

Editorial



Clinical Assessment and Outcomes Across Respiratory Diseases

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Clinical assessment of respiratory disease should establish the cause of symptoms, define functional impairment and inform management. These aims often require more than one measure. This issue brings together seven original studies on pulmonary function testing, rehabilitation, patient-reported outcomes and prognosis. The papers span airway disease, stem cell transplantation, chronic obstructive pulmonary disease (COPD), idiopathic pulmonary fibrosis (IPF), pneumonia and other interstitial lung diseases (ILD).

Subacute cough is conventionally defined as lasting three to eight weeks, but duration alone does not establish its etiology.¹ In "Pulmonary Function Test Abnormalities in Subacute Cough: A Neglected Tool," Yüksel and İlgar Akelma² compared 156 adults with subacute cough with 156 healthy controls. The cough group had lower spirometric indices, including mid-expiratory flow; postinfectious cough accounted for 37.8% of diagnoses and asthma for 25%.² These findings suggest that spirometry can identify functional abnormalities in some patients presenting during this interval. The retrospective, selected sample does not establish that all patients with subacute cough require spirometry, and an isolated forced expiratory flow at 25–75% of the pulmonary volume (FEF_{25–75}) result is not a specific diagnosis. European Respiratory Society/American Thoracic Society (ERS/ATS) interpretation standards require lung function results to be considered with the patient's history, test quality, reference range and pretest probability.³

In the asthma study, 63 of 98 adults (64.3%) had oscillometry-defined small airway dysfunction, accompanied by poorer control, worse quality of life and more exacerbations. The quality-of-life association persisted after spirometric adjustment, whereas the association with asthma control was attenuated.⁴ A 2025 ATLANTIS analysis found that R5–R20-defined dysfunction was associated with future exacerbations in patients with well controlled asthma, after adjustment for established risk factors, including forced expiratory volume in one second (hazard ratio 2.26; 95% confidence interval 1.05–4.85).⁵ Small airway measurements may therefore contribute to risk assessment even when symptoms appear controlled. Differences between oscillometry indices and thresholds need to be considered when comparing studies or applying their findings.

The study of 83 hematopoietic stem cell transplantation recipients illustrates the difference between association and predictive performance. Reduced pretransplant FEF_{25–75} was associated with a composite of post-transplant complications, including nonpulmonary events, but its standalone area under the receiver operating characteristic curve was only 0.578.⁶ The 2024 ERS/European Society for Blood and Marrow Transplantation guideline on pulmonary chronic graft-versus-host disease supports pretransplant baseline lung function assessment and subsequent physiological monitoring.⁷ Further work should establish whether small airway measurements improve prediction of specific complications beyond conventional indices and clinical risk factors.

The COPD exercise study evaluated a culturally adapted program of repeated floor-to-stand movements. Seven of 15 participants completed the nine-week program; improvements were mainly in symptoms and disease impact, without

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consistent changes in functional tests or peripheral muscle outcomes.⁸ The 2023 ATS guideline strongly recommends pulmonary rehabilitation for stable COPD and after hospitalization for an exacerbation.⁹ Evidence for this particular floor-to-stand program remains preliminary. A 2024 study found that the standardized one-minute sit-to-stand test reflected exercise capacity and responded to rehabilitation,¹⁰ but that chair-based assessment differs from floor-to-stand training. For the proposed program, larger controlled studies should assess adherence and determine whether symptom improvement is accompanied by better daily function.

The Turkish adaptation of the IPF-specific St George's Respiratory Questionnaire (SGRQ-I) was evaluated in 180 patients, with good-to-excellent test-retest reliability and moderate correlations with physiological and walking measures.¹¹ This extends previous validation of the 34-item SGRQ-I in IPF.¹² A validated Turkish version allows health status to be assessed using an instrument developed for this population. Its measurement properties must remain central to the interpretation of scores in clinical practice and research.

The King's Brief Interstitial Lung Disease (K-BILD) questionnaire is another established measure of health status in ILD. Its 15 items cover breathlessness and activities, chest symptoms and psychological impact.¹³ In a 2024 Finnish cohort of 245 patients with IPF, lower baseline K-BILD scores were associated with poorer survival.¹⁴ These observational findings do not establish K-BILD as a standalone prognostic rule. A 2025 analysis of 736 participants in the IPF-PRO Registry found only weak relationships between changes in lung function and changes in patient-reported outcomes.¹⁵ Health status therefore needs to be measured directly alongside physiology. The choice between SGRQ-I and K-BILD should take account of the intended population, questionnaire burden, measurement properties and availability of a validated language version.

In the pneumonia study, adding computed tomography (CT) severity to CURB-65 improved discrimination for intensive care admission ($P = 0.003$) among 456 adults with CT-confirmed community-acquired pneumonia. The improvement for 30-day mortality was not statistically significant ($P = 0.081$).¹⁶ A 2025 cohort comparison also supported the performance of pneumonia-specific severity scores.¹⁷ The recent ATS guideline conditionally accepts lung ultrasound as an alternative to chest radiography where appropriate expertise exists.¹⁸ The choice of diagnostic imaging and the value of imaging for prognosis need to be assessed separately. The combined CT model requires external validation, calibration assessment and evidence of improved triage before wider adoption. Results from a CT-selected cohort do not justify routine CT solely for risk scoring.

Uchiyama et al.¹⁹ studied 443 patients with ILD, of whom 158 developed an acute exacerbation. Median survival after exacerbation was two months, and older age and selected comorbidities were associated with worse outcomes. A 2026 multicentre UK study of 938 ILD-related admissions also documented high mortality, with age, preadmission oxygen use and neutrophilia associated with mortality in its acute

exacerbation subgroup.²⁰ Differences in case definitions and populations limit direct comparison of survival estimates. The age threshold of 80 years reported by Uchiyama et al.¹⁹ should not be treated as a universal threshold for individual care. Prognostic information should be considered together with disease severity, comorbidities and the patient's preferences when discussing treatment and supportive care.

These studies address practical questions about the use of familiar tests and the assessment of outcomes that matter to patients. They also show why the purpose of measurement must be explicit. An index associated with complications may discriminate poorly between individual patients, while a physiological change may not reflect a change in health status. For the proposed predictive measures, the next step is to test their added value in other populations. For rehabilitation programs and patient-reported measures, further work should examine their use over time and their effect on clinical decisions. Evidence that an assessment changes management and improves outcomes will be needed to establish its place in routine care.

Footnotes

Authorship Contributions

Concept: G.U., B.E., Literature Search: G.U., B.E., Writing: G.U., B.E.

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