Prognostic impact of typical and probable usual interstitial pneumonia pattern in idiopathic pulmonary fibrosis: is the debate about biopsy a *Star Wars* saga?

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The debate about the benefit of performing a surgical lung biopsy in patients with the probable UIP pattern needs every case to be viewed on an individual basis. This editorial attempts to bring some clarity to treating physicians and confused patients. http://bit.ly/2Qk517r

Cite this article as: Kolb M, Raghu G, Wells A. Prognostic impact of typical and probable usual interstitial pneumonia pattern in idiopathic pulmonary fibrosis: is the debate about biopsy a *Star Wars* saga? *Eur Respir J* 2020; 55: 2000590 [https://doi.org/10.1183/13993003.00590-2020].

The diagnosis of interstitial lung diseases (ILDs) can be straightforward for some experienced experts without biopsy data, but not so straightforward to others. In the context of suspected idiopathic pulmonary fibrosis (IPF), accurate non-invasive diagnosis requires recognition of the hallmark usual interstitial pneumonia (UIP) pattern on imaging, obviating lung biopsy [1, 2]. When the imaging pattern is "probable UIP", the need for histopathology confirmation of a UIP pattern in surgical lung biopsy (SLB) is often debated, despite concordance between expert groups that SLB is not mandated for IPF diagnosis when the clinical setting is appropriate and multidisciplinary discussion has taken place [1–3]. It is the radiographic pattern of "probable UIP" that is at the centre of this debate, and the question of whether a biopsy is required in order to diagnose a specific fibrotic ILD. Let us recapitulate the terminology first before summarising new evidence and arguing about the appropriate diagnostic steps. The "typical UIP pattern" on high-resolution computed tomography (HRCT) consists of peripheral reticulation with an apicobasal gradient, traction bronchiectasis and honeycombing. IPF is a definite diagnosis when this pattern is present and no cause for it is identified clinically. That is the easy one. The "probable UIP pattern" on HRCT includes the same descriptors as above, except that honeycombing is absent. This HRCT pattern can be IPF but it also can be something different. Now that sounds more difficult; or is it not?