

non-smoking woman with a positive antisynthetase antibody and otherwise unexplained NSIP and organising pneumonia may have a different ILD phenotype, prognosis and response to treatment than an older Caucasian cigarette smoking man with a positive rheumatoid factor and UIP on surgical lung biopsy who meets IPAF criteria through either a diffuse lymphoplasmacytic infiltrate or unexplained multi-compartment involvement of the airways, pulmonary vasculature or pleural or pericardial abnormalities. In addition, as many patients with NSIP and organising pneumonia are treated with immunosuppressive therapy if there is any suggestion of an autoimmune phenotype, the performance of the IPAF criteria in patients with UIP and unclassifiable ILD may be most important of all [6].

In summary, we agree with A.S. Jee and colleagues that evaluation of the patient with interstitial pneumonitis requires a multidisciplinary collaboration including rheumatology, with uniformity and standardisation in CTD definitions when applying the IPAF criteria. We are excited and inspired by the recognition, research and dialogue the formulation and publication of the IPAF criteria has generated. We look forward to the day when all patients will have a validated assessment of the contribution of autoimmunity to their ILD with a resulting diagnosis that accurately reflects their prognosis and response to treatment.



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**IPAF criteria need to be implemented in a standard fashion across centres for accurate validation** <http://ow.ly/W7Fz304BKq0>

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# Smoke-free legislation and its impact on paediatric respiratory health



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*To the Editor:*

We read with great interest the study by VARDAS *et al*. [1] confirming the independent and interacting roles of tobacco smoke exposure during pregnancy and after birth in the development of respiratory diseases.

In the accompanying editorial, ZAIRINA [2] therefore appropriately calls for the protection of pregnant women and young children from tobacco smoke exposure. In so doing, she highlighted a number of potentially effective tobacco control interventions. We were, however, surprised to see that perhaps the most obvious public health intervention to protect the population from tobacco smoke was not mentioned: the implementation of smoke-free legislation. A large body of evidence now clearly shows that implementation

of comprehensive smoke-free legislation is associated with improvements in the respiratory health of both children and adults [3, 4]. For example, this evidence has demonstrated reductions in the risk of hospitalisations from asthma exacerbations [5], and the potential to reduce hospitalisations from acute respiratory tract infections [6–8]. Reductions in second-hand smoke exposure in public places as well as the home environment are likely to have been responsible for these improvements [9].

Smoke-free legislation is probably the most straightforward population-wide policy intervention to protect people from tobacco smoke exposure, and its health impact is well supported by a large body of existing evidence [3–5]. As ZAIRINA [2] appropriately points out, the lack of studies assessing the effectiveness of tobacco control policies in low- and middle-income countries is a particularly important knowledge gap which needs to be addressed and this also accounts for smoke-free legislation [2, 5]. Over 80% of the world's population is currently not covered by comprehensive smoke-free laws [10]. Therefore, we argue that alongside the suggested focus on developing new interventions, it is important to globally increase the uptake of such policies whose effectiveness has already been established to protect the health of both children and adults.



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**Protecting children from tobacco smoke exposure via smoke-free legislation can benefit respiratory health** <http://ow.ly/FIHe3033Xr9>

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