Comment on: Survival and course of lung function in the presence or absence of antifibrotic treatment in patients with idiopathic pulmonary fibrosis

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To the Editor:

With great interest I recently read the observations of the INSIGHTS-IPF registry published in the August 2020 issue of the *European Respiratory Journal* [1]. However, the paper represents an instructive example of how peer review occasionally may fail to prevent publication of unfounded conclusions. Though lead-time bias is mentioned as a potential limitation of the study in the discussion (possibly following peer review) and though lead-time bias is evident looking at the published data, the authors conclude that their study shows a significantly lower all-cause mortality in IPF patients with antifibrotic therapy, and that withholding antifibrotic therapy from stable IPF patients may set these patients on a path of increased risk of dying. This is an audacious conclusion given the fact that their data do not show any benefit of antifibrotic therapy, to begin with no slower forced vital capacity decline. Table 1 of the article, which lacks a column showing the statistical significance of differences between untreated and treated patients, demonstrates that while age at diagnosis was similar between the groups (68.1 and 68.0 years, respectively), age at inclusion was different (70.3 and 69.2 years, respectively). That is, patients treated with antifibrotics were included about 1 year earlier than untreated patients. In figure 2, consequently, the part of the Kaplan–Meier survival curve for patients with antifibrotic therapy to be compared with the survival curve of patients without antifibrotic therapy starts at about 1 year of follow-up. To the naked eye it seems that the slope of this part of the curve is not less steep than the curve of the untreated patients. Contrary to the claim of the authors, the observations of this large registry do not argue for immediate antifibrotic treatment of patients with newly diagnosed IPF with few symptoms, minor functional impairment, and, most importantly, no evidence of progression from history, functional studies, or imaging. These patients do exist and the best therapeutic approach to them must be established in a prospective clinical trial. It might well be that the concept of progressive fibrosing interstitial lung disease, now largely accepted for non-IPF interstitial lung disease, may apply to IPF too [2].