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Reply to the letter to the editor: Pulmonary rehabilitation in hypersensitivity pneumonitis: A retrospective case series

Nazire Nur Yıldız¹, Meral Boşnak Güçlü², Nilgün Yılmaz Demirci³

ORCID:

Nazire Nur Yıldız: 0000-0001-5838-4869

Meral Boşnak Güçlü: 0000-0002-3861-9912

Nilgün Yılmaz Demirci: 0000-0001-6160-3778

We sincerely thank the authors^[1] for their thoughtful and encouraging comments regarding our recently published case series.^[2] We are grateful for their careful reading of our work and for highlighting key aspects of our study design and clinical approach.

Our individualized pulmonary rehabilitation (PR) protocols were deliberately structured to reflect real-world clinical practice for patients with hypersensitivity pneumonitis (HP) and were supported by comprehensive outcome measures to enhance clinical interpretability. As outlined in our report, the primary aim was to provide a structured, clinically applicable rehabilitation model to inform multidisciplinary management in this underrepresented population.^[2]

Inspiratory muscle training was incorporated into our PR protocols, despite normal baseline values of inspiratory

muscle strength, to preserve and enhance inspiratory muscle strength, which may decline due to the underlying pathophysiology of interstitial lung disease (ILD). Current evidence indicates that IMT improves inspiratory muscle strength and is associated with reductions in dyspnea, improvements in exercise capacity (e.g., 6-minute walk distance), and enhancements in oxygen consumption in patients with ILD.^[3-6] These studies were not restricted to patients with respiratory muscle weakness, suggesting that the benefits of IMT extend beyond a purely deficit-based indication.^[7] Because HP is a disease that can progress rapidly and result in early functional limitations, we expected that inspiratory muscle training would yield both physiological and clinical benefits. Given the limited pharmacological treatment options and the early functional deterioration in HP, rehabilitation gains are of particular importance in this pop-

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For reprints contact: kare@karepb.com



¹Department of
Cardiopulmonary
Physiotherapy, Niğde Ömer
Halisdemir University, Bor
Faculty of Health Sciences,
Niğde, Türkiye.

²Department of
Cardiopulmonary
Physiotherapy and
Rehabilitation, Gazi
University Faculty of Health
Sciences, Ankara, Türkiye.

³Department of
Pulmonology, Gazi
University Faculty of
Medicine, Ankara, Türkiye

**Address for
correspondence:**

Nazire Nur Yıldız, P.T., Ph.D.
Department of
Cardiopulmonary
Physiotherapy, Niğde Ömer
Halisdemir University, Bor
Faculty of Health Sciences,
Niğde, Türkiye.
E-mail:
nnur_yildiz_58@hotmail.com

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ulation. In this context, structured PR, including IMT, may influence morbidity and mortality outcomes, and this should be systematically investigated in prospective studies. Continuous monitoring was maintained throughout the exercise sessions, and supplemental oxygen was administered when clinically indicated to ensure patient safety and to allow individualized adjustment of exercise intensity in patients with HP. The divergence between physical and psychological outcomes underscores the multidimensional nature of PR and the need to integrate psychosocial components into structured programs.

Furthermore, the functional improvement observed in a severely deconditioned patient provides preliminary support for the feasibility of individualized rehabilitation in advanced HP. Given the retrospective design, the small number of cases, the rarity of HP, and the limited availability of structured PR data in this population, conducting large prospective studies remains challenging. To our knowledge, this report represents the first case series specifically evaluating structured, individualized PR in HP. Recent evidence published within the last five years consistently supports the role of PR in patients with ILD, particularly in improving exercise capacity and health-related quality of life.^[7,8] However, data specific to HP remain limited.^[9,10] In this context, our findings provide preliminary evidence and establish a foundation for prospective and multicenter investigations.

This constructive academic exchange underscores a gap in the literature. It emphasizes the clinical importance of structured, individualized PR in HP, while reinforcing the need for continued prospective, multicenter research in this field.

Conflicts of Interest

The authors have no conflicts of interest to declare.

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