

Peer Review File

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Reviewer A

Major comments:

1. What would be interesting is if the authors could then compare the clinical impact on their cohort of classifying more patients as typical fibrotic HP using the CHEST guidelines - does it make a difference to prognosis, exacerbation rates, outcomes?

RESPONSE: We appreciate your constructive comment. As the reviewer suggested, we made new figure 6, and we have added the following sentence to the Results section: After the reclassification with the HRCT classification of the CHEST HP guideline, no significant difference in overall survival was observed between typical HP and compatible with HP on HRCT in CHEST guideline (HR = 1.61; [95% confidence interval [CI]: 0.31–8.41]; P = 0.57) (Figure 6a). Where events were defined as death, acute exacerbation, or LTOT, no significant difference in events was observed between two groups (HR = 1.69; [95% confidence interval [CI]: 0.59–4.84]; P = 0.33) (Figure 6b).

2. If no, then should we apply the CHEST guidelines in clinical practice for higher diagnostic confidence?

RESPONSE: We appreciate your constructive comment. We have added the following sentence to the Discussion section: In this study, the diagnostic confidence of the CHEST HP guideline was low in its ability to discriminate overall survival and events of death, acute exacerbation, or initiation of long-term oxygen therapy; however, this study included only patients with compatible with fibrotic HP of the CT classification using the ATS/JRS/ALAT HP guideline.

Reviewer B

Major comments:

1. I have some major comments: Typical HRCT images according to different classification criteria need to be provided, including ATS/JRS/ALAT HP guideline and CHEST HP guideline.

RESPONSE: We appreciate your constructive comment. As the reviewer suggested, we made new figure 2, and we have added the following sentence to the Results section: In Figure 2a and b, GGOs distributed predominantly in the lower lobe were judged as the diffuse GGO pattern group with compatible with fibrotic HP according to the ATS/JRS/ALAT guideline. In Figure 2c, the ATS/JRS/ALAT guideline considered the UIP pattern group as compatible with fibrotic HP.

2. In addition to classification, can the extent of lesion involvement provide quantitative parameters, such as the volume and proportion of fibrosis and GGO involvement?

RESPONSE: We appreciate your constructive comment. We apologize very much for not being able to respond to your comments. Our current resources do not allow for quantitative evaluation of the images in this study. We would like to make this one of our next research topics.

3. HRCT images were evaluated by two respiratory physicians and need to be evaluated by radiologists and to provide consistency between the evaluations of different imaging features.

RESPONSE: We appreciate your constructive and important comment. With your suggestion, we asked our radiologist to judge the HRCT images. In a number of cases where the two respiratory physicians were divided in their decisions, we referred the diagnosis to a chest radiologist. We have added the following sentence to the Methods section: A respiratory physician (S.K.) and a respiratory physician (R.O.) specializing in ILD judged the HRCT independently, and if they disagreed on the pattern classification, they discussed the HRCT pattern together. In patients where the two respiratory physicians could not reach agreement after discussion, a chest radiologist judged the HRCT.

In addition, the number of patients in the study was changed based on the radiologist's judgment.

4. HRCT images of post-treatment follow-up showing lesion deterioration or improvement are required.

RESPONSE: We appreciate your constructive comment. As the reviewer suggested, we made new figure 5, and we have added the following sentence to the Results section: In Figure 5, the course of representative HRCT images of the diffuse GGO pattern group and the UIP pattern group was showed.

5. Typical images of two different guidelines classifying the same case differently are required, along with an explanation of the reasons for the change in classification.

RESPONSE: We appreciate your constructive comment. As the reviewer suggested, we made new figure 2, and we have added the following sentence to the Results section: In figure 2a, GGOs distributed predominantly in the lower lobes were judged as GGO pattern group in compatible with fibrotic HP according to the ATS/JRS/ALAT guideline, and compatible with fibrotic HP according to the CHEST guideline. In Figure 2b, the ATS/JRS/ALAT guideline considered the GGO pattern group as compatible with fibrotic HP; GGOs was present in all lung zone of subpleural areas, which was considered as typical fibrotic HP according to the CHEST guideline. In figure 2c, the ATS/JRS/ALAT guideline considered the UIP pattern group as compatible with fibrotic HP, while the CHEST guideline considered it as typical fibrotic HP due to the presence of centrilobular nodules of GGO in all lung zones.