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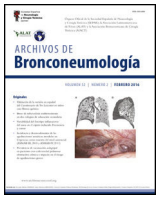

Editorial

Can Clinical Guidelines on Idiopathic Pulmonary Fibrosis be Applied in Latin America? The Need to Establish Centers of Reference☆

¿Es posible aplicar en Iberoamérica las guías clínicas sobre fibrosis pulmonar idiopática? La necesidad de establecer centros de referencia

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Idiopathic pulmonary fibrosis (IPF) is a disease that impacts significantly on 5-year survival. Fortunately, advances have been made in recent years in determining the pathogenesis, diagnosis, and treatment of this entity.[1] This has led to the publication of various clinical guidelines and statements on the diagnosis and treatment of IPF. The most widely used are the joint guidelines of the European Respiratory Society and American Thoracic Society, the Latin American Chest Association, and the Japanese Respiratory Society.[2] However, initiatives have also emerged from groups of respiratory disease experts, such as the Fleischner Society.[3] Many countries have local guidelines that are based mainly on the above-mentioned recommendations. The IPF clinical guidelines of the Spanish Society of Pulmonology and Thoracic Surgery (SEPAR) and the Latin American Chest Association (ALAT) are grounded on current scientific evidence.[4,5]

The main objective of the recommendations is to standardize the diagnostic process. This is currently highly complex, since IPF is just one of many types of diffuse interstitial lung diseases (ILD), and cannot be diagnosed with a single pathognomonic test. There is little doubt that these clinical recommendations have facilitated the work of groups involved in the diagnosis of ILDs and promoted the establishment of multidisciplinary units. They have also improved patient access to new drug treatments and, moreover, have contributed significantly to clinical research.[6] Nevertheless, in many cases, the guidelines are no more than expert consensus statements that propose a set of maxims that are a far cry from the real situation in specific cases, settings or countries, and as such, may sometimes be difficult to apply in practical terms. It is important, then, to adapt these recommendations to our specific needs.

Latin American countries differ widely in terms of their healthcare systems, economic conditions, social welfare, and in particular, individual access to public and private healthcare. Nevertheless, we also share issues that need to be discussed in depth, including the technical requirements and human resources needed to adequately implement the proposed diagnostic criteria associated with the specialization required in pulmonology.

Most recommendations have been drafted by experts for colleagues with more or less experience, but who are interested in IPF. These professionals attempt to put into practice the recommendations that are most effective for them. However, the authors of guidelines fail to emphasize a key issue: given the complexity of diffuse IPD, the diagnostic yield is closely related with the experience and knowledge of the practitioner, as demonstrated in several studies evaluating diagnostic agreement between centers according to their experience.[7,8] Even in expert centers, a low level of agreement was observed for certain diagnoses.[9,10] One reason for this discrepancy is that essential IPF diagnostic tests, such as high-resolution computed tomography, must be assessed by an experienced radiologist for proper diagnosis. The clinical interview and histological study of the lung biopsy are also highly complex. We believe, then, that not only pulmonologists, but also radiologists, pathologists, and thoracic surgeons, should have a thorough understanding of IPF. If this is not the case, the validity of multidisciplinary diagnosis is questionable.[11]

A series of highly complex techniques, such as high-resolution computed tomography, transbronchial cryobiopsy, surgical lung biopsy, and lung function studies are needed in order to implement existing guidelines. Unfortunately, for economic reasons, access to these procedures is limited in many Latin American countries, which in turn reduces the possibility of obtaining a correct diagnosis. For all these reasons, experts now suggest that patients should be diagnosed in expert centers.[12]

The problem is that in many Latin American countries no such officially recognized expert centers are available. The creation and validation of diffuse IPD reference centers in Latin America is justified for several reasons: the prevalence of these diseases is low, so larger numbers of patients will broaden the experience of the clinical teams and facilitate the inclusion of patients in clinical trials for the development of new drugs. This approach also helps focus

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and optimize health resources and improves the prescription and rational use of costly medications for the treatment of IPF. This is clearly an essential process in all minority diseases such as IPF, and one that both health professionals and patients demand.[13] A network of expert centers is essential if current clinical guidelines are to be optimally applied.

The socioeconomic reality is also a determining factor in accessing new antifibrotic drugs. Unfortunately, these treatments are currently too costly for many patients – an unfair situation and a complex problem that prevents us from achieving clinical guideline goals. The scientific community probably needs to be more forceful in denouncing the situation and helping to find effective solutions for patients. Otherwise, guidelines will be drawn up exclusively for developed countries, thereby excluding not only many Latin American countries, but also a large part of the world's population.

In short, guidelines on the diagnosis and treatment of IPF represent a step forward. However, the next step must be to apply them properly. In places where access to expert medical advice, appropriate diagnostic techniques, and recommended drugs is more difficult, the creation of reference centers that enable optimal implementation of guideline recommendations becomes even more urgent. This will clearly have a positive effect on patients, and is the primary goal of all clinical guidelines.

Conflict of interests

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