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EDITORIAL

Hypersensitivity pneumonitis: Need for a better diagnostic evaluation

To the Editor

Given the variable prevalence of Hypersensitivity Pneumonitis (HP) across the world and the absence of widely accepted criteria for the definition of acute, subacute and chronic forms, characterization of different HP phenotypes is serious and a better classification of the disease stages is desirable, together with a better correlation of radiological and pathological features, to provide an adequate implementation of diagnostic and therapeutic approach.

Santos et al. retrospectively assessed clinical and diagnostic data of a cohort of HP patients from the North of Portugal.[1] 73,7% of patients had chronic form, agreeing with the literature data; in fact, the majority of patients with hypersensitivity pneumonitis who present to specialist centers have the chronic fibrotic form of the disease.[2] Chronic HP is characterized by a varied outcome and an accelerated rate of progression may be observed in a proportion of patients, similar to Idiopathic Pulmonary Fibrosis (IPF).[2] 12,9% of patients observed by Santos et al. had undetermined exposure and there was a significant association between chronic presentation and those patients with undetermined exposure. When a specific exposure cannot be clearly identified, differentiation of chronic HP can become more challenging; on the other hand, specific IgG signal merely reflects antigen exposure and a multidisciplinary diagnosis of chronic HP may not be associated with an improved outcome over patients diagnosed with IPF, as if they were the same disease.

Furthermore, in chronic HP sub-group, patients had most frequently ground glass, reticulation and honey combing patterns, while no differences were found regarding mosaic pattern and emphysema. It is worth pointing out this result as we know from the literature that computed tomography (CT) predictors of mortality in chronic HP includes reticular pattern, honeycombing and traction bronchiectasis; whereas mosaic attenuation (although the headcheese sign may be highly specific and moderately sensitive for a high-confidence diagnosis of fibrotic HP) is usually not predictive of outcome.[2] Chronic HP patients with more extensive fibrosis may progress to death with an IPF-like disease course.[2,3]

Finally, in an era in which the multidisciplinary team diagnosis is the accepted diagnostic standard, the number of patients with diffuse parenchymal lung diseases (DPLDs) undergoing lung biopsy is inevitably reduced as invasive complementary diagnostic tests are reserved only for cases in which the multidisciplinary evaluation is not enough to conclude a definitive diagnosis. In Santos's series, 29,2% of patients needed to perform histological analysis and a significant number of patients undergoing lung biopsy had chronic HP (for which differential diagnosis is considerably more challenging).[1] More than a third of lung biopsies were obtained by transbronchial lung cryobiopsy (TBLC); although additional research is needed to enhance knowledge regarding the role of TBLC in the diagnostic algorithm of chronic HP,[4] the recent Chest guidelines have further confirmed that TBLC contribution to the diagnosis of DPLDs obtained via multidisciplinary discussion appears to be good at least in experienced centers.[5]

In conclusion, Santos et al.[1] confirms the need for a more precise and complex diagnostic evaluation for hypersensitivity pneumonitis, especially the chronic fibrotic form, due to the differential diagnosis between this form and other fibrotic interstitial pneumonias with poor prognosis.

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