Comorbidities in Interstitial Lung Diseases: An Overlooked Burden

I thought this was a really great session. When we're thinking about treating patients with ILD, often after we think about medications, we want to think about what else can we can we do to make the patient feel better and their quality of life better? And some of these sessions really focused on that, I thought. One of the sessions was about reflux, and that was by Dr. Scholand. She talked about gastroesophageal reflux and IPF, mostly in IPF and a little bit in another ILGs. And she reviewed some great older materials talking about how GERD is really prevalent in ILD and IPF, up to 90% in some studies. And there's varying data on whether or not we should treat it, so it's a question that commonly comes up in clinic. And patients want to know, "Are you sure I need to take this medication for reflux?"

And while at the end of the session, I don't think we had a great answer, I thought she provided some really good tips on how to think about it at the clinical level when you're seeing the patient. She touched on the fact that some studies have shown that patients who are treated with reflux medications have less progression of radiologic fibrosis and may even have longer survival. Some studies have shown less exacerbations and less cough in patients who are treated for reflux. But then there are other studies that are contradictory, so trying to make it a clear answer out of that is difficult.

One of the studies she focused on was the WRAP-IPF study that was published in the last year or two, that was compelling. They looked at patients who had a proven reflux based on a pH probe manometry study, and half of them underwent a Nissen fundoplication to fix reflux and the other half didn't. And while there was not a statistically significant difference in FEC at the end of that study between the two groups, there was a trend toward less decline in FEC and the patients who did undergo Nissen. So, certainly, some food for thought from that aspect.

And at the end, she summarized by talking about some, some key pearls, which were that we should really consider treating reflux in patients who are symptomatic, in patients who cough, in whom the cough might be due to reflux, in patients who have clear reflux as measured by a pH probe study, and then consider reflux as a reason for progressive ILD, progressive decline. Work it up and consider treating it as potentially that would alleviate some decline that a patient is experiencing.

Another great speaker in the session was Dr. Nathan, who covered pulmonary hypertension in ILD. And he reviewed the prevalence and some background data on the subject, reminding us that pulmonary hypertension in patients with ILD doesn't necessarily correlate with restriction, and reminded us of some key findings to look for both on history and on physical exam, such as [dismay 00:03:39] out of proportion to radiographic findings or FEC, a loud P2 on exam, a large PA by a CT scan, or an FEC to [DLCL 00:03:51] ratio of over 1.5. And he talked about some old studies, but he focused on, and what I thought was most interesting were two new studies that have come out that are showing potential treatment options for our patients who have ILD and pulmonary hypertension.

One of those was a trial published in Chest a couple of months ago looking at inhaled nitric oxide for patients who have ILD, not just IPF, but there were various forms included in this study. And the patients

were treated with inhaled nitric oxide, in addition to their usual supplemental oxygen. And patients who were treated were able to have less decline in their exercise capacity and had overall increase in their physical activity as measured by some sort of device that is able to measure their activity. The patients in the placebo group, who didn't get the nitric oxide actually had decline in their physical activity over time. And then, when the patients in the placebo group went to an open-label portion, they were able to improve their physical activity, or at least stay at a steady state again. So, that was really exciting data to see that we have a potential treatment option coming down the pipes, and there's another study going on right now in a bigger group of patients to look at inhaled nitric oxide for the set of patients.

He also touched on the increase study, which I don't believe is published yet, but that's looking at Treprostinil for patients with group three ILD. And that study is inhaled Treprostinil four times a day versus placebo. And those patients also had a positive outcome, so it was a positive study. Patients who were treated with the study drug Treprostinil had a longer six minute walk distance by... It was 20 to 30 meters improvement compared to the placebo group. So, I thought these two studies that he focused on were really, again, positive findings and exciting for patients and might actually clinically benefit a substantial portion of our patients. So, something to look forward to see if these drugs continue to be developed and become available clinically to treat our patients.