

Acute Exacerbation of Idiopathic Pulmonary Fibrosis An International Working Group Report

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Abstract

Acute exacerbation of idiopathic pulmonary fibrosis has been defined as an acute, clinically significant, respiratory deterioration of unidentifiable cause. The objective of this international working group report on acute exacerbation of idiopathic pulmonary fibrosis was to provide a comprehensive update on the topic. A literature review was conducted to identify all relevant English text publications and abstracts. Evidence-based updates on the epidemiology, etiology, risk factors, prognosis, and management of acute exacerbations of

idiopathic pulmonary fibrosis are provided. Finally, to better reflect the current state of knowledge and improve the feasibility of future research into its etiology and treatment, the working group proposes a new conceptual framework for acute respiratory deterioration in idiopathic pulmonary fibrosis and a revised definition and diagnostic criteria for acute exacerbation of idiopathic pulmonary fibrosis.

Keywords: pulmonary fibrosis; acute exacerbation; review; diagnosis; management

Acute exacerbation of idiopathic pulmonary fibrosis (IPF) has been defined as an acute, clinically significant respiratory deterioration of unidentifiable cause (1). In 2007, the National Institutes of Health–sponsored IPF

Clinical Trials Network (IPFnet) published a pulmonary perspective describing the clinical, radiological, and histopathological presentation of acute exacerbation of IPF and proposing diagnostic criteria built on

the previous literature in the field (2). These criteria included a clinical worsening of less than 30 days' duration, the presence of new radiologic abnormality on high-resolution computed tomography (CT)

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(i.e., bilateral ground-glass opacification/consolidation), and the exclusion of alternative etiologies (e.g., infection, heart failure, pulmonary embolism).

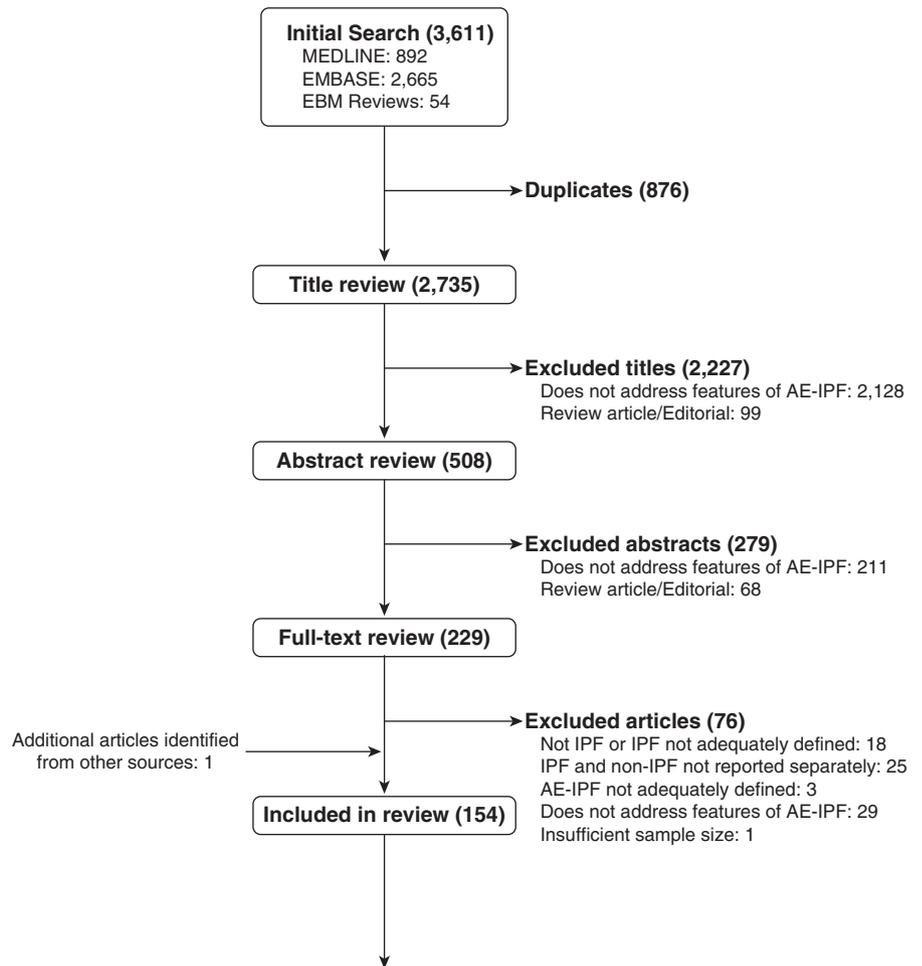
It was hoped that the 2007 IPFnet perspective would help standardize inclusion criteria for future research studies of acute exacerbation of IPF and that these criteria would be revised and modified as additional insight into acute exacerbation of IPF was achieved. Indeed, in the years since their publication, many clinical scientists and sponsors adopted the IPFnet criteria for the study of acute exacerbation of IPF, and there has been a substantial increase in the evidence base.

The objective of this international working group report is to provide a comprehensive update on acute exacerbation of IPF, systematically reviewing the literature, in particular literature published since the 2007 IPFnet perspective. It also presents a revised conceptual framework and definition for acute exacerbation of IPF that the authors believe more accurately reflects the current state of knowledge in the field.

Methods

An international multidisciplinary working group was assembled by the first and last author (H.R.C. and F.J.M.), which included 21 pulmonologists, 3 radiologists, and 2 pathologists. Initial meetings were held by teleconference and were focused on developing an updated conceptual framework and definition for acute exacerbation of IPF. A face-to-face meeting was held to finalize this aspect of the report.

In parallel, an evidence-based medicine subcommittee (H.R.C., C.J.R., T.J.C., G.J., Y.K., D.J.L., J.S.L., T.M.M., and A.U.W.) conducted a literature review to identify all English text publications and abstracts relevant to acute exacerbation of IPF (Figure 1). MEDLINE, EMBASE, and All EBM Reviews databases were searched from database inception until February 14, 2016, with a total of 2,735 unique citations identified. Publications were screened in duplicate, with a total of 154 citations meeting eligibility criteria. Details of the search strategy and literature review methodology are provided in the online supplement.



Etiology	Epidemiology	Diagnosis	Prediction	Prognosis	Management
Full text: 42 Abstract: 14	Full text: 16 Abstract: 7	Full text: 26 Abstract: 6	Full text: 16 Abstract: 10	Full text: 40 Abstract: 17	Full text: 37 Abstract: 14

Figure 1. Systematic review search strategy and results. The initial search of Medline, EMBASE, and EBM reviews yielded 3,611 citations (articles and abstracts), of which 2,735 were unique. In sequence, these citations underwent title review, abstract review, and full-text review to exclude articles that were not related to acute exacerbation of idiopathic pulmonary fibrosis (AE-IPF) or met other exclusion criteria. This yielded 154 final citations that were included in the systematic review.

The working group was divided into writing groups on the basis of content expertise. Each group was chaired by an evidence-based medicine subcommittee member and was tasked with developing a section of the document using the evidence-based summaries and individual member knowledge of the field. Three authors (H.R.C., C.J.R., and F.J.M.) merged and edited these content drafts to produce a full draft report, which was reviewed and revised by all working group members. The final document was reviewed and approved by all members prior to submission.

Evidence Review

The following sections of the report provide evidence-based updates on the epidemiology, etiology, risk factors, prognosis, and management of acute exacerbations of IPF generated after review of the literature as described above. Summary tables of relevant articles and their abstracted findings are provided in Tables E1 and E2 in the online supplement.

Epidemiology

Clinical trials published over the last decade have reported variable incidence rates for

acute exacerbation of IPF, likely due to differences in study populations (e.g., disease severity), definition of acute exacerbation used, and statistical methodology (Table 1) (3). A recent metaanalysis of six clinical trials in patients with IPF revealed a weighted average of 4.1 acute exacerbations per 100 patient-years (4). One major limitation of clinical trial-based incidence estimates may be missed events due to missing/unavailable clinical data. For example, in the STEP-IPF (Sildenafil Trial of Exercise Performance in Idiopathic Pulmonary Fibrosis) trial, a *post hoc* analysis of respiratory events demonstrated an incidence of acute exacerbation of IPF of only 4.0 per 100 patient-years when strict adherence to the 2007 criteria was required (5). The incidence increased to 20.0 per 100 patient-years when patients with definite and suspected acute exacerbations (events in which the diagnosis of acute exacerbation seemed plausible but could not be confirmed due to missing clinical information) were both included.

Cohort studies have generally reported a higher incidence of acute exacerbation of IPF than clinical trials (6–11). A registry-based U.S. study reported an annual incidence of 13.0 per 100 IPF patient-years (12); a Korean cohort study reported 1- and 3-year incidences of 14.2 and 20.7%, respectively (13); and a Japanese cohort study reported 1-, 2-, and 3-year incidences of 8.6, 12.6, and 23.9%, respectively (14). A limitation of cohort studies is potential overreporting of events due to misclassification of respiratory deteriorations of known cause as acute exacerbations. For example, in the INPULSIS program, where 7.6% of patients receiving placebo had an investigator-reported acute exacerbation of IPF over 1 year, only 10% of these events fulfilled all of the IPFnet criteria on central adjudication (15). In the three IPFnet trials, only 33% of investigator-reported acute exacerbations met criteria on central adjudication (16).

Etiology

The etiology of acute exacerbation of IPF remains uncertain (Figure 2). A central question posed by the 2007 IPFnet perspective was whether acute exacerbation of IPF represents an intrinsic acceleration of the underlying fibrotic condition or a response to occult external events (e.g., infection) leading to acute lung injury (ALI) and histopathological diffuse alveolar damage.

In addressing this question, it is useful to consider acute exacerbation of IPF in the context of what is known about the etiology of ALI. ALI and acute exacerbation of IPF share many clinical features, including increased oxygen requirements, new bilateral radiologic abnormalities (ground-glass opacification/consolidation), and the presence of diffuse alveolar damage histologically (17, 18). Indeed, occasional cases diagnosed as ALI using clinical and radiologic evaluation were found to represent acute exacerbation of IPF when the lung tissue was examined histologically

Table 1. Selected Publications Reporting Incidence of Acute Exacerbation of Idiopathic Pulmonary Fibrosis

Study	No. of Patients	Criteria*	Incidence of Acute Exacerbation
Incidence from placebo arms of randomized clinical trials			
Collard <i>et al.</i> , 2013 (5)	180	IPFnet	4 events/100 patient-years; 16 events/100 patient-years for suspected exacerbations (placebo arms)
Richeldi <i>et al.</i> , 2011 (75)	432	Akira	15.7 events/100 patient-years (placebo arm)
Richeldi <i>et al.</i> , 2014 (15)	1,066	IPFnet	7.6% incidence over 52 wk (placebo arm)
Taniguchi <i>et al.</i> , 2010 (47)	267	Taniguchi and Kondoh	4.8% incidence over 52 wk (placebo arm)
Incidence from cohort studies			
Fernández Pérez <i>et al.</i> , 2010 (12)	37	Mixed	13 events/100 patient-years
Kim <i>et al.</i> , 2006 (7)	147	Kondoh	8.5% incidence at 1 yr; 9.6% incidence at 2 yr
Kishaba <i>et al.</i> , 2014 (43)	594	Kishaba	9.8% incidence over 10 yr of follow up
Kondoh <i>et al.</i> , 2010 (14)	74	Taniguchi and Kondoh	8.6% incidence at 1 yr; 12.6% incidence at 2 yr; 23.9% incidence at 3 yr
Johansson <i>et al.</i> , 2014 (6)	436	IPFnet	5.2 events/100 patient-years
Mura <i>et al.</i> , 2012 (8)	83	Akira	18.6% incidence at 3 yr
Ohshimo <i>et al.</i> , 2014 (9)	77	IPFnet	7% incidence at 1 yr
Schupp <i>et al.</i> , 2015 (10)	71	IPFnet	23% incidence at 2 yr
Song <i>et al.</i> , 2011 (13)	461	IPFnet	14.2% incidence at 1 yr; 20.7% incidence at 3 yr
Sugino <i>et al.</i> , 2015 (11)	64	IPFnet	28% incidence at 3 yr; 43% incidence at 5 yr
Tomassetti <i>et al.</i> , 2013 (53)	122	IPFnet	19% incidence over median follow up of 2.5 yr

Definition of abbreviations: HRCT = high-resolution computed tomography; IPF = idiopathic pulmonary fibrosis; IPFnet = Idiopathic Pulmonary Fibrosis Clinical Trials Network.

*Where specified, studies used definitions for acute exacerbation on the basis of the following: IPFnet: (1) previous or concurrent diagnosis of IPF, (2) unexplained worsening or development of dyspnea within 30 d, (3) HRCT with new bilateral ground-glass opacification/consolidation, (4) no evidence of pulmonary infection by endotracheal aspirate or bronchoalveolar lavage, (5) exclusion of alternative causes. Akira: (1) progression of dyspnea over several days to 4 weeks, (2) new parenchymal ground-glass abnormalities on X-ray or HRCT, (3) decrease in PaO₂ ≥ 10 mm Hg or increase in alveolar-arterial oxygen gradient within a 1-month period that could not be otherwise explained. Taniguchi and Kondoh: (1) worsening dyspnea duration < 1 month; (2) new ground-glass opacities on HRCT in addition to previous honeycomb lesions; (3) PaO₂ is 10 mm Hg or more reduced from previous value; (4) obvious causes, such as infection, pneumothorax, cancer, pulmonary embolism, or congestive heart failure are absent. Kondoh: (1) worsening dyspnea duration < 1 month, (2) hypoxemia with a PaO₂/F_iO₂ of <225, (3) newly developed pulmonary infiltrates on chest radiography, (4) absence of apparent infection or heart disease. Kishaba: (1) worsening dyspnea duration < 30 d, (2) new bilateral infiltration accompanying known IPF or evidence of honeycombing on HRCT (all patients also had negative bronchoalveolar lavage, no echocardiographic evidence of heart failure, and no pulmonary embolism).

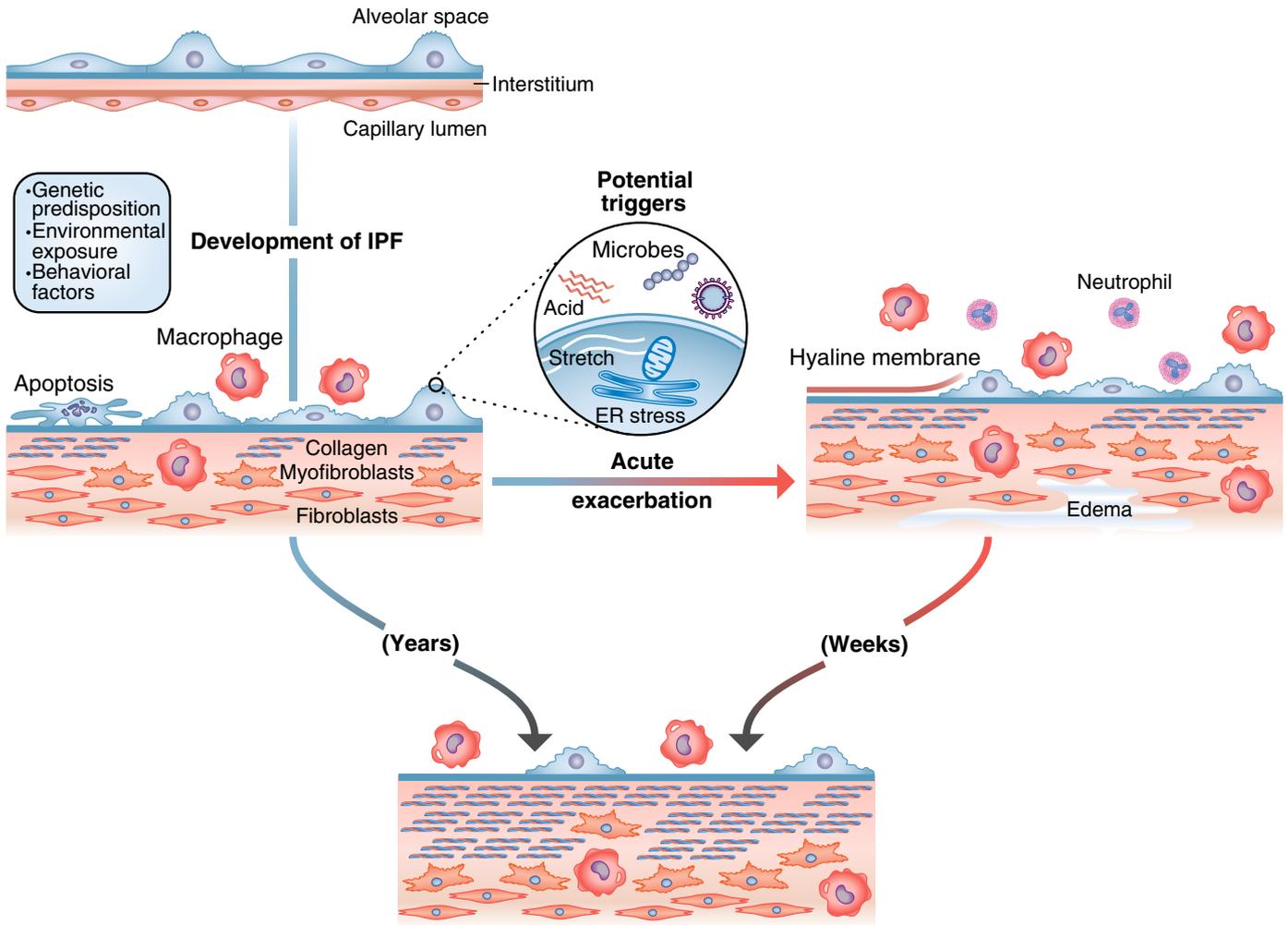


Figure 2. Pathobiological paradigm for acute exacerbation of idiopathic pulmonary fibrosis (IPF). Evidence suggests that the pathobiology of acute exacerbation of IPF involves both chronic factors (e.g., underlying epithelial cell dysfunction and fibroblast accumulation and activation) and acute factors (e.g., acute stress and acute lung injury). In IPF, a combination of genetic, environmental, and behavioral factors are believed to contribute to the development of a fibrotic phenotype characterized by extracellular matrix deposition, parenchymal scar formation, and lung remodeling. Acute exacerbation of IPF is most likely triggered by an acute event (e.g., infection, microaspiration, or mechanical stretch) that leads to widespread acute lung injury (characterized in the early stages by hyaline membrane formation and interstitial edema). Acute exacerbation of IPF may also precipitate acceleration of the underlying chronic factors contributing to the fibrotic process. ER = endoplasmic reticulum.

(19). The causes of ALI are extensive and include infection, aspiration, drugs, massive transfusion, and surgery (20). A sizable body of literature now suggests many of these same conditions may lead to events that are indistinguishable from idiopathic acute exacerbations of IPF (6, 10, 13, 21–34). Therefore, the question is not whether an external insult such as infection or aspiration can cause an acute exacerbation of IPF but whether this is the unrecognized explanation for the majority of events that occur.

Evidence of respiratory viral infection in acute exacerbation of IPF has been detected by pan-viral arrays and multiplex

polymerase chain reaction, with respiratory viral RNA present in a minority of patients (32–36). Assessment of post mortem samples from patients who died from acute exacerbation of IPF has also identified evidence of occult respiratory infection in some (26, 28) but not all (37) cohorts. Epidemiological support for an infectious etiology comes from studies demonstrating that acute exacerbation of IPF was significantly more common in the winter and spring months (5, 29) and in patients who are taking immunosuppressive medications (5, 6, 38).

Indirect evidence relating microaspiration to acute exacerbation of IPF comes

from a post hoc analysis of the placebo arms from three clinical trials, showing that acute exacerbation of IPF occurred only in those subjects not on anti-acid therapy (23). This was presumably due to anti-acid therapy reducing the potential for microaspiration-related lung injury. Also supporting this hypothesis are a small case-control study demonstrating elevated pepsin levels in the bronchoalveolar lavage of patients experiencing acute exacerbation of IPF (24) and a small cohort study describing an increased prevalence of gastroesophageal reflux in patients who experienced acute exacerbation of IPF (31).

As mentioned previously, the pathobiology of acute exacerbation of IPF may be related to **intrinsic** biological **dysfunction** of the lung that makes individuals with **IPF** **more susceptible** to **external** insults than individuals without IPF. Indirect evidence for this concept comes from comparing outcomes of thoracic surgery in patients with and without IPF. Retrospective studies have looked at the development of acute respiratory deterioration after lung cancer resection in patients with IPF, suggesting an incidence ranging from 7 to 32% (25, 30, 39, 40). Acute exacerbation has also been reported in patients with **IPF after surgical lung biopsy and bronchoscopy** (21, 22, 27, 41, 42). These data suggest that the **IPF lung is uniquely vulnerable to the stress of thoracic surgery** (either due to the surgical procedure or ventilator-induced barotrauma, volutrauma, or hyperoxia), supporting an intrinsic pathobiological contribution.

Risk Factors

Acute exacerbation of IPF is more common in patients with physiologically and functionally advanced disease. **Low FVC has proven the most consistent risk factor** for acute **exacerbation of IPF** (5, 6, 9, 10, 13, 14, 43). Other physiologic parameters have been associated with increased risk, including **low diffusing capacity for carbon monoxide (DL_{CO})** (5, 8, 10, 13, 43), **low 6-minute-walk distance** (5), **pulmonary hypertension** (44), **poor baseline oxygenation** (5, 45), **increased dyspnea** (5, 14), and recent decline in FVC (14, 45, 46). Whether patients with more advanced IPF are more susceptible to acute exacerbation or are simply more likely to require unscheduled medical care as a result of an acute exacerbation (and therefore be diagnosed) is unknown.

Additional candidate **risk factors** for **acute exacerbation** of IPF include younger age (10), comorbid coronary artery disease (5), and **higher body mass index** (14). The data on smoking and coexisting emphysema as risk factors for acute exacerbation of IPF are discordant (8, 9, 11, 13). A prior history of acute exacerbation has also been associated with increased risk (6, 46). Finally, elevated serum level of Krebs von Lungen-6 (KL-6) at baseline has been associated with increased risk for acute exacerbation of IPF, after adjustment for clinical features including vital capacity (9). Although there

has been discussion over the last decade of a possible increased risk of acute exacerbation in patients from East Asian countries, the evidence from randomized, controlled clinical trials does not support this claim (15, 47).

Prognosis

The prognostic implications of an acute exacerbation of IPF are profound. The available data suggest that **up to 46% of deaths in IPF are preceded by an acute exacerbation** (14, 48, 49), and the **median survival** of patients with IPF who experience an **acute exacerbation** is approximately **3 to 4 months** (5, 13). Respiratory failure from acute exacerbation of IPF is associated with high in-hospital mortality—in most case series upward of 50% (7, 13, 32, 43, 50–54). Limited data suggest that patients with both **acute exacerbation** of IPF and **suspected acute exacerbation** of IPF have a **similar prognosis** (5, 36).

Several candidate prognostic factors have been identified in acute exacerbation of IPF. These include lower baseline FVC and DL_{CO} (13, 14, 29), more extensive CT abnormalities at the time of acute exacerbation (7, 43, 50, 55), worse oxygenation (13, 56), and bronchoalveolar lavage neutrophil and lymphocyte percentages (13). Several blood-based markers of prognosis have been suggested, including lactate dehydrogenase, **C-reactive protein**, KL-6, circulating fibrocytes, and anti-heat shock protein 70 autoantibodies (13, 29, 43, 50, 55, 57–60). Recently, a staging system for acute exacerbation of IPF has been proposed that includes several of these factors (43).

Management

There remain **no proven, effective therapies for acute exacerbation of IPF**. This leaves the patient and clinician to consider supportive care and unproven interventions. Many patients with acute exacerbation still receive systemic **corticosteroids**, but there is **no clear evidence to support this approach**. International evidence-based guidelines on the management of IPF make a weak recommendation for the use of corticosteroids in acute exacerbation of IPF, clarifying that the recommendation places a high value on anecdotal reports of benefit and the high mortality of acute exacerbation (1). The management of acute exacerbation of IPF represents an area of

major unmet medical need, and it is essential that well-designed, scientifically robust clinical research be conducted over the next decade to provide a much-needed evidence base.

There is little argument that the management of acute exacerbation of IPF should include supportive care, **focused on palliation** of symptoms and correction of hypoxemia with supplemental oxygen. However, there is **debate** regarding the **lengths** to which **supportive care should extend**—in particular, the use of **mechanical ventilation**. The international guidelines on the management of IPF make a **weak recommendation against** the use of **mechanical ventilation** to treat **respiratory failure in IPF**, on the basis of an **estimated in-hospital mortality of as high as 90%** in this population (1). Importantly, these guidelines specify that the use of mechanical ventilation in this setting is “a value-laden decision that is best made by the patient, clinician, and family ahead of time” on the basis of a **firm understanding of the patient’s goals of care**. It may be that more contemporary management approaches to respiratory failure and ALI (e.g., **low tidal volume ventilation**) are **improving** in-hospital survival (61); this is an area in **need** of careful **study**.

There have been many published articles over the last decade describing various potential therapies for acute exacerbation of IPF (Table 2). Unfortunately, these studies are mostly small and uncontrolled. The only randomized trial to examine an intervention for acute exacerbation of IPF compared procainonin (PCT)-guided antibiotic treatment to standard clinician-determined antibiotic treatment (62). In the PCT-guided group, antibiotics were given if PCT was greater than 0.25 ng/ml and were stopped when PCT was less than 0.25 ng/ml. The PCT group experienced a shorter antibiotic duration (median, 5.8 d shorter; *P* < 0.001), but the duration of mechanical ventilation and mortality were similar in both groups.

Observational cohort studies have compared each of the following treatments to a historical or parallel untreated control arm: cyclosporine (63–65), rituximab combined with plasma exchange and intravenous immunoglobulin (66), oral tacrolimus (52), and intravenous thrombomodulin (59, 60, 67). Anti-acid therapy was similarly

Table 2. Selected Potential Therapies for Acute Exacerbation of Idiopathic Pulmonary Fibrosis

Potential Therapy*	Study	Summary
Randomized controlled clinical trials		
Nintedanib (preventative therapy)	Richeldi <i>et al.</i> , 2011 (75); Richeldi <i>et al.</i> , 2014 (15)	Richeldi (2011): 432 patients. Highest dose of nintedanib resulted in lower incidence of acute exacerbation than placebo (2.4 vs. 15.7 per 100 patient-years, $P = 0.02$) Richeldi (2014): Two parallel trials, 1,066 patients. In the first, no significant difference in time to first investigator-reported acute exacerbation was found (HR, 1.15; $P = 0.67$). In the second, there was a significant benefit (HR, 0.38; $P = 0.005$)
Pirfenidone (preventative therapy)	Azuma <i>et al.</i> , 2005 (76); Taniguchi <i>et al.</i> , 2010 (47)	Azuma: 107 patients. Acute exacerbation occurred exclusively in the placebo group (5 events vs. no events, $P = 0.0031$) Taniguchi: 275 patients. No significant difference in acute exacerbation seen between treatment groups (5.6 vs. 5.5 vs. 4.8%)
Cohort studies		
Anti-acid therapy (preventative therapy)	Controlled: Lee <i>et al.</i> , 2013 (23) Uncontrolled: none	Lee: 124 patients compared with 118 control subjects, all from placebo arms of clinical trials. Incidence of acute exacerbation was 0 vs. 8% favoring anti-acid therapy
Corticosteroid monotherapy	Controlled: none Uncontrolled: Akira <i>et al.</i> , 1997 (69); Al-Hameed <i>et al.</i> , 2004 (51); Suzuki <i>et al.</i> , 2011 (30); Tachikawa <i>et al.</i> , 2012 (68)	Total of 75 cases reported without control subjects
Cyclophosphamide	Controlled: none Uncontrolled: Akira <i>et al.</i> , 2008 (50); Fujimoto <i>et al.</i> , 2012 (55); Tachikawa <i>et al.</i> , 2012 (68); Yokoyama <i>et al.</i> , 2010 (70)	Approximately 128 cases reported without control subjects
Cyclosporine	Controlled: Homma <i>et al.</i> , 2005 (64); Inase <i>et al.</i> , 2003 (63); Sakamoto, <i>et al.</i> 2010 (65) Uncontrolled: Fujimoto <i>et al.</i> , 2012 (55); Yokoyama <i>et al.</i> , 2010 (70)	Homma: 9 patients compared with historical control subjects. Mean survival, 9.9 mo vs. 1.7 mo in control subjects Inase: 7 patients compared with 5 control subjects. Survival, 3 of 7 vs. 0 of 5 Sakamoto: 11 patients compared with 11 control subjects. Survival, 9 of 11 vs. 5 of 11 Approximately 11 cases reported without control subjects
Polymyxin-B immobilized fiber column hemoperfusion	Controlled: none Uncontrolled: Abe <i>et al.</i> , 2011 (71); Abe <i>et al.</i> , 2012 (56); Oishi <i>et al.</i> , 2013 (72); Seo <i>et al.</i> , 2006 (73); Tachibana <i>et al.</i> , 2011 (74)	Total of 127 cases reported without control subjects
Rituximab, plasma exchange and intravenous immunoglobulin	Controlled: Donahoe <i>et al.</i> , 2015 (66) Uncontrolled: none	Donahoe: 11 patients compared with 20 historical control subjects; 1-year survival, 46 vs. 0% favoring rituximab and plasma exchange
Tacrolimus	Controlled: Horita <i>et al.</i> , 2011 (52) Uncontrolled: none	Horita: 5 patients compared with 10 control subjects. Median survival, >92 d vs. 38 d favoring tacrolimus
Thrombomodulin	Controlled: Kataoka <i>et al.</i> , 2015 (67); Tsushima <i>et al.</i> , 2014 (60); Isshiki <i>et al.</i> , 2015 (59) Uncontrolled: none	Kataoka: 20 patients compared with 20 historical control subjects. HR, 0.22 for death at 3 mo with treatment Tsushima: 20 patients compared with 6 control subjects. Survival, 13 of 20 vs. 1 of 6 Isshiki: 16 patients compared with 25 control subjects; 3-mo survival, 69 vs. 40%

Definition of abbreviation: HR = hazard ratio.

*Therapies tested in randomized clinical trials without evidence of benefit are not listed in the table. These include acetylcysteine monotherapy, ambrisentan, bosentan, imatinib, IFN- γ , sildenafil, "triple therapy" (prednisone, azathioprine, and acetylcysteine), and warfarin (80–88).

studied as preventative therapy in a large clinical trial cohort with a suggestion of benefit (23). In the above reports, in which an association between the treatment and improved survival was shown, efficacy remains uncertain due to likely confounding. For example, those with greater disease severity may be deemed “too sick” for treatment, or only those who survive long enough to be considered for experimental therapy might be treated. Furthermore, historical control populations may have received less-optimal supportive care and more frequent immunosuppressive therapy. In each of these cases, these unmeasured differences could lead to the apparent benefit of the intervention.

Uncontrolled cohorts have also been published reporting outcomes of patients with acute exacerbation of IPF treated with corticosteroids (30, 51, 68, 69), corticosteroids combined with or followed by other immunomodulatory therapies (50, 55, 66, 68, 70), and polymyxin B-immobilized fiber column perfusion (56, 71–74). Unfortunately, it is not possible to determine whether changes in the clinical status of these patients

were due to the intervention, the natural history of their disease, or other unmeasured factors. Potential therapies, including the ones listed here, should be studied in randomized, controlled trials to better understand their potential benefit.

Results from clinical trials of nintedanib and pirfenidone (both currently approved for the treatment of IPF) suggest IPF therapies may help prevent the development of acute exacerbation of IPF. The data for nintedanib are more substantial, as acute exacerbation was a key secondary endpoint in all three placebo-controlled clinical trials. A 432-subject phase 2 trial of nintedanib demonstrated a delay in time to first investigator-reported acute exacerbation with nintedanib therapy (75), a finding supported but not confirmed by the 1,066-subject phase 3 program (15). Most significant in the phase 3 program was the reduction in centrally adjudicated confirmed or suspected acute exacerbation of IPF with nintedanib therapy (5.7% on placebo vs. 1.9% on nintedanib, $P=0.01$) (15). A 107-subject phase 2 trial of pirfenidone was stopped early because of a

statistically significant (but numerically small) reduction in acute exacerbation in those receiving pirfenidone, but a 275-subject subsequent trial did not replicate these results (47, 76). The definitive phase 3 clinical trials of pirfenidone did not report acute exacerbations as an endpoint (77, 78). Pirfenidone has been suggested to reduce the risk of acute exacerbation postoperatively, but these data are observational and at high risk for confounding (79). Additional data are needed to fully understand the impact of IPF therapies on the risk and outcome of acute exacerbation.

Other potential IPF therapies tested in clinical trials showed no impact on (acetylcysteine monotherapy, bosentan, IFN- γ , sildenafil) or possibly increased risk for (ambrisentan, imatinib, “triple therapy” with combination prednisone/azathioprine/acetylcysteine, and warfarin) the development of acute exacerbation of IPF (80–89).

Proposed Conceptual Framework for Acute Respiratory Deterioration in IPF

To better reflect the current state of knowledge regarding acute exacerbation of IPF and improve the feasibility of future research into its etiology and treatment, the working group iteratively developed a new conceptual framework for acute respiratory deterioration in IPF (Figure 3) and revised the definition and diagnostic criteria for acute exacerbation of IPF (Table 3). The major changes are described in more detail below.

Removing “Idiopathic” from the Definition of Acute Exacerbation

There was a majority opinion that the definition and diagnostic criteria for acute exacerbation of IPF should include any acute respiratory event characterized by new bilateral ground-glass opacification/consolidation not fully explained by cardiac failure or fluid overload. This latter qualification parallels the Berlin criteria for acute respiratory distress syndrome and is intended to exclude isolated congestive heart failure. There was general recognition, based on the literature review conducted and summarized above, that there is little clinical or biological support for distinguishing idiopathic from nonidiopathic respiratory events. Defining acute exacerbation as

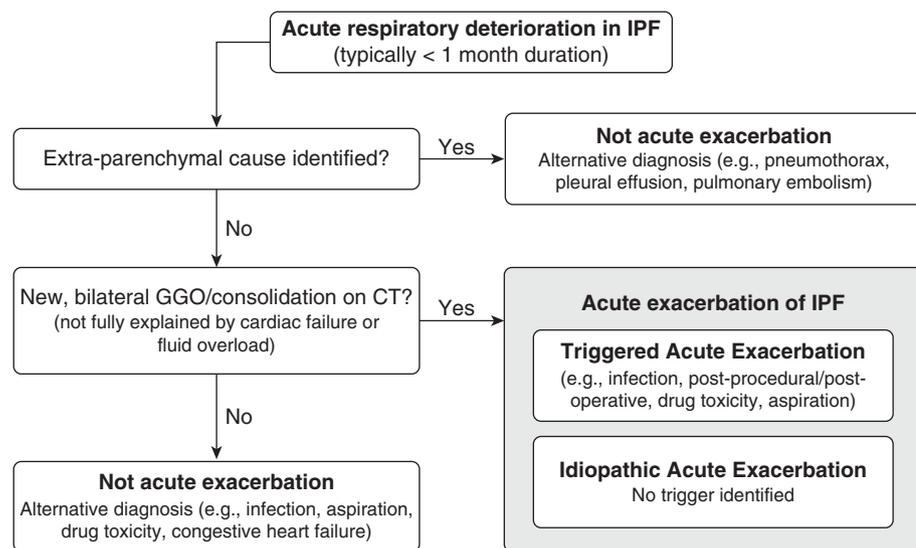


Figure 3. Proposed conceptual framework for evaluation of acute respiratory deterioration in idiopathic pulmonary fibrosis (IPF). Acute respiratory deterioration of IPF (defined as “typically <1 month in duration”) can be categorized as extraparenchymal (e.g., pulmonary embolism, pneumothorax, pleural effusion) or parenchymal. Parenchymal causes that demonstrate new bilateral ground-glass opacification (GGO)/consolidation on computed tomography (CT) that is not fully explained by cardiac failure or fluid overload are categorized as acute exacerbations of IPF, regardless of the presence or absence of a known trigger (e.g., infection). Acute exacerbations are further categorized as triggered acute exacerbation or idiopathic acute exacerbation, depending on whether an underlying trigger for acute exacerbation is found.

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