Multidisciplinary Approach Improves Autoimmune ILD Management

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Autoimmune interstitial lung disease (ILD) presents a diagnostic and management challenge due to its heterogeneous nature and overlap with various rheumatological conditions. Effective patient care necessitates a coordinated approach that integrates specialist expertise to ensure timely diagnosis and optimal therapeutic strategies.

KEY TAKEAWAYS

- The Pivot: A multidisciplinary team (MDT) approach is advocated as the standard of care for autoimmune ILD, moving beyond siloed specialist consultations.
- The Data: While specific quantitative data from a single trial is not available, expert consensus at EULAR 2026 underscored the qualitative benefits of MDT in reducing diagnostic delays and improving treatment selection.
- The Action: Clinicians managing patients with suspected or confirmed autoimmune ILD should establish formal pathways for collaboration with rheumatology, radiology, and pulmonology colleagues.

Autoimmune interstitial lung disease (ILD) is a complex condition often associated with systemic autoimmune rheumatic diseases (SARDs) such as rheumatoid arthritis, systemic sclerosis, and myositis. The pulmonary manifestations can precede, coincide with, or follow the onset of rheumatological symptoms, complicating diagnosis and management.1 The heterogeneity of ILD patterns, including usual interstitial pneumonia (UIP), non-specific interstitial pneumonia (NSIP), and organizing pneumonia (OP), further necessitates precise characterisation to guide treatment.2 Historically, patients with suspected autoimmune ILD might navigate multiple specialist appointments sequentially, leading to delays in definitive diagnosis and initiation of appropriate therapy. This fragmented approach can result in suboptimal outcomes, particularly given the progressive nature of some ILD subtypes.3 The need for a unified strategy that integrates the distinct but complementary expertise of various specialists has become increasingly apparent. The prevalence of ILD in SARDs varies significantly, with estimates ranging from 15% to 80% depending on the specific SARD and diagnostic methods employed. For instance, ILD affects a substantial proportion of patients with systemic sclerosis, often contributing significantly to morbidity and mortality. Early and accurate diagnosis is therefore paramount to mitigate disease progression and improve patient prognosis.

The Multidisciplinary Team Approach

At EULAR 2026, discussions highlighted the critical role of a multidisciplinary team (MDT) in optimising care for patients with autoimmune ILD. The proposed MDT model typically includes a rheumatologist, a pulmonologist, and

a radiologist, with input from pathologists and other specialists as needed.4 This collaborative framework aims to streamline the diagnostic process, improve the accuracy of ILD subtyping, and facilitate personalised treatment plans. The rheumatologist contributes expertise in identifying underlying SARDs, assessing systemic disease activity, and managing immunomodulatory therapies. Their role is crucial in distinguishing autoimmune ILD from idiopathic forms and in guiding the selection of immunosuppressive agents.5 The pulmonologist provides expertise in lung physiology, respiratory symptom management, and the assessment of ILD progression. They are responsible for monitoring lung function, managing respiratory complications, and coordinating lung-specific interventions.6

The radiologist's contribution is fundamental for interpreting high-resolution computed tomography (HRCT) scans of the chest. Accurate radiological pattern recognition (e.g., UIP, NSIP) is essential for diagnosis and prognostication.7 In an MDT setting, the radiologist can directly discuss imaging findings with the clinical team, correlating them with patient history and serological markers to reach a consensus diagnosis. This direct communication minimises misinterpretations and ensures that imaging data is integrated effectively into the overall clinical picture.8 Pathologists, when involved, provide crucial insights from lung biopsies, particularly in cases where HRCT findings are indeterminate or when specific histological patterns are required for definitive diagnosis or exclusion of other conditions. This comprehensive evaluation ensures that all available clinical, serological, radiological, and pathological data are considered before a final diagnosis is rendered.

The MDT approach facilitates a comprehensive evaluation of each patient, allowing for a holistic understanding of their disease. This includes not only the specific ILD pattern and its severity but also the activity of any underlying SARD, comorbidities, and individual patient preferences.9 The consensus opinion generated by the MDT can lead to more confident diagnostic labels, which in turn supports the timely initiation of targeted therapies, such as antifibrotic agents or specific immunosuppressants, potentially slowing disease progression and preserving lung function.10 For example, antifibrotic agents like nintedanib work by inhibiting multiple tyrosine kinases, thereby blocking key pathways involved in fibrotic processes. Immunosuppressants, such as mycophenolate mofetil or azathioprine, modulate the immune response to reduce inflammation and prevent further tissue damage.

While specific randomised controlled trials comparing MDT care to standard care in autoimmune ILD are challenging to design and execute, observational data and expert consensus strongly support its implementation. The qualitative benefits include reduced diagnostic delays, improved diagnostic accuracy, and enhanced treatment selection.11 Limitations of this approach primarily involve logistical challenges in coordinating multiple specialists and ensuring regular MDT meetings, particularly in resource-constrained settings. These challenges can include scheduling conflicts among busy specialists, the need for dedicated administrative support, and the technological infrastructure required for efficient information sharing. Furthermore, the availability of all necessary subspecialists, such as expert lung pathologists, may be limited in certain regions. Future research should focus on developing standardised MDT protocols and evaluating their impact on long-term patient outcomes and healthcare resource utilisation.

To deepen your understanding of the rheumatological aspects crucial to multidisciplinary autoimmune disease management, we recommend the authoritative Oxford Handbook of Rheumatology.

CLINICAL IMPLICATIONS

The emphasis on a multidisciplinary team (MDT) for autoimmune ILD at EULAR 2026 is less a novel discovery and more a formalisation of best practice. For too long, patients with complex conditions like autoimmune ILD have been shunted between specialists, each providing excellent care within their silo but often missing the crucial interplay of systemic disease and pulmonary manifestations. This fragmented approach is inefficient and, frankly, detrimental to patient outcomes, particularly when progressive fibrotic ILD is a concern. The call for rheumatologists, pulmonologists, and radiologists to collaborate formally is not merely academic; it is a pragmatic necessity that should be reflected in clinical pathways.

From a patient perspective, the benefits are clear: a more rapid and accurate diagnosis, leading to earlier intervention. This is particularly pertinent given the availability of antifibrotic agents, which are most effective when initiated early in the disease course. Delays in diagnosis mean lost opportunities to preserve lung function. For clinicians, this means moving beyond informal consultations to structured MDT meetings, which, while demanding in terms of time and coordination, ultimately lead to more confident treatment decisions and potentially better patient adherence due to a clearer understanding of their condition. The administrative burden of establishing such teams should not overshadow the clinical imperative.

Industry, particularly pharmaceutical companies developing therapies for ILD and SARDs, should recognise the implications of this shift. As diagnostic precision improves through MDT input, the patient populations for specific therapies will become better defined. This could lead to more targeted prescribing and potentially influence future trial designs, moving towards studies that reflect real-world MDT-driven diagnoses. Guideline bodies, such as EULAR and ATS/ERS, should integrate strong recommendations for MDT care into their next iterations, providing the necessary framework for widespread adoption and ensuring that this collaborative model becomes the undisputed standard of care, rather than an aspirational ideal.

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