnosis have a coexisting Heart Failure [61] and 40% of people with a primary diagnosis of heart failure have COPD also [62]. COPD and Heart failure are the most important causes of mortality and morbidity worldwide [63-66]. Both these conditions are characterized by symptoms of anxiety, depression, difficulty in breathing and tiredness [67-70]. In patients with both Heart failure and COPD, symptoms are much more serious and worse [71]. These patients struggle to cope up with their disease conditions with uncertainty in prognosis, loss of hope, faith and self-image and get isolated from the family and support systems [72-75]. Meditation relieves stress, calms the sympathetic nervous system and engages the parasympathetic nervous system [76]. In addition, it improves the functioning of cardio vascular and pulmonary systems by lowering peripheral vascular resistance and reducing work load of breathing, respectively. Meditation boosts immune functions and reduces inflammation related with chronic inflammatory diseases [77]. Consequently, disease prognosis and quality of life improves [76].

Summary:

Research findings of multiple studies from different geographical locations show a positive outcome with meditation in COPD patients by regulating autonomic nervous system, by controlling anxiety, depression and emotional stress and by suppressing chronic inflammation. So far, the available data evaluating the efficacy of meditation in COPD patients is encouraging to recommend meditation as a complementary adjunct to medical therapy, as there are no side effects associated with it. By doing a regular practice of meditation, improvements in pulmonary functions were evidenced in COPD patients along with the improvements in tolerance levels of physical activity.

Limitations in most of the conducted studies were - small numbers of participants, high attrition rate and short duration of the study period.

This shows the need for a well designed study, looking at the different effects of meditation on improving the health status in COPD patients.

As it is, Rajayoga method is not very easy to be followed with all its rigorousness by the patients with cardiopulmonary limitations, explaining the high attrition rate. Simplified Rajayoga systems matching the current lifestyles, like the Heartfulness Meditation method, are easy and effective in improving regularity and adherence - to obtain maximum benefits.

ACKNOWLEDGEMENTS

We hereby acknowledge the management of Sree Balaji Medical college and Hospital for their immense support.

REFERENCES

- [1] Engert V, Smallwood J, Singer T. Mind your thoughts: associations between self-generated thoughts and stress-induced and baseline levels of cortisol and alpha-amylase. *Biol Psychol.* 2014 Dec;103:283-91
- [2] Crews DJ, and Landers DM. (1987). A meta-analytic review of aerobic fitness and reactivity to psychosocial stressors. *Med. Sci. Sports Exerc.* 9, S114–20.
- [3] Wallace RK, Benson H, Wilson AF. A wakeful hypo-metabolic physiological state. *Am J Physiol.* 1971;221:795–9.
- [4] Iyengar BKS: Light on Yoga. New York: Schocken Books;1966.
- [5] Feuerstein G: The Yoga Tradition. Prescott: Hohm Press;1998.
- [6] De Michaelis E: A History of Modern Yoga: Patanjali and Western Esotericism. London, UK: Continuum International Publishing Group;2005.
- [7] Dictionary OE. Oxford English Dictionary. The Library.2002.
- [8] Ram Chandra. Reality at dawn. Chapter VII–Constant Remembrance.1988.
- [9] Ram Chandra. Efficacy of Raja yoga in the light of Sahaj marg. Chapter III- Meditation. VOL.1.2014
- [10] Balaji PA, Smitha VR, Sadat AS. Effects of yoga pranayama practices on metabolic parameters and anthropometry in type 2 diabetes. *Int Multidiscip Res J.* 2011;1:1–4.
- [11] Bhavanani AB, Sanjay Z, Madanmohan Immediate effect of sukha pranayama on cardiovascular variables in patients of hypertension. *Int J Yoga Therap.* 2011;21:73–6.
- [12] Sharma and Rajeev. Pranayama for better life. Lotus Press. 2006
- [13] Williams M, Cafarella P, Olds T, Petkov J, Frith P. The language of breathlessness differentiates between patients with COPD and age-matched adults. *CHEST Journal.* 2008;134(3):489-96.
- [14] Stein MB. Neurobiology of generalized anxiety disorder. *The Journal of clinical psychiatry.* 2009;70(suppl 2):15-9.
- [15] Vögele C and von Leupoldt A. Mental disorders in chronic obstructive pulmonary disease (COPD). *Respiratory medicine.* 2008;102(5):764-73.
- [16] von Leupoldt A, Taube K, Henkhus M, Dahme B, Magnussen H. The impact of affective states on the perception of dyspnea in patients with chronic obstructive pulmonary disease. *Biological psychology.* 2010;84(1):129-34.
- [17] Giardino ND, Curtis JL, Abelson JL, King AP, Pamp B, Liberzon I, et al. The impact of panic disorder on interoception and dyspnea reports in chronic obstructive pulmonary disease. *Biological psychology.* 2010;84(1):142-6.
- [18] Kim YY, Choi JM, Kim SY, Park SK, Lee SH, Lee KH. Changes in EEG of children during brain respiration-training. *The American journal of Chinese medicine.* 2002;30(02n03):405-17.
- [19] Chan AS, Han YM, and Cheung MC. Electroencephalographic (EEG) measurements of mindfulness-based Triarchic body-pathway relaxation technique: a pilot study. *Applied Psychophysiology and Biofeedback.* 2008;33(1):39-47.
- [20] Lutz A, Greischar LL, Rawlings NB, Ricard M, Davidson RJ. Long-term meditators self-induce high-amplitude gamma synchrony during mental practice. *Proceedings of the National academy of Sciences of the United States of America.* 2004;101(46):16369-73.
- [21] Scherer M, Himmel W, Stanske B, Scherer F, Koschack J, Kochen MM, et al. Psychological distress in primary care patients with heart failure: a longitudinal study. *Br J Gen Pract.* 2007;57(543):801-7.
- [22] Chin MH and Goldman L. Correlates of early hospital readmission or death in patients with congestive heart failure. *The American journal of cardiology.* 1997;79(12):1640-4.
- [23] Gomes-Neto M, Rodrigues-Jr ES, Silva-Jr WM, Carvalho VO. Effects of yoga in patients with chronic heart failure: a meta-analysis. *Arquivos brasileiros de cardiologia.* 2014;103(5):433-9.
- [24] Liu XC, Pan L, Hu Q, Dong WP, Yan JH, Dong L. Effects of yoga training in patients with chronic obstructive pulmonary disease: a systematic review and meta-analysis. *Journal of thoracic disease.* 2014;6(6):795-802.
- [25] Slagter HA, Lutz A, Greischar LL, Nieuwenhuis S, Davidson RJ. Theta phase synchrony and conscious target perception: impact of intensive mental training. *Journal of Cognitive Neuroscience.* 2009;21(8):1536-49.
- [26] Daubenmier J, Sze J, Kerr CE, Kemeny ME, Mehling W. Follow your breath: respiratory interoceptive accuracy in experienced meditators. *Psychophysiology.* 2013;50(8):777-89.
- [27] Spicuzza L, Gabutti A, Porta C, Montano N, Bernardi L. Yoga and chemoreflex response to hypoxia and hypercapnia. *The Lancet.* 2000;356(9240):1495-6.

- [28] Wolkove N, Kreisman H, Darragh D, Cohen C, Frank H. Effect of transcendental meditation on breathing and respiratory control. *Journal of Applied Physiology*. 1984;56(3):607-12.
- [29] Celli BR, MacNee W, ATS/ERS Task Force. Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper. *Eur Respir J*. 2004;23:932-46.
- [30] Toy EL, Gallagher KF, Stanley EL, Swensen AR, Duh MS. The economic impact of exacerbations of chronic obstructive pulmonary disease and exacerbation definition: a review. *COPD*. 2010;7:214-28.
- [31] Burgess A, Kunik ME, Stanley MA. Chronic obstructive pulmonary disease: assessing and treating psychological issues in patients with COPD. *Geriatrics*. 2005;60:18-21.
- [32] Yohannes AM, Baldwin RC, Connolly MJ. Depression and anxiety in elderly outpatients with chronic obstructive pulmonary disease: Prevalence, and validation of the BASDEC screening questionnaire. *Int J Geriatr Psychiatry*. 2000;15:1090-6.
- [33] Peveler R, Carson A, Rodin G. ABC of psychological medicine: depression in medical patients. *BMJ*. 2002;325:149-52.
- [34] Alexander CN, Robinson P, Rainforth M. Treating and preventing alcohol, nicotine, and drug abuse through Transcendental Meditation: A review and statistical meta-analysis. *Alcoholism Treatment Quarterly*. 1994;11(1-2):13-87.
- [35] Brown RP, Gerbarg PL. Sudarshan Kriya yogic breathing in the treatment of stress, anxiety, and depression: part I-neurophysiologic model. *J. Altern. Complement. Med*. 2005;11:189-201.
- [36] Brown RP, Gerbarg PL. Yoga breathing, meditation, and longevity. *Ann. N. Y. Acad. Sci*. 2009;1172:54-62.
- [37] Astin JA, Beckner W, Soeken K, Hochberg MC, Berman B. Psychological interventions for rheumatoid arthritis: A meta-analysis of randomized controlled trials. *Arthritis Care Res*. 2002;47:291-302.
- [38] Gaston L, Crombez JC, Joly J, Shielagh J, Marc D. Efficacy of imagery and meditation techniques in treating psoriasis. *Imagination Cognition Personality*. 1988;8(1):25-38
- [39] Creswell JD, Irwin MR, Burklund, L J, Lieberman MD, Arevalo JMG, Ma J, et al., Mindfulness-based stress reduction training reduces loneliness and pro-inflammatory gene expression in older adults: a small randomized controlled trial. *Brain, behavior, and immunity*. 2012;26(7):1095-101
- [40] Global Initiative for Chronic Obstructive Lung Disease. *Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease*. 2016.
- [41] Le Jemtel TH, Padeletti M, Jelic S. Diagnostic and therapeutic challenges in patients with coexistent chronic obstructive pulmonary disease and chronic heart failure. *Am J Coll Cardiol*. 2007;49(2):171-80.
- [42] Rutten FH, Cramer MJ, Lammers JW, Grobbee DE, Hoes AW. Heart failure and chronic obstructive pulmonary disease: an ignored combination? *Eur J Heart Fail*. 2006;8(7):707-11.
- [43] Berry CE, Wise RA. Mortality in COPD: causes, risk factors, and prevention. *COPD*. 2010;7(5):375-82.
- [44] McGarvey LP, John M, Anderson JA, Zvarich M, Wise RA; TORCH Clinical Endpoint Committee. Ascertainment of cause-specific mortality in COPD: operations of the TORCH clinical endpoint committee. *Thorax*. 2007;62(5):411-5.
- [45] Vanfleteren LE, Spruit MA, Groenen M, Gaffron S, van Empel VP, Bruijnzeel PL et al. Clusters of comorbidities based on validated objective measurements and systemic inflammation in patients with chronic obstructive pulmonary disease. *Am J Respir Crit Care Med*. 2013;187:728-35.
- [46] Barnes PJ. Cellular and molecular mechanisms of chronic obstructive pulmonary disease. *Clin Chest Med*. 2014;35(1):71-86.
- [47] Comer DM, Kidney JC, Ennis M, Elborn JS. Airway epithelial cell apoptosis and inflammation in COPD, smokers and nonsmokers. *Eur Respir J*. 2013;41(5):1058-67.
- [48] Kryvenko V. Biomarkers of systemic inflammation, oxidative stress and their interactions in patients with combined flow of chronic obstructive pulmonary disease and arterial hypertension. *Georgian Med*. 2013;216:23-8.
- [49] Miller J, Edwards LD, Agusti A, Bakke P, Calverley PM, Celli B, et al. Comorbidity, systemic inflammation and outcomes in the ECLIPSE cohort. *Respir Med*. 2013;107(9):1376-84
- [50] Barnes PJ. The cytokine network in chronic obstructive pulmonary disease. *Am J Respir Cell Mol Biol*. 2009;41:631-8.
- [51] Pinto-Plata VM, Mullerova H, Toso JF, Feudjo-Tepie M, Soriano JB, Vessey RS, et al. C-reactive protein in patients with COPD, control smokers and non-smokers. *Thorax*. 2006;61:23-8.
- [52] Sode BF, Dahl M, Nordestgaard BG. Myocardial infarction and other comorbidities with chronic obstructive pulmonary disease: a Danish Nationwide study of 7.4 million individuals. *European Heart Journal*. 2011;32:2365-75.

- [53] Yohannes AM, Willgoss TG, Baldwin RC, Connolly MJ. Depression and anxiety in chronic heart failure and chronic obstructive pulmonary disease: prevalence, relevance, clinical implication and management principles. *Int J Geriatr Psychiatry*. 2010;25:1209–21.
- [54] Doyle T, Palmer S, Johnson J, Babyak MA, Smith P, Mabe S. Association of anxiety and depression with pulmonary-specific symptoms in chronic obstructive pulmonary disease. *Int J Psychiatry in Medicine*. 2013;45(2):189–202.
- [55] Dalal AA, Shah M, Lunacsek O, Hanania NA. Clinical and economic burden of depression/anxiety in chronic obstructive pulmonary disease patients within a managed care population. *COPD*. 2011;8(4):293–9.
- [56] Willgoss TG, Yohannes AM. Anxiety disorders in patients with COPD: A systematic review. *Respir Care*. 2013;58:858–66.
- [57] Murugesan R, Govindarajalu N, Bera TK. Effect of selected yogic practices in the management of hypertension. *Indian J Physiol Pharmacol*. 2000;44:207–10.
- [58] Jain SC, Talukdar B. Role of yoga in middle aged patients of noninsulin dependent diabetes mellitus. *Indian J Clin Biochem*. 1995;10:62–5.
- [59] Singh S, Kyizom T, Singh KP, Tandon OP, Madhu SV. Influence of pranayamas and yogaasanas on serum insulin, blood glucose and lipid profile in type 2 diabetes. *Indian J Clin Biochem*. 2008;23:365–8.
- [60] Bijlani RL, Vempati RP, Yadav RK, Ray KB, Gupta V, Sharma R, et al. A brief but comprehensive lifestyle education program based on yoga reduces risk factors for cardiovascular disease and diabetes mellitus. *J Altern Complement Med*. 2005;11:267–74.
- [61] Rutten FH, Cramer MJ, Grobbee DE, Sachs AP, Kirkels JH, Lammers JW, et al. Unrecognized heart failure in elderly patients with stable chronic obstructive pulmonary disease. *European heart journal*. 2005;26(18):1887-94.
- [62] Mascarenhas J, Lourenço P, Lopes R, Azevedo A, Bettencourt P. Chronic obstructive pulmonary disease in heart failure. Prevalence, therapeutic and prognostic implications. *American heart journal*. 2008;155(3):521-5.
- [63] Cowie MR, Wood DA, Coats AJ, Thompson SG, Suresh V, Poole-Wilson PA, et al. Survival of patients with a new diagnosis of heart failure: a population based study. *Heart*. 2000;83(5):505-10.
- [64] Mosterd A and Hoes AW. Clinical epidemiology of heart failure. *Heart*. 2007;93(9):1137-46.
- [65] Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJ. Global and regional burden of disease and risk factors, 2001: systematic analysis of population health data. *The Lancet*. 2006;367(9524):1747-57.
- [66] Holguin F, Folch E, Redd SC, Mannino DM. Comorbidity and mortality in COPD-related hospitalizations in the United States, 1979 to 2001. *Chest Journal*. 2005;128(4).
- [67] Haworth J, Moniz-Cook E, Clark AL, Wang M, Waddington R, Cleland JG. Prevalence and predictors of anxiety and depression in a sample of chronic heart failure patients with left ventricular systolic dysfunction. *European journal of heart failure*. 2005;7(5):803-8.
- [68] Solano JP, Gomes B and Higginson IJ. A comparison of symptom prevalence in far advanced cancer, AIDS, heart disease, chronic obstructive pulmonary disease and renal disease. *Journal of pain and symptom management*. 2006;31(1):58-69.
- [69] Zambroski CH, Moser DK, Bhat G, Ziegler C. Impact of symptom prevalence and symptom burden on quality of life in patients with heart failure. *European Journal of Cardiovascular Nursing*. 2005;4(3):198-206.
- [70] Müllerová H, Lu C, Li H, Tabberer M. Prevalence and burden of breathlessness in patients with chronic obstructive pulmonary disease managed in primary care. *PloS one*. 2014;9(1):e85540.
- [71] Hawkins NM, S. Virani and C. Ceconi. Heart failure and chronic obstructive pulmonary disease: the challenges facing physicians and health services. *European heart journal*. 2013;34(36):2795-807.
- [72] Murray SA, Kendall M, Boyd K, Worth A, Benton TF. Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers. *Palliative medicine*. 2004;18(1):39-45.
- [73] Pinnock H, Kendall M, Murray SA, Worth A, Levack P, Porter M et al. Living and dying with severe chronic obstructive pulmonary disease: multi-perspective longitudinal qualitative study. *Bmj*. 2011;342:d142.
- [74] Selman L, Beynon T, Higginson IJ, Harding R. Psychological, social and spiritual distress at the end of life in heart failure patients. *Current Opinion in Supportive and Palliative Care*. 2007;1(4):260-6.
- [75] Selman L, Harding R, Beynon T, Hodson F, Coady E, Hazeldine C, et al. Improving end-of-life care for patients with chronic heart failure: "Let's hope it'll get better, when I know in my heart of hearts it won't". *Heart*. 2007;93(8):963-7.



- [76] Acton M. Eternal spring: taijiquan, Qi gong, and the cultivation of health, happiness and longevity. 2009: Singing Dragon.
- [77] Yadav RK, Magan D, Mehta N, Sharma R, Mahapatra SC. Efficacy of a short-term yoga-based lifestyle intervention in reducing stress and inflammation: preliminary results. J Altern Complement Med. 2012;18: 662-7