Hypersensitivity pneumonitis (HP) treatment

HP is a form of ILD that is precipitated by inhalation of specific antigens, most commonly avian proteins and mold or fungal spores.

Nonfibrotic (acute and subacute)

- Most patients with nonfibrotic have near total recovery of lung function after avoidance of antigen
- Maintenance therapy is rarely required unless unable to avoid the antigen
- There is no role for steroid-sparing agents in the management of nonfibrotic HP
    - Mild or intermittent symptoms, no PFTs abnormalities, mild HRCT findings
        - Antigen avoidance
    - Moderate to severe symptoms, reduced lung function or diffuse HRCT findings
        - Prednisone 0.5 to 1.0 mg/kg as a starting dose after excluding infection x 1-2 weeks
        - Once pt is symptomatically improved, taper over 4 weeks to complete 4 to 6 weeks

Fibrotic (chronic)

- Supportive care
    - Appropriate vaccination (influenza, pneumococcus-PCV20, RSV, and COVID-19)
    - Determination of the appropriateness of supplemental oxygen
    - Consideration of pulmonary rehabilitation
- Prednisone 0.5 to 1.0 mg/kg as a starting dose after excluding infection x 4-8 weeks
    - Followed by tapering to 10 to mg/d x3 months
    - Subsequent tapering guided by symptoms and lung function
    - Reassessment with PFTs every 2-3 months and HRCT every 6 months attempting toward tapering the corticosteroids as tolerated
    - If there is no evidence of benefit, rapid tapper off
- Use of steroid-sparing agents such as mycophenolate or azathioprine can be used
- Antifibrotic treatment for progressive pulmonary fibrosis (PPF)
    - Nintedanib
    - Off label Pirfenidone
- Lung transplant for advanced HP
    - Excellent medium-term survival