

# **Evaluation of interstitial lung diseases patients admitted at Abbasia Chest Hospital**

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## List of Abbreviations

<b>%</b>	Percent
<b>µl</b>	Microliters
<b>6MWT</b>	Six-minute walk test
<b>ABG</b>	Arterial Blood Gases
<b>ACE</b>	Angiotensin converting enzyme
<b>AEP</b>	Acute eosinophilic pneumonia
<b>AIP</b>	Acute interstitial pneumonia
<b>ANA</b>	Anti-nuclear antibodies
<b>ANCA</b>	Anti-neutrophil cytoplasmic antibodies
<b>ARDS</b>	Acute respiratory distress syndrome
<b>ATS</b>	American Thoracic Society
<b>BAL</b>	Bronchoalveolar lavage
<b>BM</b>	Basement membranes
<b>BOOP</b>	Bronchiolitis obliterans organising pneumonia
<b>CPK</b>	Creatine phosphokinase
<b>CFA</b>	Cryptogenic fibrosing alveolitis
<b>CI</b>	Confidence interval
<b>CMV</b>	Cytomegalovirus
<b>COP</b>	Cryptogenic organising pneumonia

<b>COPD</b>	Chronic obstructive pulmonary disease
<b>CT</b>	Computed tomography
<b>CTD</b>	Connective tissue disease
<b>DAD</b>	Diffuse alveolar damage
<b>DIP</b>	Desquamative interstitial pneumonia
<b>DL CO</b>	Diffusing capacity of the lung for CO
<b>DNA</b>	Deoxyribonucleic acid
<b>DPLD</b>	Diffuse parenchymal lung disease
<b>EBV</b>	Epstein Barr virus.
<b>ELISA</b>	Enzyme-Linked-Immune-Sorbent-Assay
<b>ERS</b>	European Respiratory Society
<b>ESR</b>	Erythrocyte Sedimentation Rate
<b>FEV1</b>	Forced expiratory volume in one second
<b>Fig.</b>	Figure
<b>FiO<sub>2</sub></b>	Fraction of inspired Oxygen
<b>FRC</b>	Functional residual capacity
<b>FVC</b>	Forced vital capacity
<b>GGO</b>	Ground glass opacity
<b>GIP</b>	Giant cell interstitial pneumonia
<b>Hb</b>	Hemoglobin

<b>HCT</b>	Hematocrit
<b>HDL</b>	High-density lipoprotein
<b>HIV</b>	Human immunodeficiency virus
<b>HLA</b>	Human leukocyte antigen
<b>HP</b>	Hypersensitive pneumonitis
<b>HRCT</b>	High resolution computed tomography
<b>HSV</b>	Herpes simplex virus
<b>IBW</b>	Ideal body weight
<b>ICU</b>	Intensive care unit
<b>IHS</b>	Idiopathic hypereosinophilic syndrome
<b>IIP</b>	Idiopathic interstitial pneumonia
<b>ILD</b>	Interstitial Lung Disease
<b>IPF</b>	Idiopathic pulmonary fibrosis
<b>Kg</b>	Kilogram
<b>LAM</b>	Lymphangioleiomyomatosis
<b>LBW</b>	Lean body weight
<b>LDH</b>	Lactate dehydrogenase
<b>LDHC</b>	Low-dose Hydrocortisone
<b>LDL</b>	Low-density lipoprotein
<b>LIP</b>	Lymphoid interstitial pneumonia
<b>MCP-1</b>	Monocyte chemoattractant protein-1

<b>MDR</b>	Multidrug Resistant
<b>Mg</b>	Milligram
<b>MgSO<sub>4</sub></b>	Magnesium Sulphate
<b>mm</b>	Millimeter
<b>mm Hg</b>	Millimeter mercury
<b>MRI</b>	Magnetic resonant image
<b>MRSA</b>	Methicillin Resistant Staphylococcus aureus
<b>n.</b>	Number
<b>NSIP</b>	Non-specific interstitial pneumonia
<b>OR</b>	odds ratio
<b>PaO<sub>2</sub></b>	arterial O <sub>2</sub> pressure
<b>PAP</b>	pulmonary alveolar proteinosis
<b>PCP</b>	Pneumocystis pneumonia
<b>PCR</b>	Polymerase chain reaction
<b>Plt</b>	Platelets
<b>PO<sub>2</sub></b>	Alveolar–arterial pressure difference for O <sub>2</sub>
<b>RBILD</b>	Respiratory bronchiolitis-associated interstitial lung disease
<b>REM</b>	Rapid eye movement
<b>RNA</b>	Ribonucleic acid
<b>RSV</b>	Respiratory syncytial virus

<b>RV</b>	Residual volume
<b>S.aureus</b>	Staphylococcus aureus
<b>SaO2</b>	arterial O2 saturation
<b>SD</b>	Standard Deviation
<b>SGOT</b>	Serum glutamic oxaloacetic transaminase
<b>SGPT</b>	Serum glutamic pyruvic transaminase
<b>SPE</b>	Simple pulmonary eosinophila
<b>TBB</b>	Transbronchial biopsy
<b>TLC</b>	Total lung capacity
<b>TLC</b>	Total leucocytic count
<b>UIP</b>	Usual interstitial pneumonia
<b>VATS</b>	video-assisted thoracoscopic
<b>WBC</b>	White blood cells
<b>WHO</b>	World health organization

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# INTRODUCTION

Interstitial Lung Disease is also known as diffuse parenchymal lung disease (DPLD) and refers to a large group of acute and chronic pulmonary diseases characterized by damage to the lung parenchyma, with varying patterns of inflammation and/or fibrosis (**Leslie, 2006**).

Presence of inflammation was proven by research on alveolitis conducted during the mid-1970s and early 1980s following the introduction of a new medical procedure called bronchoalveolar lavage (BAL); Later with the introduction of high resolution computed tomography (HRCT), the presence of ground glass opacities was found to be consistent with edema and/or inflammation, features viewed as 'less fibrotic' occurring in very stages of the disease. This was the rationale behind treating these patients with high-dose of anti-inflammatory drugs such as dexamethasone. However, as clinicians became confronted with the fact that many forms of ILD are recalcitrant to corticosteroid treatment, a new hypothesis of disease pathogenesis emerged, namely that fibrosis itself could arise and progress in the absence of inflammation (**Chapman, 2004**).

The new hypothesis relating to the absence of inflammation in the progression of lung fibrosis and this new pathologic classification have been well-received by specialists because the histopathology of different types of lung fibrosis is clearly defined and provides a basis for research on antifibrotic therapeutics, instead of anti-inflammatory agents (**Du Bois & King, 2007**).

With the general acceptance of these distinct histological patterns together with the changing nature of the pathophysiologic model during the final three decades of the last millennium, the American Thoracic Society (ATS) and the European Respiratory Society (ERS) put forth in the years 2000-2002 joint consensus statements that defined classification, diagnosis, and management of ILD (**ATS/ERS, 2002**). These guidelines classify the ILDs based on clinical, radiologic, and pathologic findings into four main categories: (1) ILD of known cause (e.g. environmental exposure, drug exposure, association with a connective tissue disease (CTD), etc.) (2) Granulomatous ILD (i.e. sarcoidosis, Wegener's Granulomatosis) (3) extremely rare ILD with well-defined clinico-pathologic features (e.g. pulmonary alveolar proteinosis (PAP), eosinophilic pneumonia, lymphangioleiomyomatosis (LAM), etc.) (4) Idiopathic interstitial pneumonia (IIP) (Figure 4). The latter is further subdivided into seven distinct clinico-pathologic disease entities, the causes of which are unknown by definition. In the order of relative frequency, they are: idiopathic pulmonary fibrosis (IPF), non-specific interstitial pneumonitis (NSIP), cryptogenic organizing pneumonia (COP), acute interstitial pneumonitis (AIP), respiratory bronchiolitis-interstitial disease (RBILD), desquamative interstitial pneumonia (DIP), and lymphoid interstitial pneumonia (LIP)