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Letter to the Editor

RE: Comment on: Pulmonary Function and Diffusing Capacity of Carbon Monoxide in Hypersensitivity Pneumonitis: An Observational Study of 152 Patients

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We thank Remnani and Kundan[1] for their Letter to the Editor titled "Comment On: Pulmonary Function and Diffusing Capacity of Carbon Monoxide In Hypersensitivity Pneumonitis: An Observational Study of 152 Patients." Here are our responses to their well-taken queries:

1. The diagnosis of HP is done by multidisciplinary discussion with the identification of the inciting antigen, HRCT chest, bronchoalveolar lavage, and lung biopsy. PFT and DLCO can be used only for monitoring of the disease. The identification of the inciting antigen was not possible in 30%-50% cases.[2,3] Studies have found a highly variable diagnostic yield of lung biopsy in HP (9%-75%). A meta-analysis of TBLB revealed a diagnostic yield of 64.3% and is not 100% specific. The BAL lymphocytosis is also not specific and yields variable results.[3-5] We propose that PFT and/or DLCO can be considered among patient where the inciting agent cannot be identified, and patients are contraindicated or not willing to undergo a lung biopsy.
2. There are limited data on PFT in HP. So the role of PFT in diagnosing HP is questionable or unclear. Recent ATS documents on HP diagnosis and Delphi HP diagnostic criteria for chronic HP did not mention PFT in HP.[6,7] The earlier diagnostic criterion did mention spirometry and DLCO as minor diagnostic criteria.[8-11] We conducted the study with the aim to determine the type of defect, lung volume, and DLCO in HP and to assess their importance in diagnosing and monitoring HP.
3. We have already mentioned in the article that major recent documents did not include it, which is why we conducted the study to find any value and correlation for HP diagnosis and monitoring.
4. Confirmed exposure history with matching clinical profiles should be considered for acute HP, even with shorter durations. The duration of 3 months should also be considered for further investigation of HP, even if there is no direct or confirmed exposure, such as the presence of pigeons on roof and window. The newer classifications of HP mentions that a duration of <6 months are considered acute/inflammatory and possibly reversible.[2]
5. The PFT classification and severity were done as per ERS and Indian guidelines, with references mentioned in the manuscript. The details of all parameters according to abnormality classification are mentioned in Table 2.
6. The overall FEF 25%-75% was reduced in most of the patients. We presented the details of FEF 25%-75% with the type of PFT abnormality in Table 2. A small paragraph in the text describes it. We did not discuss it in detail, but this can be considered for further discussion.
7. The isolated decreased DLCO was seen in only 10% of cases, not in 50% cases. Yes, this may be due to the stage of the disease and early presentation. Similar to this study, previous 2 studies also mentioned isolated reduced DLCO in 7%-10% of cases. We presented a comparative table of all studies (Table 3) and also mentioned it in the discussion with references.
8. The patient distribution is not uniform, with the majority (87) of patients showing restriction and a small population showing mixed results (18). This finding may be explained by the unequal number of cases. Further studies are needed to clarify this with the same number of cases.
9. Thanks you for your kind comments about our data and study. The aim of the study was to consider the importance of PFT in HP for diagnosis, prognosis, and patient follow-up.

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