

RESEARCH

Open Access



Psychometric properties and minimal important differences of SF-36 in Idiopathic Pulmonary Fibrosis

Sabine Witt^{1*}, Ekaterina Krauss^{2,3}, María Asunción Nieto Barbero^{2,4}, Veronika Müller^{2,5}, Philippe Bonniaud^{2,6}, Carlo Vancheri^{2,7}, Athol U. Wells^{2,8}, Martina Vasakova^{2,9}, Alberto Pesci^{2,10}, Walter Klepetko^{2,11}, Werner Seeger^{2,3,12}, Bruno Crestani^{2,13}, Reiner Leidl^{1,14}, Rolf Holle¹, Larissa Schwarzkopf¹ and Andreas Guenther^{2,3,12,15}

Abstract

Background: Idiopathic pulmonary fibrosis (IPF) is a rare disease with a median survival of 3–5 years after diagnosis with limited treatment options. The aim of this study is to assess the psychometric characteristics of the Short Form 36 Health Status Questionnaire (SF-36) in IPF and to provide disease specific minimally important differences (MID).

Methods: Data source was the European IPF Registry (eurIPFreg). The psychometric properties of the SF-36 version 2 were evaluated based on objective clinical measures as well as subjective perception. We analysed acceptance, feasibility, discrimination ability, construct and criterion validity, responsiveness and test-retest-reliability. MIDs were estimated via distribution and anchor-based approaches.

Results: The study population included 258 individuals (73.3% male; mean age 67.3 years, SD 10.7). Of them 75.2% (194 individuals) had no missing item. The distribution of several items was skewed, although floor effect was acceptable. Physical component score (PCS) correlated significantly and moderately with several anchors, whereas the correlations of mental component score (MCS) and anchors were only small. The tests showed mainly significant lower HRQL in individuals with long-term oxygen therapy. Analyses in stable individuals did not show significant changes of HRQL except for one dimension and anchor. Individuals with relevant changes of the health status based on the anchors had significant changes in all SF-36 dimensions and summary scales except for the dimension PAIN. PCS and MCS had mean MIDs of five and six, respectively. Mean MIDs of the dimensions ranged from seven to 21.

Conclusion: It seems that the SF-36 is a valid instrument to measure HRQL in IPF and so can be used in RCTs or individual monitoring of disease. Nevertheless, the additional evaluation of longitudinal aspects and MIDs can be recommended to further analyse these factors. Our findings have a great potential impact on the evaluation of IPF patients.

Trial registration: The eurIPFreg and eurIPFbank are listed in <https://clinicaltrials.gov> (NCT02951416).

Keywords: Idiopathic pulmonary fibrosis, Rare diseases, Quality of life, Patient-reported outcome

* Correspondence: sabine.witt@helmholtz-muenchen.de

¹Helmholtz Zentrum München, German Research Center for Environmental Health (GmbH), Institute of Health Economics and Health Care Management, Member of the German Center for Lung Research (DZL), Comprehensive Pneumology Center Munich (CPC-M), Neuherberg, Germany
Full list of author information is available at the end of the article



Background

Idiopathic pulmonary fibrosis (IPF) is a rare disease with a median survival of 3–5 years after diagnosis [1]. Current treatment options as pirfenidone and nintedanib are still limited in respect to prolonging life [2]. Mortality alone does not appear to be a sufficient clinical endpoint regarding patients' outcomes [1, 3–5]. Thus, health-related quality of life (HRQL) as a patient-reported outcome gains relevance [6]. Existing HRQOL instruments are not yet sufficiently validated as clinically meaningful endpoints in IPF [7–9]. Therefore, the utilisation of validated HRQL instruments is strongly recommended for marketing-authorisation application of novel treatments [10, 11].

The Short Form 36 Health Status Questionnaire (SF-36) is a generic instrument [12] which is frequently used in clinical trials in IPF as a secondary endpoint [13–15]. Generic HRQOL instruments are designed to measure overall health states and allow comparisons across patients with different diseases and the general population. Evaluating the validity of these generic instruments in specific diseases is indispensable and is also needed for the SF-36 in IPF [9]. Currently, two studies provide psychometric characteristics of the SF-36 in IPF based on longitudinal data [16, 17]. It is our knowledge that only these studies analysed if the SF-36 can detect changes or stability over time of HRQL, which is essential as an endpoint in clinical trials. Tomioka et al. used observational data of a single outpatient centre in Japan [16]. The analysis of Swigris et al. was based on international multicentre-data, which were part of the randomised clinical trial BUILD-1. Thus, the study population was subject to numerous inclusion and exclusion criteria [17, 18]. Hence, the external validity of the results of both studies might be reduced. Belkin et al. proposed additional research should take place before a broad implementation of the SF-36 [8]. Moreover, only Swigris et al. provide disease specific minimally important differences (MID), which are obligatory to evaluate changes in QOL over time [17, 19]. Therefore, patients would benefit from further longitudinal analysis based on multicentre-data and in a real-world setting.

The aim of this study was (1) to assess the psychometric characteristics of the SF-36 in IPF (acceptance and feasibility; discrimination ability; construct and criterion validity, and internal consistency; responsiveness and test-retest-reliability). Furthermore, we intended (2) to evaluate disease specific MIDs, using data from a comprehensive European registry, which provides real-world data from patients in different disease stages and ethnical backgrounds.

Materials and methods

Data and participants

Data source was the European IPF Registry (eurIPFreg), one of Europe's leading IPF longitudinal databases with

nine participating countries and eleven study centres [20]. Both, eurIPFreg and eurIPFbank (biobank of eurIPFreg) have been reviewed and received positive votes from institutional review boards in Germany (e.g. Ethics Committee of Justus-Liebig-University of Giessen; 111/08), France, Italy, Austria, Spain, Czech Republic, Hungary and the UK. The research was conducted strictly according to the principles of the Declaration of Helsinki. The eurIPFreg and eurIPFbank are listed in [ClinicalTrials.gov](https://clinicaltrials.gov) (NCT02951416). Patients were included into the registry starting November 2009. The datasets generated and investigated during the current study are not publicly available due to registry regulations, but are available from the corresponding author on reasonable request and agreement of the Principle Investigators of the eurIPFreg.

Patients' data were collected by standardised questionnaires for physicians and patients at baseline and follow-up visits with intervals of three to six months, considering individual necessity and practical issues. Interim documentation in case of unscheduled visits was possible. The collected data was comprehensive and included besides clinical measurements and demographic data, also patient-self-reported instruments [21].

The study population was comprised of incident and prevalent IPF patients. There were following exclusion criteria: subjects without information of sex and age, absence of IPF diagnosis validated by a multidisciplinary team, missing lung function test at baseline, absent or incomplete information on SF-36 items (more than 50% missing values within each dimension) [22]. In case of missing date of filling out the questionnaires or medical examinations, we used the predefined follow-up date.

HRQL instrument

The SF-36 version 2 was used [22]. It contains 36 items categorised into 8 dimensions (vitality (VITAL), physical functioning (PFI), bodily pain (PAIN), general health perceptions (GHP), physical role functioning (ROLPH), emotional role functioning (ROLEM), social role functioning (SOCIAL), mental health (MHI)) and a physical as well as a mental component score (PCS and MCS), which can be calculated for individuals providing all dimensions. The dimensions range from zero to 100; higher values imply higher functional health and well-being. The PCS and MCS are adjusted to normal distribution (mean equal 50, standard deviation (SD) equal 10) with higher values for better functional health and well-being. Scores were calculated based on German scoring system to provide comparability since the majority of considered patients were Germans [23].

Anchors

For purposes of examining the validity of the SF-36 in IPF, we used the following anchors at baseline and

follow-up: 6 min walking distance (6MWD) [24–26], percent of the predicted value of forced vital capacity (FVC % pred) (based on Global Lungs Initiative (GLI) equations), percent of predicted value of carbon monoxide diffusion capacity of the lung (corrected for haemoglobin, and if not available uncorrected values (DLCO % pred)), and also modified New York Heart Association Classification (NYHA) grade, evaluated by the physician (I–IV, the higher the more impaired) [27],

Baseline Dyspnoea Index (BDI) (scale 0–12, the lower the more impaired) (baseline only) and Transitional Dyspnoea Index (TDI) (scale –9 to 9, the lower the more impaired) (follow-up only) [28], long-term oxygen therapy (LTOT) (baseline only), Modified Medical Research Council (mMRC) Dyspnea Scale (1–5, the higher the more impaired) (baseline only) [29], and an item of the SF-36 which indicates perceived change in health during the previous year (follow-ups only). This SF-36 item was not included in any of the dimensions and component scores [12, 22].

Cross-sectional analysis

The SF-36 value was not captured during the first visit in all cases. Therefore, in this study we defined baseline as the date of the first filled in SF-36. Additionally, not all examinations were performed at each visit and we therefore decided to accept anchors within a timeframe of plus/minus 45 days around the first visit filled in SF-36. The time frame of 45 days was chosen because frequently, the date was only given as month/year and we needed to set the day to the 15th. Since the SF-36 considers the health status of the last 4 weeks and in some cases the exact date of examination was set to the mid of month, we decided to use 45 days as the maximum interval between anchors and SF-36.

Acceptance and feasibility

To assess acceptance and feasibility we examined the frequency of missing responses to items. As there might be some differences in specific populations, we searched for a possible influence of age, gender and severity of disease (estimated by DLCO % pred, FVC % pred, 6MWD) on the frequency of missing items via Pearson and Spearman correlation for metric and categorical variables, respectively.

Discrimination ability

Ceiling and floor effects in single items were examined as a possible indicator of an insufficient discrimination ability.

Construct and criterion validity, and internal consistency

The construct validity of the domains and summary measures was checked for individuals with and without

LTOT via Wilcoxon-Mann-Whitney test to consider possible non-normal distribution. We assumed that individuals with LTOT have a lower HRQOL than individuals without [30].

The criterion validity of the domains and summary measures was evaluated via Pearson correlation in case of metric anchors and Spearman correlation in case of ordinal anchors. A better health status and thus better values of the anchors should implicate higher HRQOL and vice versa. Strength of correlation was categorized according to Cohen in great (greater than 0.5), moderate (0.3–0.5), small (0.1–0.3), and trivial (less than 0.1) [31]. Internal consistency was assessed with Cronbach's alpha for the domains and summary scores of the SF-36.

Longitudinal analysis

Considering the flexible intervals between the visits, the time frame between baseline and follow-up could not be defined a priori. As the SF-36 evaluates the HRQOL of the last four weeks, the interval between baseline and follow up needed to be of at least 28 days, except the SF-36 change item which has a time horizon of one year, here we considered only follow-ups with an interval of 300 to 450 days.

Consistent with the baseline procedure, the follow-up anchors were selected within a time frame of plus/minus 45 days around a filled in SF-36 form. For this purpose, we used a stepwise approach to find the nearest anchor around the SF-36 measurement and excluded matched anchors before we started the next search. An anchor examination was never used for two SF-36 measurements. The number of follow up visits with documented HRQOL and anchors varied and could possibly be more than one. In order to improve the power of these analyses, we decided to use the first and last observation per anchor and individual, provided their health status (improved vs. baseline, deteriorated vs. baseline, same as baseline) varied between these two observations. For example, if the health status was initially stable but deteriorated afterwards, we used both events in different groups and therefore different analyses. Considering an individual twice in one group (e.g. deterioration) would have lead to a bias. In this case, we considered only the last measurement of the respective anchor. For TDI we used only one observation, which was plus/minus 45 days around a filled in SF-36 compared to the preceding SF-36 as the instrument measures the change between two visits.

Responsiveness and test-retest- reliability

For assessing responsiveness and test-retest-reliability the individuals were categorized depending on whether their health status and thus their anchors changed during the follow-up or not. We defined variations with

more than the MID of the anchor as improvement and deterioration, respectively. If the shift from baseline to follow up was less than the MID, we defined the anchor as unchanged. We defined the following MIDs for the changes of the anchors: 6MWD ≥ 30 m [32–34], FVC % pred $\geq 10\%$, and DLCO % pred $\geq 15\%$ [35], TDI =1 [28, 36], modified NYHA score ≥ 1 [37]. If the anchor is stable, there should not be a significant difference in the SF-36 between baseline and follow up (test-retest-reliability). The responsiveness was tested by comparing baseline and follow up values of the SF-36 for improved and deteriorated anchors separately. A relevant change of the anchors should implicate a significant shift of HRQL. We used Wilcoxon signed-rank test in case to consider possible non-normal distribution of differences and possible small numbers of observations within the anchors per group.

Minimal important difference (MID)

The MIDs of the summary scores and the dimensions were estimated anchor- and distribution-based. To obtain distribution-based MIDs we used half standard deviation (SD) of baseline values of normally distributed domains [38, 39]. Normality was evaluated by visual inspection [38, 39].

For anchor-based MIDs, only anchors providing a correlation ≥ 0.3 at baseline to ensure sufficient relationships were considered [31, 39]. MIDs were estimated via linking, which are unaffected by the degree of correlation [40]. Therefore, the MID of the anchor was multiplied by the quotient of the baseline SD of the HRQL domain and the baseline SD of the anchor.

$$MID_{HRQL} = MID_{anchor} \times (SD_{HRQL}/SD_{anchor})$$

As only metric anchor provide meaningful SD, categorical anchors needed to be excluded and only following metric anchors were used: 6MWD, FVC % pred, and DLCO % pred. The mean of distribution- and anchor-based MIDs (if normally distributed and anchor correlated significantly and $r \geq 0.3$) was calculated to provide an overall estimate of the specific MID. Additionally, the mean of the distribution-based MID with the MID of the anchor with the highest correlation was provided.

Sensitivity analysis

To detect possible bias we tested a possible influence of study sites on HRQL, adjusted for age, gender, DLCO % pred, FVC % pred and 6MWD.

All statistical analyses were performed using SAS software (version 9.3, ©2002–2010 by SAS Institute Inc., Cary, NC, USA).

Results

Cross-sectional analysis

Out of 528 IPF patients, we excluded 139 patients as they had no SF-36 and one individual who had only answered one question. From the resulting 388 patients we excluded three individuals without information on gender and six individuals without date of birth. From the remaining 379 individuals, there was no FVC measurement around the first SF-36 in 121 cases. That does not mean there was no FVC measurement at all, but not within 45 days around the first SF-36. The study population included 258 individuals (73.3% male) with a mean age of 67.3 years (SD 10.7) and on average 2.6 years since first diagnosis (SD 2.8). In spite of a tolerance, a period of plus/minus 45 days between SF-36 and anchor, it was not possible to provide all anchors for each patient. HRQL presented in MCS and PCS was considerably reduced compared with norm values (mean 45.3, SD 11.8 and mean 34.6, SD 10.5 versus mean 50.0, SD 10.0) (Table 1). Except for ROLEM and ROLPH all HRQL measures were normally distributed based on visual validation.

Acceptance and feasibility

Regarding single items, 75.2% (194 individuals) had no missing item in the SF-36, 21.3% ($n = 55$) one to ten and 3.5% ($n = 9$) eleven to 28 missing items. The number of missing items and age ($r = 0.13$, $p = 0.03$) correlated significantly. Gender as well as severity of disease were of no significant influence. A graphic representation on item level can be found in the Additional file 1 Figure S1. Within the dimensions, the percentage of completely answered items ranged from 93.0% (ROLEM) to 95.7% (PAIN) (Table 2).

Discrimination ability

The distributions of several items were skewed, six had a tendency of more than 60% towards the worst answer category: ROLPH 1–4 (67.9, 74.3, 69.1 and 69.1%) and PFI 1 (78.9%) and 4 (65.6%). Almost half of the study population rejected (answer: ‘definitely false’) that their ‘health is excellent’ (45.8%, item 5 of GHP, possible answers: definitely true; mostly true; don’t know; mostly false; definitely false) (Additional file 2 Figure S2).

Construct and criterion validity, and internal consistency

PCS correlated significantly and moderately with several anchors whereas MCS did not correlate with any anchor with $r \geq 0.3$. ROLEM, MHI and PAIN did not reach moderate or high correlations either. Other dimensions correlated significantly with particular anchors on a moderate to high level (Table 3). The tests showed significant lower HRQL in individuals with LTOT except for MCS, MHI, and PAIN (Table 4). Cronbach’s alpha

Table 1 Baseline characteristics

		n valid	n missing	mean / frequency	sd / %
Age (in years)	mean (sd)	258	0	67.3	10.7
Gender	frequency (%)	258	0		
	male			189	73.3
Study site	frequency (%)	258	0		
	Paris			73	28.3
	Giessen			153	59.3
	London			9	3.5
	Vienna			12	4.7
	Prague			3	1.2
	Napoli			1	0.4
	Budapest			6	2.3
Smoker	frequency (%)				
	current or ever	248	10	181	73.0
Time since diagnosis (in years)	mean (sd)	249	9	2.6	2.8
FVC (in percent of predicted)	mean (sd)	258	0	62.7	19.8
DLCO (in percent of predicted)	mean (sd)	228	30	41.8	18.8
6MWD (in meters)	mean (sd)	181	77	403.1	120.1
LTOT	frequency (%)				
	current	244	14	82	33.6
LTx	frequency (%)	239	19		
	listed			3	1.3
	transplantated			4	1.7
SF-36	mean (sd)				
	PCS	232	26	34.6	10.5
	MCS	232	26	45.3	11.8
	GHP	250	8	40.3	18.4
	PFI	253	5	42.2	27.8
	ROLPH	247	11	30.2	40.5
	ROLEM	244	14	56.2	45.8
	SOCIAL	257	1	62.0	28.5
	MHI	250	8	62.5	21.3
	PAIN	255	3	65.1	28.2
BDI (range 0–12)	frequency (%)	140	118		
	4			2	1.4
	5			3	2.1
	6			44	31.4
	7			48	34.3
	8			30	21.4
	9			10	7.1
	10			3	2.1

Table 1 Baseline characteristics (*Continued*)

		n valid	n missing	mean / frequency	sd / %
mMRC (range 1–5)	frequency (%)	196	62		
	1			35	17.9
	2			61	31.1
	3			44	22.5
	4			27	13.8
Modified NYHA scale (1–4)	frequency (%)	229	29		
	1			23	10.0
	2			97	42.4
	3			95	41.5
	4			14	6.1

Abbreviations: *sd* standard deviation, *FVC* forced vital capacity, *DLCO* Diffusing capacity of the lungs for carbon monoxide, *6MWD* 6 min walking distance, *LTOT* Long-term oxygen therapy, *LTx* Lung transplantation, *SF-36*, *BDI* Baseline Dyspnoea Index, *mMRC* Modified Medical Research Council Dyspnea Scale, *NYHA* New York Heart Association

ranged from 0.85 (SOCIAL) to 0.87 (ROLEM), MCS and PCS showed a good internal consistency as well (0.86 both).

Longitudinal analysis

SF-36 follow-up data were available of 161 individuals, where almost half of them (78, 48.5%) had up to four further documentations of HRQL and the maximum of filled in SF-36 was 10. The mean time between baseline and all considered follow-ups was 1.3 years (SD 0.88, range 0.1–5.0 years). The number of considered matches of anchors and HRQL ($n = 591$) was higher than the number of individuals within the follow-up study population, as different visits per patient needed to be considered to provide as much timely congruent documented anchors and filled in SF-36 questionnaires per individual as possible. Moreover, we accepted individuals twice with their first and last observation per anchor, if their health status of the respective anchor varied.

Test-retest-reliability and responsiveness

Analyses for test-retest-reliability did not show significant differences of HRQL except for SOCIAL and the anchor FVC % pred (Table 5). Individuals with relevant changes of the health status based on the anchors had significant changes in all SF-36 dimensions and summary scales except for PAIN (responsiveness) (Table 6).

Minimal important difference (MID)

The normal distribution could not be assumed for ROLEM and ROLPH and valid distribution-based MIDs could not be provided for both dimensions. As we considered only anchors with a correlation of at least 0.3

Table 2 Missing items within the dimensions

	GHP		PFI		ROLPH		ROLEM		SOCIAL		MHI		PAIN		VITAL		
Number of items within dimension	5		10		4		3		2		5		2		4		
Number of missing values (%)	0	242	93.8	234	90.7	241	93.41	240	93.02	245	94.96	244	94.57	247	95.74	246	95.35
	1	6	2.33	12	4.65	5	1.94	4	1.55	12	4.65	5	1.94	8	3.1	4	1.55
	2	2	0.78	4	1.55	1	0.39	5	1.94	1	0.39	1	0.39	3	1.16	3	1.16
	3	2	0.78	1	0.39	8	3.1	9	3.49			2	0.78				
	4	6	2.33			3	1.16					2	0.78			5	1.94
	5			2	0.78							4	1.55				
	6																
	7			1	0.39												
	8			2	0.78												
	9			1	0.39												
	10			1	0.39												

Abbreviations: *GHP* General health perceptions, *PFI* Physical functioning, *ROLPH* Physical role functioning, *ROLEM* emotional role functioning, *SOCIAL* Social role functioning, *MHI* Mental health, *PAIN* bodily pain, *VITAL* Vitality

and none of the anchors correlated sufficiently with MCS, ROLEM, GHP, MHI and PAIN, it was not possible to provide any anchor based-MIDs for them. Combining the criteria of normal distribution and an at least moderate correlation, it was not possible to calculate a MID for ROLEM. The overall mean MID of PCS and MCS were five and six, respectively. Mean MIDs of the dimensions ranged from seven to 21 based on anchors correlating with $r \geq 0.3$ and estimated MIDs of normally distributed domains and summary scores. Taking only distribution-based values and the MID of the anchor with the highest correlation, the mean MIDs ranged from seven to 14 (Table 7).

Sensitivity analysis.

The patients of the study sites varied in HRQL, disease severity, age and gender. After adjusting for age, gender,

DLCO % pred, FVC % pred and 6MWD there was no influence of study site on HRQL detectable.

Discussion

The SF-36 seems to provide adequate psychometric properties to assess HRQL in IPF cohort. Our analysis demonstrated an increased number of missing items in older patients [41]. It is well known, that in an older population the number of missing items is higher [42, 43]. Especially items containing the wording 'work or other regular daily activity' (dimensions ROLEM and ROLPH) led to a higher number of missing values in our study as well as in the studies of Hayes et al. and Mallinson [42, 43].

A possible reason could be a misunderstanding of the wording 'work or other regular daily activity' as probably most of the older participants were retired or not able to

Table 3 Criterion validity analysed via correlation coefficients

	n ^c	PCS	MCS	PFI	ROLEM	ROLPH	GHP	MHI	VITAL	SOCIAL	PAIN
FVC % pred ^a	232–257	0.35**	−0.01	0.35**	0.11	0.35**	0.26**	< 0.01	0.20*	0.11	0.07
DLCO % pred ^a	208–227	0.36**	0.05	0.39**	0.14*	0.37**	0.22*	0.04	0.20*	0.23*	0.02
6MWD ^a	167–180	0.44**	0.17*	0.53**	0.18*	0.37**	0.29*	0.22*	0.32**	0.31**	0.17*
mMRC ^b	180–196	−0.48**	−0.11	−0.61**	−0.14	−0.3**	−0.32**	−0.13	−0.37**	−0.31**	−0.16*
BDI ^b	131–140	0.25*	−0.05	0.38**	−0.02	0.11	0.09	0.01	0.22*	0.14	0.14
NYHA ^b	206–228	−0.33**	−0.09	−0.41**	−0.17*	−0.37**	−0.22*	−0.13*	−0.3**	−0.18*	−0.09

^aPearson correlation

^bSpearman correlation

^csample size varying depending on temporal relation of anchors and filled in SF-36, number of missing items within SF-36 and the possibility to calculate dimensions and summary scores

* $p < 0.05$

** $p < 0.0001$

bold at least moderate criterion validity ($r \geq 0.3$)

Abbreviations: *FVC* pred forced vital capacity percent predicted, *DLCO* pred diffusing capacity of the lungs for carbon monoxide percent predicted, *6MWD* 6 min walking distance, *mMRC* Modified Medical Research Council Dyspnea Scale, *BDI* Baseline Dyspnoea Index, *NYHA* New York Heart Association, *GHP* general health perceptions, *PFI* physical functioning, *ROLPH* physical role functioning, *ROLEM* emotional role functioning, *SOCIAL* social role functioning, *MHI* Mental health, *PAIN* bodily pain, *VITAL* Vitality

Table 4 Construct validity: mean difference of QOL between patients without and with long-term oxygen therapy; significant differences of QOL confirm criterion validity

n ^a = 220–243	mean difference	sd
PSC	7.7**	9.9
MSC	4.0	11.9
PFI	25.4**	25.7
ROLEM	19.9*	45.3
ROLPH	25.7**	38.8
GHP	10.2*	18.9
MHI	5.9	21.2
VITAL	10.4*	19.4
SOCIAL	19.7*	28.2
PAIN	2.4	28.3

a sample size varying depending on temporal relation of anchors and filled in SF-36, number of missing items within SF-36 and the possibility to calculate dimensions and summary scores

* $p < 0.05$

** $p < 0.001$

Abbreviations: QOL Quality of life, sd standard deviation, PCS Physical component score, MCS Mental component score, GHP General health perceptions, PFI Physical functioning, ROLPH physical role functioning, ROLEM emotional role functioning, SOCIAL Social role functioning, MHI Mental health, PAIN bodily pain, VITAL vitality

hold down a regular job [42]. As 75.2% of participants completed the questionnaire without any missing values in our study, we assumed that the higher age of most of the patients suffering IPF is not necessarily a limiting factor.

As we expected in a severe disease such as IPF, there was a floor effect of the items regarding limitations in 'vigorous activities' and 'climbing several flights of stairs' (dimension PFI) as well as the statement 'my health is excellent' (dimension GHP). As the dimension PFI contains ten items and considers different levels of activities, the floor effect of two items may be acceptable. Surprisingly, 4.4 and 7.9% of our study population declared to have no limitations at all in these two physical activity categories and 1.6% rated their health as excellent.

Construct validity was also given. However, the measured dimensions MHI and PAIN and the MCS were not significantly reduced in individuals suffering LTOT. This might be caused by a positive influence of LTOT on well-being in some IPF patients. Regarding the criterion validity, it needs to be mentioned that the correlation of the anchors and MCS was lower than the correlation of the anchors and the PCS, which was also found in other studies [17, 44, 45]. Furthermore, the influence of dyspnea and physical activity measured via mMRC, BDI, NYHA, and 6MWD on HRQL was higher than the influence of clinical parameters as vital and diffusion capacity. Other studies also showed similar results with varying interpretation of the relevance of the correlation between pulmonary function and HRQL [16, 46–49].

Longitudinal analysis indicated sufficient psychometric properties, whereas the small number of observations

Table 5 Test-retest-reliability: mean change of QOL in stable health status in anchor; non-significant changes of QOL confirm test-retest-reliability

n ^a	FVC		DLCO		6MWD		SF-36 item		TDI		NYHA	
	mean	sd	mean	sd	mean	sd	mean	sd	mean	sd	mean	sd
PSC	-0.7	8.4	-0.4	7.7	-0.8	7.0	0.6	9.4	-0.3	7.9	-0.7	8.3
MSC	-0.7	10.0	-0.2	9.9	-1.0	8.7	-0.3	7.0	0.1	8.7	-0.7	10.5
PFI	-1.0	19.7	-1.7	20.7	-4.7	18.1	2.8	21.9	1.6	21.4	-3.0	21.3
ROLEM	-0.7	51.9	-0.9	47.8	-2.1	43.9	0.0	46.3	12.1	43.1	-3.3	51.9
ROLPH	-1.3	35.9	-1.2	32.8	-5.3	31.7	6.8	42.1	6.1	35.0	0.8	35.9
GHP	-1.3	16.8	-0.5	17.0	-5.0	19.1	-1.3	15.7	-0.9	12.9	-0.1	18.5
MHI	-1.7	15.6	-0.9	15.8	-4.3	15.2	0.2	14.0	-0.3	13.9	-0.7	15.9
VITAL	-0.1	16.1	-1.2	16.2	-1.8	14.1	1.0	13.7	-7.2	17.6	-1.5	14.8
SOCIAL	-3.4*	21.4	-1.0	22.9	0.0	21.7	-5.3	17.1	-1.6	25.1	-4.3	23.5
PAIN	0.2	28.3	1.2	27.3	2.5	24.3	0.4	29.2	-6.2	26.4	-2.2	28.3

a sample size varying depending on temporal relation of anchors and filled in SF-36, number of missing items within SF-36 and the possibility to calculate dimensions and summary scores

* $p < 0.05$

** $p < 0.001$

Abbreviations: PCS physical component score, MCS mental component score, GHP general health perceptions, PFI physical functioning, ROLPH physical role functioning, ROLEM emotional role functioning, SOCIAL social role functioning, MHI mental health, PAIN bodily pain, VITAL vitality, sd standard deviation, FVC forced vital capacity, DLCO diffusing capacity of the lungs for carbon monoxide, 6MWD 6 min walking distance, SF-36 item indicating health status of the last year, TDI Transitional Dyspnoea Index, NYHA New York Heart Association

Table 6 Responsiveness: mean change of QOL in changed health status in anchor; significant changes of QOL confirm responsiveness

Improvement in the specific anchor												
n ^a	FVC		DLCO		6MWD		SF-36 item		TDI		NYHA	
	9–11		10–11		14–17		10–15		15–16		18–19	
	mean	sd	mean	sd	mean	sd	mean	sd	mean	sd	mean	sd
PSC	6.2*	6.5	−3.9	9.6	3.0	10.5	4.0	10.1	4.3*	11.1	1.8	9.4
MSC	−3.6	13.1	−1.8	10.5	−1.1	10.2	−0.7	9.0	−0.7	8.3	−1.4	7.3
PFI	15.3	24.0	−3.9	19.9	1.6	19.7	5.4*	11.7	5.5	18.9	−3.2	24.1
ROLEM	−16.7	72.4	0.0	64.8	−8.9	47.9	0.0	62.9	−6.3	42.5	−20.4*	36.4
ROLPH	17.5	39.2	−25.0	45.6	11.7	28.1	30.0	55.0	20.3	44.0	2.8	34.2
GHP	7.1	20.8	−11.9*	14.6	2.3	14.5	4.1	24.2	5.0	22.8	2.6	19.4
MHI	2.0	19.0	−4.2	10.2	3.2	11.7	−1.0	9.6	1.9	16.7	1.7	11.7
VITAL	4.5	12.8	−2.3	14.0	4.4	13.4	4.0	16.5	7.4	14.8	1.1	14.1
SOCIAL	1.1	30.8	−10.2*	9.4	0.0	15.3	1.8	18.9	3.1	23.0	6.6	21.0
PAIN	0.2	31.9	4.9	23.9	11.5	28.8	1.3	23.8	−0.3	36.1	6.9	29.6
deterioration in the specific anchor												
n ^a	FVC		DLCO		6MWD		SF-36 item		TDI		NYHA	
	30–36		22–28		29–36		37–45		55–73		29–40	
	mean	sd	mean	sd	mean	sd	mean	sd	mean	sd	mean	sd
PSC	−2.6	10.3	−5.0	10.4	−2.8*	8.5	−3.0*	9.5	−2.4	7.8	−1.1	9.0
MSC	−2.9	13.0	−2.8	10.0	0.1	9.6	−3.0*	9.5	−0.7	8.3	−1.0	11.0
PFI	−12.9*	23.8	−14.1*	25.0	−9.3*	21.4	−10.2*	22.3	−3.9	21.3	−2.7	25.2
ROLEM	−7.3	62.1	−15.9	49.1	−3.1	44.3	−4.4	48.5	−1.7	37.9	2.2	57.7
ROLPH	−2.3	51.7	−15.0	36.8	−14.5*	33.0	−10.1	35.8	−9.0*	35.7	−4.9	39.6
GHP	−7.3*	17.1	−6.9	16.8	−2.3	17.4	−5.0	15.0	−4.8*	13.8	−6.7	17.1
MHI	−8.1	17.2	−4.4	17.3	−2.1	14.5	−5.8	17.3	−4.1*	13.5	−3.3	17.7
VITAL	−8.2*	18.8	−3.7	22.0	−3.0	15.7	−6.8*	15.0	−4.7*	15.8	−0.4	19.3
SOCIAL	−10.8*	29.6	−12.9*	25.6	−7.3	30.5	−13.3*	24.8	−1.5	23.2	−14.1*	32.2
PAIN	−3.1	32.6	−10.0	35.1	4.6	27.4	−3.3	37.9	−2.7	27.3	−8.1	31.0

a sample size varying depending on temporal relation of anchors and filled in SF-36, number of missing items within SF-36 and the possibility to calculate dimensions and summary scores

SD standard deviation

* $p < 0.05$

** $p < 0.001$

Abbreviations: PSC Physical component score, MCS Mental component score, GHP General health perceptions, PFI Physical functioning, ROLPH physical role functioning, ROLEM emotional role functioning, SOCIAL Social role functioning, MHI Mental health, PAIN bodily pain, VITAL vitality, sd standard deviation, FVC Forced vital capacity, DLCO Diffusing capacity of the lungs for carbon monoxide, 6MWD 6 min walking distance, SF-36 item indicating health status of the last year, TDI Transitional Dyspnoea Index, NYHA New York Heart Association

limited the validity. Additionally, MIDs could not be estimated in all cases due to lacking sufficient correlation of anchors or missing normal distribution. If assumptions were given, the mean MIDs were higher compared to Swigris et al. (this study: range 5–21; Swigris et al.: range 2–4). Considering only the anchor with the highest correlation, the mean MIDs decreased and approached the MIDs of Swigris et al. Authors of the latter study used different methods and only two anchors [17]. Additionally, the amount of correlations or distribution patterns were not considered in providing MIDs. The different methods in combination with the strongly

selected study sample of the BUILD-1 trial may explain the differences in our results.

The strength of this study lies in the international multicentre population of the IPF individuals of all ages and disease stages without strict inclusion and exclusion criteria, which provides a ‘real life’ setting and transferable results. We investigated a potential influence of the study sites and countries on HRQL. After adjusting for age, gender, DLCO % pred, FVC % pred and 6MWD there was no correlation with HRQL. The number of incorrect diagnoses should be negligible as the diagnosis was based on multidisciplinary discussion and on ATS/

Table 7 Minimal important differences (MID)

	PCS	MCS	PFI	ROLEM	ROLPH	GHP	MHI	VITAL	SOCIAL	PAIN	
Distribution based											
1/2 sd	5.2	5.9	13.9			9.2	10.6	9.4	14.3	14.1	
Anchor based via linking											
FVC	5.3		14.1		20.5						
DLCO	8.4		22.2		32.3						
6MWD	2.6		6.9		10.1			4.7	7.1		
MID	Range ^a	2.6–8.4	5.9	10.1–22.2		10.1–32.3	9.2	10.6	4.7–9.4	7.1–14.3	14.1
	mean all ^a	5	6	14		21	9	11	7	11	14
	mean selected ^b	4	6	10		10	9	11	7	11	14

^a based on anchor (if estimate is significant, $r \geq 0.3$ or $R^2 \geq 0.09$) and distribution based MID (in case of normal distribution)

^b based on anchor with the highest correlation (if estimate is significant, $r \geq 0.3$ or $R^2 \geq 0.09$) and distribution based MID (in case of normal distribution)

Abbreviations: *sd* standard error, *SEM* Standard error of the mean, *FVC* pred forced vital capacity percent predicted, *DLCO* pred diffusing capacity of the lungs for carbon monoxide percent predicted, *6MWD* 6 min walking distance, *PCS* Physical component score, *MCS* Mental component score, *GHP* General health perceptions, *PFI* Physical functioning, *ROLPH* physical role functioning, *ROLEM* emotional role functioning, *SOCIAL* Social role functioning, *MHI* Mental health, *PAIN* bodily pain, *VITAL* vitality

ERS/JRS/ALAT guideline criteria [4, 50]. To consider clinical and patient-centred values, we used objective anchors as lung function values (FVC % pred, DLCO % pred) and need of supplemental oxygen, (LTOT), as well as subjective parameters as dyspnea scores (self-reported by patients (mMRC, BDI/TDI) and physician (NYHA)) and a measure of physical functioning (6MWD). The MID was estimated based on anchors as well as on distribution as widely recommended [51, 52].

Our study has several limitations. First of all, the follow-up intervals varied and only 62.6% of the study population had at least one follow-up SF-36. Additionally, in some cases the date of examination and visit was missing and the scheduled visit date was used as proxy instead. For example, in 19 of 364 analysed baseline and follow up SF-36 questionnaires the date needed to be approximated. The share of missing values of single items still met regulatory requirements. Some analyses were based on a small number of observations.

Conclusion

SF-36 appears to be a valid instrument to measure HRQL in IPF and so can be used in RCTs or individual monitoring of this disease. Nevertheless, the additional evaluation of longitudinal aspects and MIDs can be recommended to further analyse these factors. Our findings have a great potential impact on the evaluation of IPF patients in clinical trials as well as individual disease monitoring.

Additional files

Additional file 1: Figure S1. Missingness map: On the y axis the individuals are sorted based on the frequency of missing items. On the x axis there are the single items clustered by their dimension. Bright fields indicate missingness, dark fields indicate answered items. (DOCX 70 kb)

Additional file 2: Figure S2. Frequencies of answer categories on single item level including missing answers. The y axis shows the grouped items, the x axis indicates the frequency in numbers of the answer category or absence of answering, respectively. (DOCX 77 kb)

Abbreviations

6MWD: 6 min walking distance; BDI: Baseline Dyspnoea Index; DLCO % pred: percent of predicted value of carbon monoxide diffusion capacity of the lung; FVC % pred: percent of the predicted value of forced vital capacity; GHP: general health perception; GLI: Global Lungs Initiative; LTOT: long-term oxygen therapy; MHI: mental health; mMRC: Modified Medical Research Council Dyspnea Scale; NYHA: modified New York Heart Association Classification; PAIN: bodily pain; PFI: physical functioning; ROLEM: emotional role functioning; ROLPH: physical role functioning; SOCIAL: social role functioning; TDI: Transitional Dyspnoea Index; VITAL: Vitality

Acknowledgements

We would like to thank all the participants and physicians who contribute to the registry, as well as our patients who participated in this effort.

Funding

From 2008 to 2011 the European Commission funded the European IPFnetwork (eurlPFnet) within the Seventh Framework Programme. Since then the work has been continued on local funding through the members home institutions and through limited funding from pharma industry (Roche; Boehringer Ingelheim) and foundations ("Lung Fibrosis" Stipend of the Foundation Waldhof-Elgershausen, German Lung Foundation as well as Robert Pfitzer Foundation). With the end of the initial public funding cycle of eurlPFnet, the eurlPFreg/bank was continued as independent project of the section "Registries and Biobanks in Pneumology" of the TransMIT, the Intellectual Property Agency of the Justus-Liebig-University Gießen. The eurlPFreg Steering Committee which has been governing the registry since 2009 remains in charge. This Committee is comprised of Prof. Bruno Crestani (Hopital Bichat, Paris, France), Prof. Andreas Günther (University of Giessen, Germany), Prof. Carlo Vancheri (University of Catania, Italy) and Prof. Athol Wells (Royal Brompton Hospital London, United Kingdom). Prof. Günther is the main Coordinator of the registry.

Availability of data and materials

The datasets generated and investigated during the current study are not publicly available due to registry regulations, but are available from the corresponding author on reasonable request and agreement of the Principle Investigators of the eurlPFreg.

Authors' contributions

SW analysed and interpreted the patient data, performed the statistical analysis and wrote the manuscript. SW, RL, RH and LS created the statistical analysis plan. EK, NB, VM, PB, CV, AW, MV, AP, WK, WS, BC and AG recruited IPF patients for the registry and have been involved in drafting or revising the manuscript. All authors read and approved the final manuscript.

Ethics approval and consent to participate

Both, eurlPFreg and eurlPFbank (biobank of eurlPFreg) have been reviewed and received positive votes from institutional review boards in Germany (e.g. Ethics Committee of Justus-Liebig-University of Giessen; 111/08), France, Italy, Austria, Spain, Czech Republic, Hungary and the UK. The research was conducted strictly according to the principles of the Declaration of Helsinki. The eurlPFreg and eurlPFbank are listed in ClinicalTrials.gov (NCT02951416).

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Author details

¹Helmholtz Zentrum München, German Research Center for Environmental Health (GmbH), Institute of Health Economics and Health Care Management, Member of the German Center for Lung Research (DZL), Comprehensive Pneumology Center Munich (CPC-M), Neuherberg, Germany. ²European IPF Registry & Biobank (eurlPFreg/bank), Giessen, Germany. ³Universities of Giessen and Marburg Lung Center (UGMLC), Member of the German Center for Lung Research (DZL), Giessen, Marburg, Germany. ⁴Hospital Clinico San Carlos, Madrid, Spain. ⁵Department of Pulmonology, Semmelweis University, Budapest, Hungary. ⁶Reference Center for Rare Pulmonary Diseases, Centre Hospitalier Universitaire Dijon-Bourgogne, INSERMU1231, Université Bourgogne/Franche-Comté, Dijon, France. ⁷Department of Clinical and Molecular Biomedicine, Università degli Studi di Catania, Catania, Italy. ⁸Interstitial Lung Disease Unit, Royal Brompton Hospital, London, UK. ⁹First Faculty of Medicine, Thomayer University Hospital Prague, Prague, Czech Republic. ¹⁰Ospedale San Gerardo, Monza, Italy. ¹¹Department of Thoracic Surgery, Vienna University Hospital, Vienna, Austria. ¹²Cardio-Pulmonary Institute (CPI), EXC 2026, Project ID: 390649896, Justus-Liebig University Giessen, Giessen, Germany. ¹³Institut National de la Santé et de la Recherche Médicale (INSERM 700), Hôpital Bichat, Service de Pneumologie, Paris, France. ¹⁴Ludwig-Maximilians-University, Munich Center of Health Sciences, Munich, Germany. ¹⁵AGAPLESION Lung Clinic Waldhof-Elgershausen, Greifenstein, Germany.

Received: 12 October 2018 Accepted: 20 February 2019

Published online: 01 March 2019

References

- Bradley B, Branley HM, Egan JJ, Greaves MS, Hansell DM, Harrison NK, Hirani N, Hubbard R, Lake F, Millar AB, et al. Interstitial lung disease guideline: the British Thoracic Society in collaboration with the Thoracic Society of Australia and New Zealand and the Irish thoracic society. *Thorax*. 2008; 63(Suppl 5):v1–58.
- Behr J, Gunther A, Bonella F, Geissler K, Koschel D, Kreuter M, Prasse A, Schonfeld N, Sitter H, Muller-Quernheim J, et al. German guideline for idiopathic pulmonary fibrosis - update on pharmacological therapies 2017. *Pneumologie*. 2018;72(2):155–68.
- Behr J, Gunther A, Ammenwerth W, Bittmann I, Bonnet R, Buhl R, Eickelberg O, Ewert R, Glaser S, Gottlieb J, et al. German guideline for diagnosis and management of idiopathic pulmonary fibrosis. *Pneumologie*. 2013;67(2):81–111.
- Raghu G, Collard HR, Egan JJ, Martinez FJ, Behr J, Brown KK, Colby TV, Cordier JF, Flaherty KR, Lasky JA, et al. An official ATS/ERS/JRS/ALAT statement: idiopathic pulmonary fibrosis: evidence-based guidelines for diagnosis and management. *Am J Respir Crit Care Med*. 2011;183(6):788–824.
- Raghu G, Rochweg B, Zhang Y, Garcia CA, Azuma A, Behr J, Brozek JL, Collard HR, Cunningham W, Homma S, et al. An official ATS/ERS/JRS/ALAT clinical practice guideline: treatment of idiopathic pulmonary fibrosis. An update of the 2011 clinical practice guideline. *Am J Respir Crit Care Med*. 2015;192(2):e3–19.
- Russell A-M, Sprangers MAG, Wibberley S, Snell N, Rose DM, Swigris JJ. The need for patient-centred clinical research in idiopathic pulmonary fibrosis. *BMC Med*. 2015;13:240.
- Raghu G, Collard HR, Anstrom KJ, Flaherty KR, Fleming TR, King TE Jr, Martinez FJ, Brown KK. Idiopathic pulmonary fibrosis: clinically meaningful primary endpoints in phase 3 clinical trials. *Am J Respir Crit Care Med*. 2012; 185(10):1044–8.
- Belkin A, Swigris JJ. Health-related quality of life in idiopathic pulmonary fibrosis: where are we now? *Curr Opin Pulm Med*. 2013;19(5):474–9.
- Swigris JJ, Fairclough D. Patient-reported outcomes in idiopathic pulmonary fibrosis research. *Chest*. 2012;142(2):291–7.
- Reflection paper on the regulatory guidance for the use of health-related quality of life (HRQL) measures in the evaluation of medicinal products [www.ema.europa.eu/docs/en_GB/document_library/Scientific_guideline/2009/09/WC50003637.pdf].
- Guidance for Industry and FDA Staff - Qualification Process for Drug Development Tools [<https://www.fda.gov/downloads/drugs/guidances/ucm230597.pdf>].
- Ware JE Jr, Sherbourne CD. The MOS 36-item short-form health survey (SF-36). I. Conceptual framework and item selection. *Med Care*. 1992; 30(6):473–83.
- Han MK, Bach DS, Hagan PG, Yow E, Flaherty KR, Toews GB, Anstrom KJ, Martinez FJ. Sildenafil preserves exercise capacity in patients with idiopathic pulmonary fibrosis and right-sided ventricular dysfunction. *CHEST Journal*. 2013;143(6):1699–708.
- King TE, Brown KK, Raghu G, du Bois RM, Lynch DA, Martinez F, Valeyre D, Leconte I, Morganti A, Roux S, et al. BUILD-3: a randomized, controlled trial of bosentan in idiopathic pulmonary fibrosis. *Am J Respir Crit Care Med*. 2011;184(1):92–9.
- Raghu G, Brown KK, Costabel U, Cottin V, du Bois RM, Lasky JA, Thomeer M, Utz JP, Khandker RK, McDermott L, et al. Treatment of idiopathic pulmonary fibrosis with Eteanercept. *Am J Respir Crit Care Med*. 2008;178(9):948–55.
- Tomioka H, Imanaka K, Hashimoto K, Iwasaki H. Health-related quality of life in patients with idiopathic pulmonary fibrosis—cross-sectional and longitudinal study. *Intern Med*. 2007;46(18):1533–42.
- Swigris JJ, Brown KK, Behr J, du Bois RM, King TE, Raghu G, Wamboldt FS. The SF-36 and SGRQ: validity and first look at minimum important differences in IPF. *Respir Med*. 2010;104(2):296–304.
- King TE Jr, Behr J, Brown KK, du Bois RM, Lancaster L, de Andrade JA, Stahler G, Leconte I, Roux S, Raghu G. BUILD-1: a randomized placebo-controlled trial of bosentan in idiopathic pulmonary fibrosis. *Am J Respir Crit Care Med*. 2008;177(1):75–81.
- Johnston BC, Ebrahim S, Carrasco-Labra A, Furukawa TA, Patrick DL, Crawford MW, Hemmelgarn BR, Schunemann HJ, Guyatt GH, Nesrallah G. Minimally important difference estimates and methods: a protocol. *BMJ Open*. 2015;5(10):e007953.
- Guenther A, European IPF. Network: the European IPF network: towards better care for a dreadful disease. *Eur Respir J*. 2011;37(4):747–8.
- Guenther A, Krauss E, Tello S, Wagner J, Paul B, Kuhn S, Maurer O, Heinemann S, Costabel U, Barbero MAN, et al. The European IPF registry (eurlPFreg): baseline characteristics and survival of patients with idiopathic pulmonary fibrosis. *Respir Res*. 2018;19(1):141.
- Ware J, Kosinsky M, Dewey J: How to Score Version 2 of the SF-36® Health Survey. Lincoln, RI: QualityMetricIncorporated; 2000.
- Morfeld M, Kirchberger I, Bullinger M: SF-36 - Fragebogen zum Gesundheitszustand - deutsche Version des Short Form-36 Health Survey 2, ergänzte und überarbeitete Auflage: Hogrefe; 2011.
- Butland RJ, Pang J, Gross ER, Woodcock AA, Geddes DM. Two-, six-, and 12-minute walking tests in respiratory disease. *Br Med J (Clin Res Ed)*. 1982; 284(6329):1607–8.
- McGavin CR, Gupta SP, McHardy GJ. Twelve-minute walking test for assessing disability in chronic bronchitis. *Br Med J*. 1976;1(6013):822–3.
- Mungall IP, Hainsworth R. Assessment of respiratory function in patients with chronic obstructive airways disease. *Thorax*. 1979;34(2):254–8.
- Criteria Committee of the New York Heart Association: Diseases of the heart and blood vessels. In: Nomenclature and Criteria for Diagnosis of Diseases

- of the Heart and Great Vessels. 7th edn. Edited by Harvey R, et al. Boston, MA: Little, Brown & Co.; 1973.
28. Mahler DA, Weinberg DH, Wells CK, Feinstein AR. The measurement of dyspnea. Contents, interobserver agreement, and physiologic correlates of two new clinical indexes. *Chest*. 1984;85(6):751–8.
 29. Mahler DA, Wells CK. Evaluation of clinical methods for rating dyspnea. *Chest*. 1988;93(3):580–6.
 30. Belkin A, Swigris JJ. Patient expectations and experiences in idiopathic pulmonary fibrosis: implications of patient surveys for improved care. *Expert Rev Respir Med*. 2014;8(2):173–8.
 31. Cohen J: *Statistical power analysis for behavioral sciences*, second edn. Hillsdale, NY: Lawrence Erlbaum Associates; 1988.
 32. Holland AE, Hill CJ, Conron M, Munro P, McDonald CF. Small changes in six-minute walk distance are important in diffuse parenchymal lung disease. *Respir Med*. 2009;103(10):1430–5.
 33. Nathan SD, du Bois RM, Albera C, Bradford WZ, Costabel U, Kartashov A, Noble PW, Sahn SA, Valeyre D, Weycker D, et al. Validation of test performance characteristics and minimal clinically important difference of the 6-minute walk test in patients with idiopathic pulmonary fibrosis. *Respir Med*. 2015;109(7):914–22.
 34. du Bois RM, Weycker D, Albera C, Bradford WZ, Costabel U, Kartashov A, Lancaster L, Noble PW, Sahn SA, Swarcberg J et al: Six-minute-walk test in idiopathic pulmonary fibrosis: test validation and minimal clinically important difference. *Am J Respir Crit Care Med* 2011, 183(9):1231–1237.
 35. Ley B, Collard HR, King TE Jr. Clinical course and prediction of survival in idiopathic pulmonary fibrosis. *Am J Respir Crit Care Med*. 2011;183(4):431–40.
 36. Witek TJ Jr, Mahler DA. Minimal important difference of the transition dyspnoea index in a multinational clinical trial. *Eur Respir J*. 2003;21(2):267–72.
 37. Pires LA, Abraham WT, Young JB, Johnson KM. Clinical predictors and timing of New York heart association class improvement with cardiac resynchronization therapy in patients with advanced chronic heart failure: results from the multicenter InSync randomized clinical evaluation (MIRACLE) and multicenter InSync ICD randomized clinical evaluation (MIRACLE-ICD) trials. *Am Heart J*. 2006;151(4):837–43.
 38. Norman GR, Sloan JA, Wyrwich KW. Interpretation of changes in health-related quality of life: the remarkable universality of half a standard deviation. *Med Care*. 2003;41(5):582–92.
 39. Revicki D, Hays RD, Cella D, Sloan J. Recommended methods for determining responsiveness and minimally important differences for patient-reported outcomes. *J Clin Epidemiol*. 2008;61(2):102–9.
 40. Fayers PM, Hays RD. Don't middle your MID: regression to the mean shrinks estimates of minimally important differences. *Qual Life Res*. 2014; 23(1):1–4.
 41. Bender H, Dintsios CM. Gesundheitsbezogene Lebensqualität im Rahmen der frühen Nutzenbewertung von Arzneimitteln nach § 35a SGB V: Ein Endpunkt mit vielen Herausforderungen für alle beteiligten Akteure. *Gesundheitswesen (EFirst)*.
 42. Hayes V, Morris J, Wolfe C, Morgan M. The SF-36 health survey questionnaire: is it suitable for use with older adults? *Age Ageing*. 1995; 24(2):120–5.
 43. Mallinson S. The short-form 36 and older people: some problems encountered when using postal administration. *J Epidemiol Community Health*. 1998;52(5):324–8.
 44. Chang JA, Curtis JR, Patrick DL, Raghu G. Assessment of health-related quality of life in patients with interstitial lung disease. *Chest*. 1999;116(5):1175–82.
 45. Jastrzebski D, Kozielski J, Banas A, Cebula T, Gumola A, Ziora D, Krzywiecki A. Quality of life during one-year observation of patients with idiopathic pulmonary fibrosis awaiting lung transplantation. *J Physiol Pharmacol*. 2005; 56(Suppl 4):99–105.
 46. Bahmer T, Kirsten AM, Waschki B, Rabe KF, Magnussen H, Kirsten D, Gramm M, Hummler S, Brunnemer E, Kreuter M, et al. Clinical correlates of reduced physical activity in idiopathic pulmonary fibrosis. *Respiration*. 2016;91(6):497–502.
 47. Glaspole IN, Chapman SA, Cooper WA, Ellis SJ, Goh NS, Hopkins PM, Macansh S, Mahar A, Moodley YP, Paul E, et al. Health-related quality of life in idiopathic pulmonary fibrosis: data from the Australian IPF registry. *Respirology*. 2017.
 48. Swigris JJ, Esser D, Wilson H, Conoscenti CS, Schmidt H, Stansen W, Leidy NK, Brown KK. Psychometric properties of the St George's respiratory questionnaire in patients with idiopathic pulmonary fibrosis. *Eur Respir J*. 2017;49(1).
 49. Zimmermann CS, Carvalho CR, Silveira KR, Yamaguti WP, Moderno EV, Salge JM, Kairalla RA, Carvalho CR. Comparison of two questionnaires which measure the health-related quality of life of idiopathic pulmonary fibrosis patients. *Braz J Med Biol Res*. 2007;40(2):179–87.
 50. Raghu G, Remy-Jardin M, Myers JL, Richeldi L, Ryerson CJ, Lederer DJ, Behr J, Cottin V, Danoff SK, Morell F, et al. Diagnosis of idiopathic pulmonary fibrosis. An official ATS/ERS/JRS/ALAT clinical practice guideline. *Am J Respir Crit Care Med*. 2018;198(5):e44–68.
 51. Revicki DA, Cella D, Hays RD, Sloan JA, Lenderking WR, Aaronson NK. Responsiveness and minimal important differences for patient reported outcomes. *Health Qual Life Outcomes*. 2006;4:70.
 52. Guyatt GH, Osoba D, Wu AW, Wyrwich KW, Norman GR. Clinical significance consensus meeting G: methods to explain the clinical significance of health status measures. *Mayo Clin Proc*. 2002;77(4):371–83.

Ready to submit your research? Choose BMC and benefit from:

- fast, convenient online submission
- thorough peer review by experienced researchers in your field
- rapid publication on acceptance
- support for research data, including large and complex data types
- gold Open Access which fosters wider collaboration and increased citations
- maximum visibility for your research: over 100M website views per year

At BMC, research is always in progress.

Learn more biomedcentral.com/submissions

