Combining patient history, physical examination, laboratory studies, imaging, and pathologic analysis allows for these entities to be distinguished from other forms of diffuse parenchymal lung disease. However, these computed tomography (CT) and histologic patterns of lung injury are frequently similar or identical to those seen in many other conditions, including connective tissue disease, drug reactions, asbestosis, and chronic hypersensitivity pneumonitis. The term idiopathic is reserved for those conditions in which the cause of the lung injury pattern is unknown.

Previous classifications of the IIPs have been replaced with a unified classification composed by the American Thoracic Society and European Respiratory Society emphasizing the...
complementary roles of the pathologist, radiologist, and clinician in diagnosis. These societies convened an international committee of pulmonary clinicians, thoracic radiologists, and pulmonary pathologists to clarify disease nomenclature and patterns. Although the classification of IIPs is rooted in histologic criteria, there is a definite recognition that the pattern at thin-section CT is important in delineating the morphology of the IIPs.

UIP is one of the most common interstitial lung diseases, and high-resolution CT (HRCT) features prominently in the American Thoracic Society (ATS) diagnostic algorithm for IPF. The diagnosis of UIP is frequently based on clinical and imaging features, without the need for surgical biopsy, because of the high accuracy of thin-section CT diagnosis in many cases of UIP. Typical CT-based morphologic patterns are associated with the IIPs, and radiologists play an important role in diagnosis and characterization. Basal and peripheral predominant reticular pattern with honeycombing and traction bronchiectasis characterizes UIP. Basal and peripheral or peribronchovascular ground-glass opacity with or without reticular pattern and traction bronchiectasis characterizes NSIP. The smoking-related lung diseases RB-ILD and DIP demonstrate centrilobular nodules and lower-lobe predominant ground-glass opacity (frequently with cysts), respectively. Patchy peripheral or peribronchovascular consolidation and ground-glass typifies COP. Diffuse lung consolidation and ground-glass opacity characterizes AIP. Ground-glass opacity and perivascular cysts typify LIP. Dense upper-lobe pleuroparenchymal fibrosis characterizes IPPFE. All IIPs should be classified using an interdisciplinary approach. Plain film features are non-specific. While chest radiographs can be even normal in patients with very early disease, in advanced disease, it may show decreased lung volumes and basal fine to coarse reticulation. Usually, due to the more extensive involvement of the lower lobes, the major fissure is shifted inferiorly which is best seen on the lateral chest radiograph.

**REFERENCES**


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**Description of the images**

The chest x-ray reveals subtle peripheral patchy opacities and elevation of the right hemidiaphragm as consequence of lung volume loss.

The CT images show peripheral bibasilar honeycombing images associated with retraction bronchiectasis and reticular opacities.

Diagnosis: Usual interstitial pneumonia (UIP)

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**Answer to the Quiz**

1. A, C and D
2. A, B and E