Comparing the 2017 Fleischner Society Guidelines and the 2018 ATS Guidelines for Diagnosing IPF

David Lynch, MB:

This afternoon we will be discussing the Fleischner Society's guidelines for diagnosis of IPF published last year and of course we will also be comparing them with the recently published guidelines by the American Thoracic Society and sister societies.

For the CT aspects of the Fleischner Society guidelines, the categories are clear. Typical UIP, probable UIP, indeterminate, and suggestive of an alternative diagnosis. And so the fortunate thing with the ATS guidelines is that those categories are almost identical. There are slight differences in the recommendations between the two guidelines, but those are a matter of emphasis rather than two difference, and the other feature is that people really have to learn that the diagnosis of IPF is along a probability scale. So certain CT patterns give you a probability of a UIP diagnosis over 90% or over 80%, and then there are less specific CT patterns where the probability is probably about 50%.

I think we, as clinicians, have to get used to thinking in terms of a probability scale rather than the binary UIP versus non-UIP.

The new ATS guidelines were published last month and they are an important advance. They differ from the Fleischner Society guidelines in that they follow the rigid grade methodology for evaluating diagnostic tests but both sets of guidelines are evidence based and based on literature search. There is a difference in the ATS guidelines in that they suggest biopsy. They don't recommend biopsy, they suggest biopsy, in patients who have a CT pattern of probable UIP, whereas the Fleischner Society guidelines feel that in the correct clinic context, those patients, because they have more than 80% probability of UIP, do not need biopsy.

But I think the important points to emphasize is the fact that these are just minor differences and they really just reflect clinical uncertainty in making this diagnosis.

Steven Nathan, MD:

As most folks are aware, there were new IPF guidelines that were published early September in our Blue Journal, they had been presented at the ATS meeting in May and there was a presentation around them at the ERS meeting as well and I think in some ways, they are a little bit helpful. But I think there're also some concerns I have, quite truthfully, about the guidelines. I think the move to change possible UIP to probable, is a good move, I think that gives us a greater level of confidence. The indeterminate category worries me a little bit because I think that certainly there are some patients, and we look at the CT and we say, "I'm just not sure what this is, that doesn't look like UIP."

But there are some patients who previously were possible UIP who now might be regarded in that indeterminate category. The one group that I think is being missed are patients with subpleural reticulation. No honeycombing, no traction bronchiectasis, no traction bronchiectasis. By the strict definition, those patients are now in the indeterminate category. Previously, they were in the possible UIP category.

So I think what we might see as a result of this is that more patients might be regarded as candidates for a surgical lung biopsy to affirm the diagnosis. Now, that might be good, I don't know. Maybe some patients would get unnecessary surgical lung biopsies but I think, for my overall sense it does move the needle a little bit, hopefully it will be helpful to clinicians in the field. I think there are a lot of nuances in terms of the guidelines. There was increasing emphasis on the multidisciplinary team discussion, that if you look at the algorithm that's in the new guidelines, the MDD is at two points in terms of deciding if there should be a procedure, bronchoscopy or surgical lung biopsy, and then at the end in terms of making the diagnosis. So I think there's increasing emphasis on the MDD.

There was also mention of cryobiopsies for the first time, no hard stance was made about cryobiopsies. There was mention of the role of bronchoscopy, and that I think was not in the prior guidelines, so this introduces the concept that bronch might yield material that might enable a diagnosis, and there was a presentation by Dr. David Lynch on Monday about the role of transbronchial biopsies and looking at a genomic signature or

fingerprint that might increase the diagnosis of IPF, so it was good to see that that was introduced to the guidelines. I think that's kind of a doorway to genomic analysis in terms of enabling us to make an accurate diagnosis.