Reviewer's report

Title: Interstitial Lung Diseases In The Hospitalized Patient

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Reviewer: Katerina Antoniou

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I have read with interest this article dealing with the management of hospitalized ILD patients. It contains a lot of useful information but I think that it is written in a way that does not provide useful guidance to the readers.

General comment

The text should be subdivided according to the ILDs (for instance, IPF, CTD-ILDs (teasing out the characteristic of the most frequent forms), COP etc) and try to ask the questions they have put for each one of these entities. It would be nice to read their opinion in the cases where guidelines or trials do not exist regarding the management of these entities as they come from a well known referral center. Finally the authors should comment quite extensively on the presence of comorbidities which can be a frequent cause of hospitalization of ILD patients. Acute pulmonary embolism, left heart disease, ischemic heart disease, arrhythmias due to hypoxemia.

Specific comment

Background, 2nd para: ‘Recently, a multidisciplinary panel of American Thoracic Society/European Respiratory Society (ATS/ERS) members published a revised classification of ILDs based on their clinical, radiologic, and histopathologic findings (1, 2).’

Ref number 1 does not fit with the sentence (they talk about the consensus). Please rephrase

Background, 3rd para: Not all CTD-ILDs present acutely. Please be more specific.

Acute manifestation: ‘Summarized below are clinical manifestations of ILDs that most commonly require hospitalization.’

I think the sentence is misleading. What follows describes different clinical entities with their own clinical manifestation. Please rephrase

IPF and acute exacerbations: ‘Radiographically, a high resolution computed tomography (HRCT) of the chest in an IPF patient reveals bilateral subpleural reticulation, traction bronchiectasis, an absence of ground glass opacities and subpleural honeycombing.’

Absence of GGOs is not the only finding inconsistent with UIP/IPF pattern. The sentence is misleading. Please rephrase according to the 2011 statement
published in AJRCCM and add the respective ref.

IPF and acute exacerbations: ‘Patients may be hospitalized at the time IPF is first recognized, often when the patient has an intercurrent infection, or may suffer an acute exacerbation of their disease (AE-IPF).’

It is not always possible to distinguish infection from AEIPF and if it was would that make any difference? Please comment and refer to Huie TJ, et al. Respirology. 2010;15:909-17.

IPF and acute exacerbations: ‘AE-IPF is characterized by acute worsening of respiratory symptoms, typically over several weeks, accompanied by new lung opacities on chest imaging(11). The characteristic HRCT of the chests hows new ground glass opacities with or without consolidation overlying the typical radiographic changes of IPF (11).’

I believe that the definition of AEIPF should be corrected as well as the ref. One of the authors is also the first author of the statement of AEIPF published in 2007 in AJRRRCM. Please rephrase.

Connective tissue disease-associated ILDs (CTD-ILD): ‘NSIP and UIP are the most common radiologic and histopathologic patterns found in patients with CTD.’

Please be more specific. In which CTD UIP and NSIP is more predominant and add that OP is the most predominant in antisynthetase syndrome. Please rephrase and add refs.

Cryptogenic organizing pneumonia (COP): ‘Pathological predictors of unfavorable outcome are co-existent lung fibrosis, which suggest the organizing pneumonia is not present in isolation (21).’

The meaning of the sentence is not clear. Please rephrase. Please comment also for the presence of perilobular pattern in HRCT which is characteristic of OP. Add refs.

What is the Role of Bronchoscopy? The role of BAL is not clear. Does it add in terms of diagnosis and treatment? Please discuss the role in AEIPF and in AECTD-ILD (rule out/ confirm infection or AECTD-ILD and treat accordingly)

What pharmacologic treatments should be administered? ‘Nevertheless, clinical experience suggests that patients with specific interstitial lung diseases improve with corticosteroid treatment. ILDs that appear to be steroid responsive are COP, AEP, some cases of connective tissue disease-associated interstitial lung disease and drug induced ILDs.’

Please be more precise. In SSc-ILD it is not recommended to use high doses of steroids. Therefore the sentence may be misleading for non experts in the field.
What pharmacologic treatments should be administered? ‘The use of cytotoxic medications should be carefully considered in these patients, especially given data showing that corticosteroids and azathioprine are associated with worse outcomes in IPF patients or patients with other forms of DAD(40).’

Cytotoxic agents are definitely not recommended in the treatment of IPF and AEIPF and their use should not be carefully considered as stated. In few cases iv steroids could be used but most of times without effect. Please comment on the use of broad spectrum antibiotics in patients with acute deterioration of IPF.

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.