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Contents

Figure E1 Search Strategies for EMBASE

Overall ILD or cryptogenic fibrosing alveolitis search term
epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
ILD.mp.*
**interstitial lung disease/ or interstitial lung diseas*.mp.*
11 or 12
10 and 13
limit 14 to human
limit 15 to english language
limit 16 to yr="2009 - 2019"

Asbestosis or Silicosis search terms
epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
*asbestosis.mp. or *asbestosis/*
*silicosis.mp. or *silicosis/*
**asbestosis/ or *silicosis/*
11 or 12 or 13
10 and 14
limit 15 to human
limit 16 to english language
limit 17 to yr="2009 - 2019"

Pneumoconiosis search term
epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
ILD.mp.*
**interstitial lung disease/ or interstitial lung diseas*.mp.*
11 or 12
10 and 13
pneumoconiosis.mp. or exp pneumoconiosis/
10 and 15
limit 16 to human
limit 17 to english language
limit 18 to yr="2009 - 2019"

Respiratory bronchiolitis search term
epidemio.mp.*
**epidemiology/*

**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
ILD.mp.*
**interstitial lung disease/ or interstitial lung diseas*.mp.*
11 or 12
10 and 13
exp bronchiolitis/ or Respiratory bronchiolitis.mp.
10 and 15
limit 16 to human
limit 17 to english language
limit 18 to yr="2009 - 2019"

Hypersensitivity pneumonitis or Extrinsic alveolar alveolitis search terms
epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
hypersensitivity pneumonitis.mp. or exp allergic pneumonitis/
**hypersensitivity pneumonitis/ or *extrinsic alveolar alveolitis/ or *EAA/ or *HP/*
10 or 11
4 or 9
12 and 13
limit 14 to human
limit 15 to english language
limit 16 to yr="2009 - 2019"

Cystic lung disease
epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*

prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
cystic lung diseas.mp.*
cystic lung diseas.mp. or exp lymphangioleiomyomatosis/ or exp Birt Hogg Dube syndrome/*
**birt hogg dube/ or *LAM/ or *PLCH/ or *LIP/ or *lymphangioleiomyomatosis/ or *pulmonary Langerhans cell histiocytosis/ or *lymphoid interstitial pneumonia/ or *Birt-Hogg-Dube/*
11 or 12 or 13
10 and 14
limit 15 to human
limit 16 to english language
limit 17 to yr="2009 - 2019"

Sarcoidosis search term

epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
**lung sarcoidosis/ or *sarcoidosis/ or sarcoidosis*.mp.*
10 and 11
limit 12 to human
limit 13 to english language
limit 14 to yr="2009 - 2019"

Idiopathic interstitial lung disease

epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8

4 or 9
idiopathic interstitial pneumon.mp.*
**idiopathic interstitial pneumonia/ or *IIP/ or *idiopathic interstitial/*
**idiopathic interstitial pneumonia/ or idiopathic interstitial pneumon*.mp. or *Idiopathic Interstitial Pneumonias/*
11 or 12 or 13
10 and 14
limit 15 to human
limit 16 to english language
limit 17 to yr="2009 - 2019"

Idiopathic pulmonary fibrosis
epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
**idiopathic pulmonary fibrosis/*
**lung fibrosis/ or *fibrosing alveolitis/ or idiopathic pulmonary fibrosis*.mp.*
11 or 12
10 and 13
limit 14 to human
limit 15 to english language
limit 16 to yr="2009 - 2019"

Autoimmune ILDs
epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
ILD.mp.*
**interstitial lung disease/ or interstitial lung diseas*.mp.*
11 or 12

10 and 13
exp autoimmune disease/ or autoimmune.mp.*
**autoimmune/ or *RA/ or *Rheumatoid arthritis/ or *rheumatoid arthritis/ or *scleroderma/ or *Scleroderma/ or *systemic sclerosis/ or *Systemic Sclerosis/*
15 or 16
10 and 13 and 17
limit 18 to human
limit 19 to english language
limit 20 to yr="2009 - 2019"

Other ILDs
epidemio.mp.*
**epidemiology/*
**public health/*
1 or 2 or 3
inciden.mp.*
prevalen.mp.*
**mortality/ or *mortality risk/ or *mortality rate/*
**prevalence/ or epidemiological data/ or epidemiology/ or statistical concepts/ or statistical parameters/*
5 or 6 or 7 or 8
4 or 9
ILD.mp.*
**interstitial lung disease/ or interstitial lung diseas*.mp.*
11 or 12
cryptogenic organizing pneumonia.mp.
exp bronchiolitis obliterans organizing pneumonia/ or exp cryptogenic organizing pneumonia/ or cryptogenic organizing pneumonia.mp.*
exp bronchiolitis obliterans organizing pneumonia/ or exp bronchiolitis obliterans/ or bronchiolitis obliterans.mp.*
exp antidepressant agent/ or antidepressive.mp.*
exp hyperthermic intraperitoneal chemotherapy/ or exp maintenance chemotherapy/ or exp chemotherapy/ or exp induction chemotherapy/ or exp cancer chemotherapy/ or exp adjuvant chemotherapy/ or Chemotherapy.mp. or neoadjuvant chemotherapy/ or exp combination chemotherapy/*
**Amiodarone/ or *Fluoxetine/ or *Nitrofurantoin/ or *amiodarone/ or *fluoxetine/ or *nitrofurantoin/*
14 or 15 or 16 or 17 or 18 or 19
10 and 13 and 20
limit 21 to human
limit 22 to english language
limit 23 to yr="2009 - 2019"

Figure E2: ILD Aetiological Classification

ILD Subgroups	Individual ILDs

Occupational or Exposure related ILD	Asbestosis or silicosis
	Pneumoconiosis
	Respiratory bronchiolitis (RB-ILD) and other smoking related ILD
	Hypersensitivity pneumonitis (HP)
Idiopathic interstitial pneumonia	Idiopathic pulmonary fibrosis (IPF)
	Idiopathic non-specific interstitial pneumonia (NSIP)
	Desquamative interstitial pneumonia (DIP)
	Cryptogenic organizing pneumonia (COP)
Autoimmune ILD	Rheumatoid arthritis associated ILD (RA-ILD)
	Systemic sclerosis associated ILD (SSc-ILD)
	Sjogren's syndrome associated ILD (SS ILD)
	Inflammatory myositis associated ILDs and anti-synthetase syndromes
	Other autoimmune ILDs
Pulmonary sarcoidosis	Pulmonary sarcoidosis
Unclassifiable ILD	Unclassifiable ILD
Cystic lung disease	Birt Hogg-Dube (BHD)
	Lymphangioleiomyomatosis (LAM)
	Pulmonary Langerhans cell histiocytosis (PLCH)
	Lymphoid interstitial pneumonia (LIP)
Other ILDs	Obliterative bronchiolitis
	Drug induced ILD (eg. Amiodarone, Nitrofurantoin, Fluoxetine, Chemotherapy induced)
	Radiation induced ILD

Figure E3 PRISMA Flow Diagram to Demonstrate Studies Identified, Screened And Included

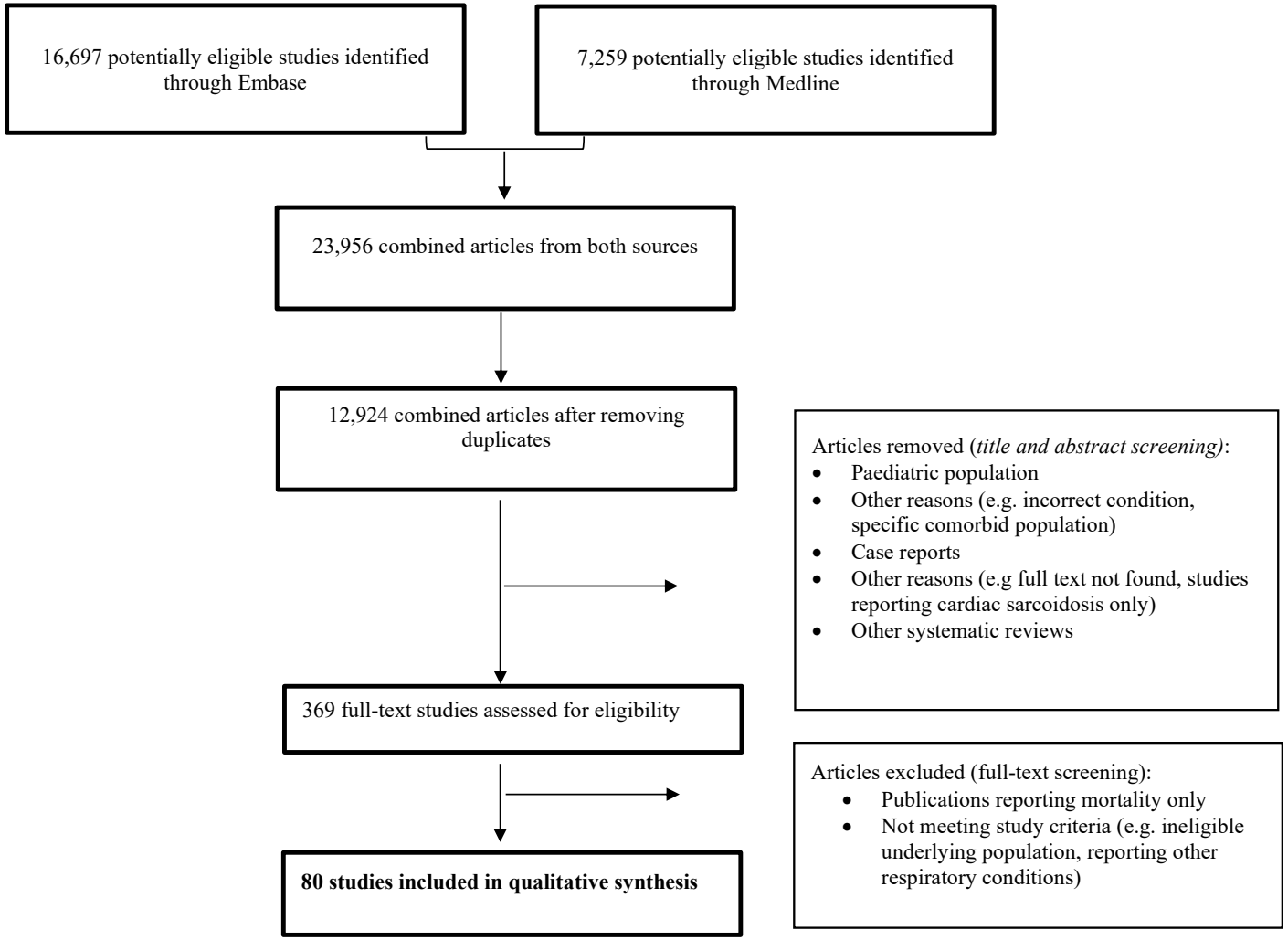
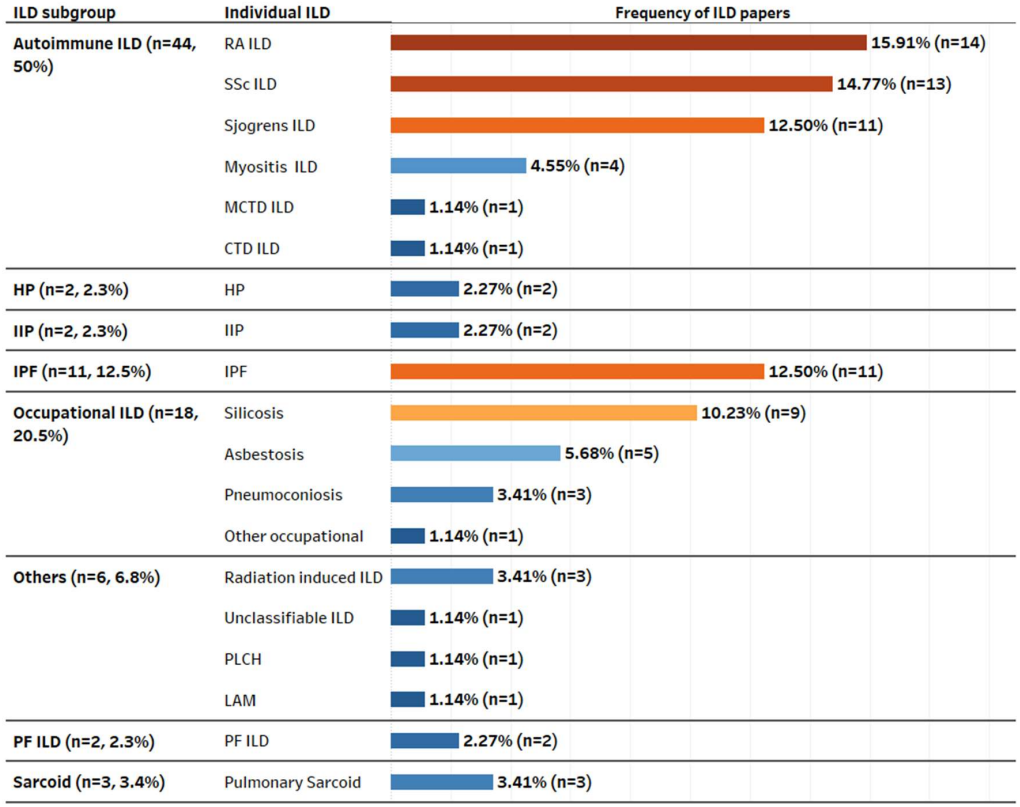
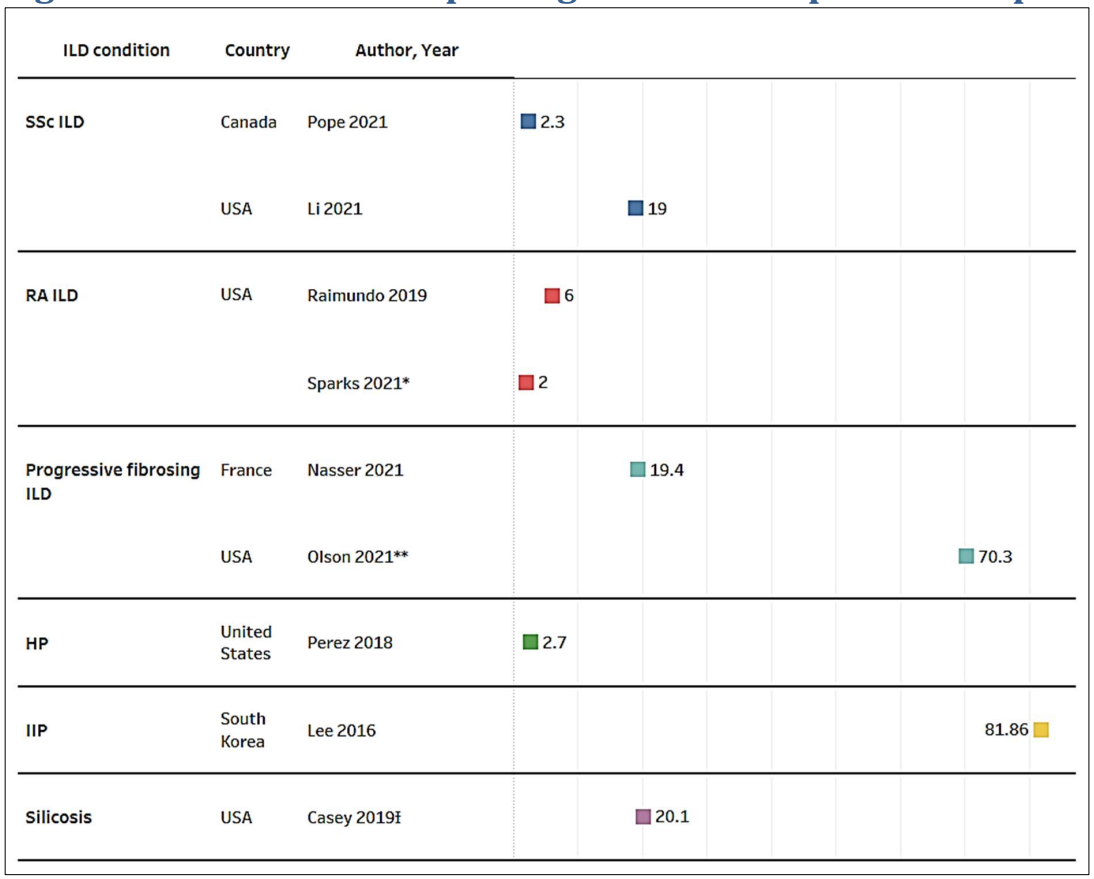


Figure E4 Distribution of Included Publications by ILD Subgroups and Individual Disorder Type



RA ILD, rheumatoid arthritis; SSc, systemic sclerosis; MCTD, mixed connective tissue disorder; CTD, connective tissue disorder; HP, hypersensitivity pneumonitis; IIP, idiopathic interstitial pneumonia; IPF, idiopathic pulmonary fibrosis; PLCH, pulmonary Langerhans cell histiocytosis; LAM, lymphangioleiomyomatosis; PF, progressive fibrosing

Figure E5 Publications reporting non-IPF-ILD prevalence per 100,000 persons



SSc ILD, Systemic sclerosis ILD; RA ILD, Rheumatoid arthritis ILD; HP, Hypersensitivity pneumonitis; MCTD, mixed connective tissue disorder; IIP, Idiopathic interstitial pneumonia; USA, United States of America

*Unit of reporting is percentage of the study population (%); **Age and sex adjusted estimate; ǂ Narrow silicosis definition used: Medicare beneficiaries with any claim that included ICD-9-CM code 502, pneumoconiosis due to other silica or silicates, listed in any position during 1999-2014, with at least one inpatient, skilled nursing or home health agency claim, or at least two outpatient provider claims within 365 days of each other and cases with a chest X-ray or CT scan 30 days before or 30 days after a silicosis claim.

Tables E1-E31: Characteristics of Included Studies (n=88)

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Glossary Of Abbreviations And Definition Of Terms

AHP	Acute hypersensitivity pneumonitis
ATS/ERS	American Thoracic Society /European Respiratory Society
ATS/ERS/JRS/ALAT	American thoracic society/ European respiratory society/ Japanese Respiratory Society/ Latin American Thoracic Society
CHP	Chronic hypersensitivity pneumonitis
CIHI	Canadian Institute for Health Information
CLD	Cystic lung disease
CPRD	Clinical practice research datalink
CS	Cross sectional study design
CT	Computed tomography
CXR	Chest x-ray
DAD	Discharge Abstract Database
DLCO	Diffusing capacity of the lungs for carbon monoxide
dcSSc	Diffuse cutaneous systemic sclerosis
FEV	Forced expiratory volume
FHP	Fibrotic hypersensitivity pneumonitis
FLD	Farmers lung disease
FVC	Forced vital capacity
HIRA	Health Insurance Review and Assessment Service
HP	Hypersensitivity pneumonitis
HRCT	High-resolution computed tomography
ICD	International code for diagnosis
IIP	Idiopathic interstitial pneumonia
ILD	Interstitial lung disease
ILO	International labor organization
IPF	Idiopathic pulmonary fibrosis
LAM	Lymphangioleiomyomatosis
lcSSc	Limited cutaneous systemic sclerosis
MDD	Multidisciplinary discussion
NACRS	National Ambulatory Care Reporting System
NIH	National insurance of health
NR	Not reported
NSIP	Non-specific interstitial idiopathic pneumonia
PFT	Pulmonary function tests
PH	Pulmonary hypertension
PLCH	Pulmonary Langerhans cell histiocytosis
Prosp	Prospective study design
py	Person-years
RA	Rheumatoid arthritis
RID	Rare and Intractable Diseases
Rtr	Retrospective study design
SLB	Surgical lung biopsy

pSS	Primary Sjogren's syndrome
sSS	Secondary Sjogren's syndrome
SSc	Systemic sclerosis
ssSSc	Sine scleroderma
TLC	Total lung capacity
TLB	Transbronchial biopsy
UIP	Usual interstitial idiopathic pneumonia
UK	United Kingdom
USA	United States of America

*Table E1: List of Publications Reporting **Prevalence of IPF**, Sorted By Publication Year*

Author, year	Study design	Country	Study population	ILD assessment	Sample size	No. of IPF cases by ILD definition	Mean age; Female (%)	Reported Prevalence (per 100,000 persons)
Kaunisto 2015	CS	Finland	University hospital	• ICD codes J84.1 and J84.9 • Pulmonary physician re-evaluated the patients 'data by reading through the patient charts.70–80 % of patients 'diagnoses did not meet the clinical criteria of idiopathic pulmonary fibrosis. • Baseline CT scans were centrally re-evaluated by chest radiologist and radiology resident. • HRCT scans were evaluated and SLB was performed in 27 (22 %) patients.	NR	111	74;40	8.6
Lee 2016	Rtr	Korea	HIRA database	Patients with IPF were defined as those with a disease code of K-J84.18.	51,026,868	2010, 2011, 2012, 2013;16,325	NR	30.4,30.1,32.4,35
Harari 2016	Rtr	Italy	Healthcare administrative database of Lombardy	GCD: Defined as IPF cases all individuals with at least one hospitalization with diagnosis of IPF or at least one outpatient visits with diagnosis of IPF (ICD-9-CM code 516.3) during the study period	Approx. 10 million	5,441	Majority >65 years; 46	35.51 (35.02–36.00)
				BCD: Defined IPF cases those patients that satisfied the GCD and had no claims (inpatient or outpatient) with a diagnosis code for any other type of ILDs on or after the date of the last claim with IPF diagnosis		3,573	Majority >65 years; 43	22.39 (21.9-22.8)
				NCD: Defined IPF cases those patients that satisfied the BCD and had one or more claim with a procedure code for surgical lung biopsy, transbronchial lung biopsy or computed tomography of the thorax, on or before the date of the last claim with a diagnosis code for IPF.		2,097	Majority >65 years; 43	12.55 (12.3-12.8)
Hopkins 2016	Rtr	Canada	National databases: DAD and NACRS	Broad definition: by excluding cases with an ICD-10 CA code for another ILD after the J84.1 code, like other studies	NR	14,259	NR	41.8
				Narrow definition further excluded cases that did not have chest CT, bronchus or lung biopsy, or bronchoscopy prior to establishing a J84.1 code.		6,390	NR	20
Raghu 2016	Rtr	USA	Optum Clinformatics	Primary cohort: IPF patients were first identified if they had at least one claim with ICD-9-CM diagnosis code 516.3 (idiopathic fibrosing alveolitis, which is used by providers to identify IPF) during the study period. Two subgroups of the primary cohort were further identified by applying additional criteria to form more restrictive cohorts of prevalent IPF patients:	9,375,020	2005, 2006, 2007, 2008, 2009,2010; 7,671	NR	15.1, 16.9, 17.5, 18.4, 18.2, 13.4
				Broad case definition excluded patients if they had a claim with the diagnosis code 515 after the last diagnosis code 516.3.		2005, 2006, 2007, 2008, 2009,2010; 2,670	NR	8.4, 9.7, 10.6, 10.8, 11.6, 11.3
				Narrow case definition further restricted the broad case subgroup patients by requiring a claim for a surgical lung biopsy, transbronchial lung biopsy, or computed tomography scan of the thorax prior to the last diagnosis code 516.3.		2005, 2006, 2007, 2008, 2009,2010; 1,685	NR	4.6, 5.6, 6.1, 6.2, 6.9, 6.7
Raimundo 2016	CS	USA	Optum Humedica	Patients with at least one IPF inpatient claim, or two IPF outpatient claims with [ICD-9-CM] code 516.3) anytime in that calendar year (with no other ILD claim)	4,138,796	2009, 2010, 2011; 1,191, 1292, 1136	70-71;49-52	28.8, 28.1, 19.8
Strongman 2018	Rtr	UK	CPRD	Broad IPF -clinical syndrome definition included the following three additional Read codes: H563100 (Diffuse pulmonary fibrosis), H563200 (Pulmonary fibrosis), and H563.11 (Hamman-Rich syndrome).	9,748,108	2010 to 2013;4,527	NR	19.94 (18.48, 21.47) to 38.82 (37.04, 40.66)

Author, year	Study design	Country	Study population	ILD assessment	Sample size	No. of IPF cases by ILD definition	Mean age; Female (%)	Reported Prevalence (per 100,000 persons)
Zhang 2021	Rtr	USA	Veterans Health Administration (VHA) electronic health record	Broad: Patients who had a diagnosis code for IPF (ICD-9-CM code 515, 516.3, 516.31 or ICD10-CM code J84.111, J84.112, J84.89, J84.9, J84.10, J84.17) recorded during study period • Patients were considered to have IPF if they did not have any other diagnosis code for an alternative interstitial lung disease	10.7 million	NR	NR	1,160
				Narrow: Patients who had a diagnosis code for IPF (ICD-9-CM code 515, 516.3, 516.31 or ICD10-CM code J84.111, J84.112, J84.89, J84.9, J84.10, J84.17) recorded during study period • Patients were considered to have IPF if they did not have any other diagnosis code for an alternative interstitial lung disease • Patients who had procedure code for a lung biopsy or a CT scan of the thorax before the last IPF diagnosis		NR	NR	725

GCD, general case definition; BCD, broad case definition; NCD, narrow case definition

*Table E2: List of Publications Reporting **Incidence of IPF**, Sorted By Publication Year*

Author, year	Study design	Country	Study population	ILD assessment	Sample size	No. of IPF cases by ILD definition	Mean age; Female (%)	Reported Incidence
Gjonbrataj 2015	Rtr	South Korea	HIRA	• Definition 1: codeJ84, ICD-10 code; (BAL) or lung biopsy;	36,765,374	21,805	NR; 38	48.5 per 100,000
				• Definition 2: code J84 and HRCT, bronchoalveolar lavage or lung biopsy		13,680	NR; 25	32.2 per 100,000
				• Definition 3: code J84.1, ICD-10 code;		5,881	NR; 12	16.2 per 100,000
				• Definition 4: codeJ84.1 and HRCT, BAL or lung biopsy; and		4,219	NR: 8.5	11.4 per 100,000
				• Definition5: code J84.1A, based on the 2011 international statement.		615	NR; 0.9	1.7 per 100,000
Lee 2016	Rtr	South Korea	HIRA	Patients with IPF were defined as those with a disease code of K-J84.18.	51,026,868	2011,2012;657	NR	13.1 and 12.9 per 100,000
Harari 2016	Rtr	Italy	Healthcare administrative database of Lombardy	IPF was defined as: GCD: Defined as IPF cases all individuals with at least one hospitalization with diagnosis of IPF or at least one outpatient visits with diagnosis of IPF (ICD-9-CM code 516.3) during the period from 1st January 2000 to 31st December 2010.	Approx. 10 million	2,951	Majority >65 years; 43	5.24 (5.06-5.44) per 100,000 py
				BCD: Defined IPF cases those patients that satisfied the GCD and had no claims (inpatient or outpatient) with a diagnosis code for any other type of ILDs on or after the date of the last claim with IPF diagnosis		2,093	Majority >65 years;40	3.74 (3.58-3.90) per 100,000 py
				NCD: Defined IPF cases those patients that satisfied the BCD and had one or more claim with a procedure code for surgical lung biopsy, transbronchial lung biopsy or computed tomography of the thorax, on or before the date of the last claim with a diagnosis code for IPF.		1,309	Majority >65 years ;41	2.33(2.20-2.46) per 100,000 py
Hopkins 2016	Rtr	Canada	National databases: DAD and NACRS	Broad definition: by excluding cases with an ICD-10 CA code for another ILD after the J84.1 code, like other studies.	NR	6,390	NR	18.7 per 100,000

Author, year	Study design	Country	Study population	ILD assessment	Sample size	No. of IPF cases by ILD definition	Mean age; Female (%)	Reported Incidence
				Narrow definition further excluded cases that did not have chest CT, bronchus or lung biopsy, or bronchoscopy prior to establishing a J84.1 code.		3,057	NR	9 per 100,000
Raghu 2016	Rtr	USA	Optum Clinformatics	Primary cohort: IPF patients were first identified if they had at least one claim with ICD-9-CM diagnosis code 516.3 (idiopathic fibrosing alveolitis, which is used by providers to identify IPF) during the study period. Two subgroups of the primary cohort were further identified by applying additional criteria to form more restrictive cohorts of prevalent IPF patients:	9,375,020	4,206	53;51	5.8 per 100,000
				Broad case definition excluded patients if they had a claim with the diagnosis code 515 after the last diagnosis code 516.3.		2,670	53;52	3.6-5.1 per 100,000
				Narrow case definition further restricted the broad case subgroup patients by requiring a claim for a surgical lung biopsy, transbronchial lung biopsy, or computed tomography scan of the thorax prior to the last diagnosis code 516.3.		1,685	54;53	2.4-2.9 per 100,000
Strongman 2018	Rtr	UK	CPRD	Narrow IPF-CS case definition were H563.00 (Idiopathic fibrosing alveolitis), H563.12 (Cryptogenic fibrosing alveolitis), H563z00(Idiopathic fibrosing alveolitis NOS), H563300(Usual interstitial pneumonitis), and H563.13(Idiopathic pulmonary fibrosis).	9,748,108	1,491	NR	2.85(2.7-3) per 100,000 py
				Broad IPF -CS definition included the following three additional Read codes: H563100 (Diffuse pulmonary fibrosis), H563200 (Pulmonary fibrosis), and H563.11 (Hamman-Rich syndrome).		4,527		8.7 (8.4-8.9) per 100,000 py
Lim 2019	Rtr	South Korea	Korean National Health Insurance Service (NHIS) database for patients registered with the co-payment assistance policy for rare and incurable diseases.	ICD codes	2011: 50,908,646, 2012: 51,169,141, 2013: 51,448,491, 2014: 51,757,146 2015: 52,034,424	NR	NR	2011: 27.85 2012: 28.36 2013: 31.28 2014: 32.21 2015: 35.82 Cumulative 2011-2015: 31.03 per 100,000
Belbasis 2021	Prosp	UK	Biobank, self-reported (all unrelated individuals of White ethnicity participating in the UK Biobank)	Broad included all individuals with an ICD, Tenth Revision, diagnosis of J84.1 and J84.9 or an ICD, Ninth Revision, diagnosis of 516.3.	437,453 individuals	1,234	63,41	282.1 per 100,000
				Narrow: individuals with pulmonary fibrosis excluding other medical conditions that cause pulmonary fibrosis or interstitial lung disease		802	NR	183.3 per 100,000
Zhang 2021	Rtr	USA	Veterans Health Administration (VHA) electronic health record	Broad: Patients who had a diagnosis code for IPF (ICD-9-CM code 515, 516.3, 516.31 or ICD10-CM code J84.111, J84.112, J84.89, J84.9, J84.10, J84.17) recorded during study period • Patients were considered to have IPF if they did not have any other diagnosis code for an alternative interstitial lung disease	10.7 million	139,116	71;7	331 per 100,000
				Narrow: Patients who had a diagnosis code for IPF (ICD-9-CM code 515, 516.3, 516.31 or ICD10-CM code J84.111, J84.112, J84.89, J84.9, J84.10, J84.17) recorded during study period • Patients were considered to have IPF if they did not have any other diagnosis code for an alternative interstitial lung disease • Patients who had procedure code for a lung biopsy or a CT scan of the thorax before the last IPF diagnosis		82,557	707	210 per 100,000 py

GCD, general case definition; BCD, broad case definition; NCD, narrow case definition

*Table E3: List of Publications Reporting **Prevalence of IIP**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type of IIP	No. of ILD cases	Mean age; Female (%)	Prevalence
Lee 2016	Korea	Rtr	HIRA database	Diagnosis codes; Patients with IIP were defined as those with two or more medical visits or at least one hospitalisation with an IIP diagnostic code	51,026,868	IIP	41,770	NR; 50	81.86 per 100,000 persons
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• A MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	IIP	145	56;50	12.14 per 100,000 persons
						NSIP	20		1.7 per 100,000 persons
						DIP	10		0.8 per 100,000 persons
						OP	9		0.8 per 100,000 persons
						RB-ILD	2		0.2 per 100,000 persons

*Table E4: List of Publications Reporting **Incidence of IIP,** Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type of IIP	No. of ILD cases	Mean age; Female (%)	Incidence
Lee 2016	Korea	Rtr	HIRA database	Diagnosis codes; Patients with IIP were defined as those with two or more medical visits or at least one hospitalisation with an IIP diagnostic code	51,026,868	IIP	17,826	NR; 50	34.93 per 100,00 persons
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• A MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	IIP	52	56;50	4.4 per 100,000 person per year
						NSIP	10		0.8 per 100,000 person per year
						DIP	3		0.3 per 100,000 person per year
						OP	1		0.1 per 100,000 person per year

*Table E5: List of Publications Reporting **Prevalence of Systemic Sclerosis-ILD,** Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type of SSc	No. of ILD cases	Mean age; Female (%)	Prevalence
Simeon-Aznar 2015	Spain	Rtr	RESCLE registry	Pulmonary involvement is defined by the presence of ILD or PH. ILD was established if any of the following criteria were identified: • restrictive pulmonary pattern with FVC below 80% of expected value on PFTs, • pulmonary interstitial pattern evidenced by chest radiograph HRCT scan, • alveolitis confirmed by bronchoalveolar lavage (defined as neutrophilia of ≥3%, eosinophilia of ≥2%, or lymphocytosis ≥15%).	879	Overall SSc	421	44.4;85	47.8%
Wangkaew 2016	Thailand	Prosp	Maharaj Nakorn Chiang Mai Hospital	• All HRCTs images were reviewed by an experienced thoracic radiologist • We used HRCT to categorize pattern of the lung parenchyma findings that represented ILD, which were unexplainable by any other causes.	113	Overall SSc	80	53.4;58	69.1%
					89	dcSSc,	70	54.1;51	78.7%
					24	LcSSc,	11	50.6;88	45.8%
Tomiyama 2016	Japan	Rtr	SSc who visited hospital department	ILD were evaluated by radiologists using high-resolution computed tomography (HRCT). Follow-up CT scans were performed when patients experienced a worsening of respiratory symptoms	139	Overall SSc	66	49.2;82	47.5%
					116	lcSSc	48	NR	41.4%
					23	dcSSc	18	NR	78.3%
Sanchez-cano 2018	Spain	CS	RESCLE is a nation-wide, multi-center registry	ILD: evidence consistent with pulmonary fibrosis present on chest radiograph or HRCT. Additionally, FVC value was considered to categorise as ILD severity, we took a 70% value as cutoff, between mild and moderate–severe ILD.	1,374	Overall SSc	595	57;86	43.3%
					1,374	lcSSc	316	60;87	53.1%
					1,374	dcSSc	240	52;85	40.3%
					1,374	ssSSc	39	58;80	6.6%
Janardana 2019	India	Rtr	Department of Clinical Immunology & Rheumatology, Christian Medical College	• The diagnosis of ILD was made HRCT of the chest reported by radiologists at our institute in majority of the cases. • Only for occasional patients, the diagnosis was based on clinical examination findings and CXR	327	Overall SSc	288	35.1,8	88.1%
Morrisroe 2019	Australia	Prosp	SSc patients enrolled in the Australian Scleroderma Cohort Study (ASCS),	ILD was defined by characteristic changes on HRCT.	1,727	Overall SSc	489	46.6;86	28.3%
Noviani 2019	Singapore	Prosp	Three tertiary rheumatology centres in Singapore	• ILD was diagnosed by HRCT and the severity of ILD was determined by PFT. • HRCT was performed in patients with clinical symptoms (dyspnea or cough) or signs suggestive of ILD (end-inspiratory bibasilar crepitations), chest radiographs suspicious of ILD or restrictive pattern on PFT with FVC or TLC <80% predicted or DLCO <75% predicted. • Significant ILD was defined by FVC <70% predicted and categorised under the ILD group	490	Overall SSc	135	49; 83	27.6%
Bauer 2020	France	Rtr	Patients treated at Nancy University Hospital	• Pulmonary involvement was determined with functional measurement in terms of obstructive and restrictive defects and decreased diffusing capacity of the lungs for carbon monoxide DLCO (<80%) • With a specific examination of the CT scan by an experienced radiologist	77	Overall SSc	24	NR	31.2%
					58	lcSSc	14		24.1%
					19	dcSSc	10		52.6%
Jaafar 2021	USA	Prosp	Multicentre national Prospective Registry of Early Systemic Sclerosis (PRESS) registry	Not clearly reported. Based on the results, ILD was diagnosed using HRCT and significant functional progression of ILD was defined as an absolute FVC decline of ≥10% as compared to baseline FVC during the whole course of the study.	239	Overall SSc	128	51,70	53.6%
Li 2021	USA	Rtr	IBM MarketScan claims database	ICD codes	78,964,708	Overall, SSc	15,005	NR	19 per 100,000 persons

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type of SSc	No. of ILD cases	Mean age; Female (%)	Prevalence
Pope 2021	Canada	Rtr	SSc Patients were identified using the CIHI, NACRS, DAD.	ICD 10 codes	NR	Overall, SSc For year: (2017/18)	257	Age groups: 18-29: 0 30-50:1.7 51-64:4.2 65+:3.2; 3.6	2.3 per 100,000 persons (12% SSc cases with ILD)
Fairley 2021	Australia	Prosp	Consecutive patients with SSc who prospectively enrolled in the Australian Scleroderma Cohort Study (ASCS)	• HRCT were used to diagnose ILD • These were usually performed in response to clinical examination findings (chest crepitations) or abnormal respiratory function testing	1,505	SSc only	393	NR	26.1%
Carton 2021	Belgium	Rtr	Consecutive SSc patients, included in two Flemish cohort	• Each HRCT was centrally analysed by an experienced investigator who was blinded. • Patients were classified into three subgroups ("no ILD", limited ILD or extensive ILD), according to the simplified flow diagram described by Goh et al	722	Overall, SSc	243	NR	34%

Table E6: List of Publications Reporting ***Incidence of Systemic Sclerosis-ILD,*** *Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type of SSc	No. of ILD cases	Mean age; Female (%)	Incidence rate (per 100,000 py)
Wangkaew 2016	Thailand	Prosp	Maharaj Nakorn Chiang Mai Hospital, Chiang Mai University	• All HRCTs were obtained with one of two MDCT platforms • All images were reviewed by an experienced thoracic radiologist blinded to clinical and laboratory data. • HRCTs were categorized by the pattern of the lung parenchyma findings that represented ILD,	89	dcSSc	NR	53.4;58	58.8
Wangkaew 2016					24	lcSSc	NR	53.4;58	17.3
Carton 2021	Belgium	Rtr	Consecutive SSc patients, included in two Flemish cohort	• •Each HRCT was centrally analysed by an experienced investigator who was blinded. • Patients were classified into three subgroups ("no ILD", limited ILD or extensive ILD), according to the simplified flow diagram described by Goh et al	722	SSc, overall	39		2,570 (1,800-3,560) (8%)
					281	lcSSc	26		2,300 (1,500-3,360) (9%)
					64	dcSSc	10		3,730 (1,790 – 6,850) (16%)
Li 2021	USA	Rtr	IBM MarketScan claims database	ICD codes	78,964,708	Overall, SSc	8,252	58,82	4.3 (4.2 -4.4)

Table E7 List of Publications Reporting ***Prevalence of Rheumatoid Arthritis - ILD****, Sorted By Publication Year*

Author, year	Country	Study design	Study population descriRption	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Unit of measurement	Prevalence
Md Yosuf 2017	UK	Prosp	Patients with moderate to severe RA who were treated with RTX at participating site	• PFT collected at 6–12 months pre-RTX, at the time of treatment with RTX, 6–12 months post-RTX and at the most recent follow-up. • HRCT scans were acquired (when clinically indicated) in patients with worsening dyspnoea and/or deterioration in lung function using a standardised method. The scans were scored independently by two radiologists, both blinded to lung function information and the sequence of scans. • In order to account for missing PFT data of those with severe ILD who were unable to perform the test, data from the HRCT and survival status were incorporated into the overall lung response.	700	56	64;98	Percentage of study cohort	8
Kim 2017	South Korea	Prosp	RA Patients from the KORean Observational study Network for Arthritis cohort	• ILD was diagnosed based on the results of CXR or CT scans. • The CXRs and CT scans were read by expert radiologists at each hospital and the chest imaging records were collected from each hospital. The ILD group consisted of all patients whose chest image reports contained key words such as “pulmonary fibrosis”, “interstitial fibrosis”, “interstitial pneumonia”, “interstitial lung disease” and “ILD”,USA in addition to a descriptions of patterns of the lung disease such as “usual interstitial pneumonia” and “nonspecific interstitial pneumonia”.	3,555	64	63.2;70	Percentage of study cohort	1.8 (95% CI 1.4–2.3)
Zhang 2017	China	Rtr	Patients who were diagnosed with RA at the Capital Medical University, Beijing Chaoyang Hospital, during the study period	Not reported, ILD cases were reported as seen in the medical history	550	32	57.6;63	Percentage of study cohort	5.8
Sakr 2018	Egypt	Rtr	RA patients attending the Rheumatology outpatient clinic, Kasr Alainy Hospital, Cairo University	ILD presence was extracted from patient’s medical history, details of ILD assessment are not reported.	3,219	27	NR	Percentage of study cohort	0.8
Duarte 2019	UK	Rtr	RA patients that attended the Rheumatology Department of University College London Hospital	• Types of lung involvement were based on HRCT, with the date of the exam being considered the date of lung disease diagnosis. • Subsequent HRCT results were also recorded. • PFTs including gas transfer (transfer factor for carbon monoxide), were collected for patients with lung involvement	1,129	45	63.2;67	Percentage of study cohort	3.98
McFarlane 2019	USA	CS	RA inpatient discharges during study period, that took place at NY hospitals	• A chest radiologist, pulmonary specialist, and a rheumatologist i.e. MDD reviewed the clinical course, management, pulmonary function tests, and chest CT images for each patient during the multidisciplinary reviews.	503	32	64;88	Percentage of study cohort	6.4
Kiely 2019	UK	Prosp	The study used data from ERAS (1986–2001) and ERAN (2002–2012), two multicentre early RA inception cohorts.	The diagnosis of ILD at each centre was according to standard practice, with confirmatory evidence from standard investigations including pulmonary function tests, chest radiographs and HRCT scans. ILD was deemed to be present if the terms pulmonary fibrosis or ILD were listed on the CRF or the death certificate using ICD codes.	1114	53	NR	Percentage of study cohort	4.8
Raimundo 2019	USA	Rtr	Truven Health MarketScan Commercial and Medicare Supplemental	Patients meeting ≥ 1 of the following criteria were identified as potential RA-ILD cases: • ≥ 2 claims with an International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnosis code for pulmonary disease (fibrosis: ICD-9-CM 515, 516.3, 516.31; rheumatic lung disease: ICD-9-CM 714.81) on	over 150 million lives	648	66;67	**2004**, per 100,000 RA persons	3.2 (95% CI 3.0–3.4)

Author, year	Country	Study design	Study population descriRption	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Unit of measurement	Prevalence
Raimundo 2019			health insurance databases	different days, with the second claim occurring within 12 months of the first plus ≥ 2 claims with a diagnosis of RA (ICD-9-CM 714.xx, excluding 714.3x and 714.4x) on different days in the 12 months before or after the first claim for pulmonary disease; • ≥ 2 claims with a diagnosis of rheumatic lung disease (ICD-9-CM 714.81) on different days, with the second claim occurring within 12 months of the first based on a previously published algorithm.		1,575	65;70	**2013**, per 100,000 RA persons (general population)	6.0 (95% CI 5.7–6.2)
Ke 2021	China	Rtr case control	Subjects were selected from RA diagnosed patients who were hospitalized in the Department of Rheumatology and Immunology; there 2 cohorts: i) patients aged above 60 years, ii) patients between 18 to 59 years.	• Not reported (self-report)	142 (79 EORA ie elderly onset patient developed RA after the age of 60 years and 63 YORA (developed RA at a younger age)	21	NR	Percentage of study cohort	14.8
Kronzer 2021	Sweden	Matched case control	RA patients enrolled in EIRA (Epidemiological investigation of RA) which is a population-based, case–control study of incident RA in central and southern Sweden that began in 1995	• Diagnosis code in linked EHR record (ie the Swedish National Patient Register)	1631	10	NR	Percentage of study cohort	0.6
Paulin 2021	Argentina	CS	RA patients recruited from 2 rheumatology outpatient clinics with less than 2 years of RA diagnosis (Early RA study)	• Scans HRCT used to detect abnormalities	83	6	NR	Percentage of study cohort	7.5
Samy 2021	Egypt	CS	RA Patients were recruited from the outpatient clinic and the inpatient Department of Rheumatology at a university hospital	• RA-ILD patients had any of the following HRCT abnormalities: ground glass opacities, septal lines, reticulation, subpleural fibrosis, traction bronchiectasis, architectural distortion, and/or honey combing. • Radiographic abnormalities could occur with/without clinical symptoms of dyspnea and cough or significant PFTs abnormalities.	160	102	45;86	Percentage of study cohort	63.7
Shin 2021	South Korea	Rtr	RA patients were enrolled into the KORean Observational study Network for Arthritis (KORONA) database by rheumatologists from 23 centres	• Self-report (questionnaire responses at study enrolment)	5,376	45	NR	Percentage of study cohort	0.84
Sparks 2021	USA	Rtr	Medicare claims data that includes nearly all	• Among patients ever identified with RA, we identified ILD by the presence of two or more ICD-9 or ICD-10 codes for ILD in any position by a	509,787	10,306	73;73	Percentage of study cohort	2

Author, year	Country	Study design	Study population descriRption	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Unit of measurement	Prevalence
			Americans 65 years of age and some younger individuals with disabilities certain disabilities.	rheumatologist or pulmonologist separated by 7–365 days, as previously validated (PPV 72.4%) • RA-ILD date was defined as the second billing code for ILD that fulfilled the algorithm. • Incident RA-ILD was defined as occurring after the RA index date.					

AD, airway disease; NY, New York

*Table E8 List of Publications Reporting **Incidence of Rheumatoid Arthritis** - ILD, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Unit of measurement	Incidence
Zhang 2017	China	Rtr	Patients who were diagnosed with RA at the Capital Medical University, Beijing Chaoyang Hospital, during the study period	Not reported, ILD cases were reported as seen in the medical history	550	205	57.6;63	Percentage of RA study cohort	37.3
Raimundo 2019	USA	Rtr	Truven Health MarketScan Commercial and Medicare Supplemental health insurance databases	Patients meeting ≥ 1 of the following criteria were identified as potential RA-ILD cases: • ≥ 2 claims with an International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnosis code for pulmonary disease (fibrosis: ICD-9-CM 515, 516.3, 516.31; rheumatic lung disease: ICD-9-CM 714.81) on different days, with the second claim occurring within 12 months of the first plus ≥ 2 claims with a diagnosis of RA (ICD-9-CM 714.xx, excluding 714.3x and 714.4x) on different days in the 12 months before or after the first claim for pulmonary disease; • ≥ 2 claims with a diagnosis of rheumatic lung disease (ICD-9-CM 714.81) on different days, with the second claim occurring within 12 months of the first based on a previously published algorithm.	over 150 million lives	NR	NR	2004, Per 100,00 persons	2.7 (95% CI 2.5-2.9)
						NR	NR	2013, Per 100,00 persons (general population)	3.8 (95% CI 3.5-4.0)
Sparks 2021**	USA	Rtr	Medicare claims data that includes nearly all Americans 65 years of age and some younger individuals with disabilities certain disabilities.	• Among patients ever identified with RA, we identified ILD by the presence of two or more ICD-9 or ICD-10 codes for ILD in any position by a rheumatologist or pulmonologist separated by 7–365 days, as previously validated (PPV 72.4%) • RA-ILD date was defined as the second billing code for ILD that fulfilled the algorithm. • Incident RA-ILD was defined as occurring after the RA index date.	499,481	13,372	NR	Per 100,000 person-years among RA patients	714 (700-730) per 100,000 persons (2.7%)

** Adjusted for age and sex

*Table E9 List of Publications Reporting **Prevalence of Myositis ILD**, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age (years); Female (%)	Prevalence (%)
Ishizuka 2016	Japan	Rtr	Enrolled patients with PM/DM who were referred to our department	The presence of ILD was evaluated by computed tomography (CT).	124	76	53.5;65	61.3
Ishizuka 2016					46 (PM)	25	NR	54.3
Ishizuka 2016					78 (DM)	51	NR	65.4
Gomez 2021	Argentina	CS	Argentine registry of IMM that includes patients older than 18 years who have been diagnosed with myositis ILD	HRCT or biopsy	360	99	NR	27.5
Huang 2021	Taiwan	Rtr	Patients who underwent complete myositis autoantibody serology examination at university hospital	NR	97	46	56;80	47.4

*Table E10 List of Publications Reporting **Incidence of Myositis ILD**, Sorted By Publication Year*

None reported

*Table E11 List of Publications Reporting **Prevalence of Sjogren's Syndrome ILD**, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age (years); Female (%)	Type of SS	Prevalence (%)
Kvarnstorm 2015	Sweden	Prosp	All incident patients referred to the dept. of Rheumatology at the Karolinska University Hos.	• ILD assessment not reported	199	2	55;94	p-SS	1
Zhao 2015	China	CS	Patients from 16 Chinese medical centers nationwide	• Pulmonary involvement was indicated by persistent cough and/or dyspnea with chronic diffuse interstitial infiltrates on X-rays, altered patterns on pulmonary function tests, and/or evidence of lung alveolitis or fibrosis in computed tomography (CT) scans.	317	59	49;94	p-SS	18.6
Manfredi 2017	Italy	Prosp	All consecutive patients diagnosed as pSS during the study period	• ILD assessment was based on HRCT and PFTs. • HRCT was categorized as definite, possible, or inconsistent with usual interstitial pneumonia (UIP) pattern according to the 2011 ATS/ERS/JRS/ALAT Guidelines for Diagnosis and Management of IPF	77	13	67;77	p-SS	16.9
Roca 2017	France	Rtr	Medical records from 2 participating institutional centers	• ILD was investigated by PFTs, and HRCT scan of the lungs; no patient underwent lung biopsy.	263	11	63;86	p-SS	4.2
Gao 2018	China	Rtr	Hospitalized patients admitted to Peking	• Diagnosis of pSS-ILD was made according to HRCT abnormalities and/or impaired PFTs, with or without pulmonary signs	853	165	61;92	p-SS	19.3
					488	126	61;92	s-SS	25.8
Kampolis 2018	Greece	CS	Department of Pathophysiology (Medical School, University of Athens)	• HRCT scan of the lungs was performed in all patients at the day of pulmonary function testing. Abnormal HRCT findings were classified into four major categories: reticular (septal thickening, honeycombing), nodular (multiple large or small nodules), high attenuation	Overall, 384; Asymptomatic patients who	7	63;95	p-SS	17.9

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age (years); Female (%)	Type of SS	Prevalence (%)
				(consolidation, ground glass opacities) and low attenuation (air trapping, lung cysts) pattern. CT images were independently evaluated by two experienced radiologists.	underwent HRCT: 39				
Wang 2018	China	Prosp	Newly diagnosed pSS were recruited from Beijing Chao-Yang Hospital	• All patients underwent HRCT scans. The scans included both lungs in the field of view. Each HRCT scan was reviewed independently by two experienced thoracic radiologists blinded to the clinical data before the therapeutic interventions. 65% pSS-ILD patients underwent percutaneous lung biopsy or bronchoscopy, including bronchoalveolar lavage total cell counts and cell differentials and transbronchial lung biopsy. PFTs were performed according to the guidelines.	201	158	62;85	p-SS	78.6
Gao 2021	China	Rtr	pSS patients admitted to Peking university hospital	• Expert radiologist re-assessment of the imaging	934	178	62;87	p-SS	19.1
Kam 2021	Singapore	Rtr	pSS between 1993 and 2013, seen at Tan Tock Seng Hospital	• NR	102	2	NR	p-SS	1.96
Nilsson 2021	Sweden	CS	Patients with pSS had been previously investigated for pulmonary involvement at university hospital	• HRCT, pulmonary function tests	40	15	NR	p-SS	38
Omair 2021	Saudi Arabia	CS	Study participants were recruited from patients with pSS attending the rheumatology and pulmonary clinics at a university hospital	• NR	41	36	NR	p-SS	87.8

*Table E12 List of Publications Reporting **Incidence of Sjogren's Syndrome ILD**, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age (years); Female (%)	Type of SS	Incidence (%)
Roca 2017	France	Rtr	Medical records from 2 participating institutional centers	• ILD was investigated by PFTs, and HRCT scan of the lungs; no patient underwent lung biopsy.	263	9	63;86	p-SS	3.4

*Table E13 List of Publications Reporting **Prevalence/Incidence of Other Autoimmune Conditions***

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age (years); Female (%)	Prevalence (%)	Incidence (%)
Reiseter 2018	Norway	Rtr	Nationwide MCTD cohort from depts of Rheumatology	• CT scans and PFTs	119	Prevalent: 47 Incident: 2	91;38	40%	1.7%
Olaosebikan 2021	Nigeria	CS	CTD patients managed at the Rheumatology Unit of Lagos State University Teaching Hospital	• Clinical information including socio-demographics, signs and symptoms of ILD, pattern(s) of CTD, serology, pulmonary function, and radiology findings as well as treatment outcomes were retrieved from patients' records	318	Prevalent: 23 Incident: 8	39;90	7.2%	2.5%

*Table E14 List of Publications Reporting **Prevalence of Hypersensitivity pneumonitis**, Sorted By Type of Hypersensitivity pneumonitis and Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type of HP; No. of cases	Unit of Prevalence	Prevalence
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	HP; 28	Per 100,000 persons per year	2.3
Perez 2018	United States	Rtr	Truven Health Market Scan Commercial and Medicare	• This research developed novel claims-based coding algorithms to identify HP, CHP, FHP cases, these algorithms validity and reliability were assessed with clinical data from National Jewish Health. • The case validation procedure involved medical record review performed using the electronic medical records. • An expert chest radiologist reviewed CT scans, blinded to subjects' clinical information and the primary radiologist's interpretation, to determine whether pulmonary fibrosis was present and whether the CT met criteria for consistent or possible HP or was inconsistent with HP. Last, a clinical-radiological consensus diagnosis of HP or not HP was applied.	158,270,350	HP; 7,498	Per 100,000 persons	1.67 (95% CI, 1.5 - 1.8) - 2.71 (95% CI, 2.6 -2.9)
					4,093	FLD; 157	% of the HP cohort	3.8
					4,093	Bagassosis; 11	% of the HP cohort	0.3
					4,093	Bird fancier's; 89	% of the HP cohort	2.2
					4,093	Suberosis; 71	% of the HP cohort	1.7
					4,093	Malk workers; 21	% of the HP cohort	0.5
					4,093	Mushroom workers; 55	% of the HP cohort	1.3
					4,093	Maple bark strippers; 26	% of the HP cohort	0.6
					4,093	Ventilation pneumonitis; 201	% of the HP cohort	4.9
					4,093	Other Spec; 482	% of the HP cohort	11.8
					4,093	Unspec; 3,015	% of the HP cohort	73.7
					4,093	CHP; 2,308	Per 100,000 persons	0.91 (95% CI, 0.8–1.0) - 1.7 (95% CI, 1.6–1.8)
					4,093	FHP; 941	Per 100,000 persons	0.41 (95% CI, 0.3–0.5) - 0.8 (95% CI, 0.7– 0.9)

*Table E15 List of Publications Reporting **Incidence of Hypersensitivity pneumonitis**, Sorted By Type of Hypersensitivity pneumonitis and Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type of HP; No. of cases	Unit of Prevalence	Prevalence
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	HP; 11	per 100,000 per year	0.9
Perez 2018	United States	Rtr	Truven Health Market Scan Commercial and Medicare	• Novel claims-based coding algorithms to identify HP, CHP, FHP cases • The case validation procedure involved medical record review performed using the electronic medical records • An expert chest radiologist reviewed CT scans, blinded to subjects' clinical information and the primary radiologist's interpretation, to determine whether pulmonary fibrosis was present and whether the CT met criteria for consistent or possible HP or was inconsistent with HP. • Last, a clinical-radiological consensus diagnosis of HP or not HP was applied.	158,270,350	HP; 3405	Per 100,000	1.28-1.9 (1.7 – 2.2)
					158,270,350	CHP; NR	Per 100,000	0.63 (95% 0.5– 0.7) – 1.08 (95% CI, 0.9– 1.3)
					158,270,350	FHP; NR	Per 100,000	0.29 (95% CI, 0.2–0.4) - 0.43 (95% CI, 0.4– 0.5)

*Table E16 List of Publications Reporting **Prevalence of Cystic Lung Disease**, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type & No. of ILD cases	Prevalence
Duchemann 2017	France	CS, Rtr	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	LAM, 9	0.8 per 100,000 persons
Duchemann 2017						PLCH, 4	0.3 per 100,000 persons

*Table E17 List of Publications Reporting **Incidence of Cystic Lung Disease**, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	Type & No. of ILD cases	Incidence
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	A multi-disciplinary team of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and surgical lung biopsy (SLB), when applicable. The aetiology of ILD was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. The aetiology of ILD remained undetermined when a diagnosis could not be established based on available investigations after multidisciplinary discussion (MDD). For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	LAM, 4	0.3 per 100,000 persons per year
Duchemann 2017						PLCH,2	0.2 per 100,000 persons per year

*Table E18 List of Publications Reporting **Incidence and Prevalence of Unclassifiable ILD**, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Prevalence	Incidence
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• A MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	Prevalent: 60 Incident: 22	5 per 100,000 persons	1.8 per 100,000 persons per year

*Table E19 List of Publications Reporting **Prevalence of Silicosis**, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Exposure duration	Prevalence
Knight 2015	South Africa	Prosp	Baseline survey using a random sample of approximately 1,000 miners in each cluster (a subset of the total workforce) was conducted, staggered over calendar time (2006–2009).	• Radiographs were read for silicosis according to the ILO Classification. All radiographs were read by an experienced nursing health professional for silicosis. For the purpose of the silicosis study an experienced occupational medicine physician and trained reader read • All radiographs reported as silicosis ILO grade ≥0/1 by reader I,	11,557	1,374	NR	NR	11.9%
Siribadda 2016	Srilanka	CS	Workers at a silica factory in Matale District	• A screening questionnaire was used to assess symptoms of silicosis as well as tuberculosis which is a recognized complication of silicosis. • The chest radiographs were reported according to the guidelines of ILO and the diagnosis of silicosis was made according to the following criteria as per the guidelines of the ILO • Chest imaging (usually a conventional chest radiograph) that shows opacities consistent with silicosis.	250	14	30;13	< 5 yrs: 6 5 - 10 yrs: 7 > 10 yrs: 1	5.6%

Silanum 2017	Thailand	CS	Stone carving workers	• The questionnaire (that was developed from reviewing silicosis relevant documents) was performed by interviewing prior to performing the chest x-ray. • Reading and interpreting chest films were done by NIOSH B reader according to ILO film.	315	80	NR	NR	25.4%
Souza 2017	Brazil	CS	Mineworkers in semi-precious stone mining	• The diagnosis of silicosis was made by a physician based on exposure history and alterations typical of the disease shown on the chest X-ray. • The chest X -rays were interpreted independently by a radiologist and a pulmonologist according to the ILO of Pneumoconioses. • Silicosis was diagnosed in those patients whose chest X-ray showed rounded opacities with profusion equal to or greater than 1/0.	348	129	48; NR	Duration of exposure (years): 28.3 (10.4) years; Avg time working per day, hours: 8.7 (2.3) hours	37%
Casey 2019	USA	Rtr	Medicare beneficiaries	Three case definitions were used to identify beneficiaries with silicosis: • Broad: Any claim that included ICD-9-CM code 502, pneumoconiosis due to other silica or silicates, listed in any position during 1999-2014 • Intermediate: Among broad definition cases those who used i) at least one inpatient, skilled nursing, or home health agency claim or ii) at least two outpatient provider claims within 365 days of each other. • Narrow: Among intermediate cases, a narrow definition applied included, that cases have a chest X-ray or CT scan 30 days before or 30 days after a silicosis claim.	4,99,23,987	Broad: 19,696	65-84 years: 84; 19	NR	39.5 per 100,000
						Interm: 11, 469	65-84 years: 85; 11	NR	23 per 100,000
						Narrow: 10,026	65-84 years: 84; 16	NR	20.1 per 100,000
Hoy 2021	Australia	Rtr	V- SHARP is a population-based health assessment programme for current and former stonemasons	• HRCT, lung function tests	239	86			36%
Poinen-Rughooputh 2021	China	CS	Silica dust-exposed workers employed for at least 1 year during the study period in any of eight Chinese pottery factories	• Diagnosis of silicosis were based on 1986 Chinese pneumoconiosis Roetgen diagnostic criteria which classified silicosis as stages 1, II or III similar to ILO of 1/1 or greater	8,887	1,219	40;25	Cum. Exp: 5.7 (mg/m^3 yr); Net years if dust exp: 25.8	13.7%
Requena-Mullor 2021	Spain	CS	Workers in the stone sector handling artificial stone or silica compacts that were exposed to crystalline silica dust daily	• NR	311	64	39;0	with the average number of years exposed being 8.40 (6.75) years for workers with silicosis	20.6%
Monteiro 2021	Brazil	CS	The targeted population was composed of 776 workers from 277 mines registered in A cooperative that organizes the mining operation in the region	• NR, self-reported	258	27	53;0	Median crude dust exposure estimated by ART was 13.2 mg/m^3	10.5%

ART, Advanced REACH (Registration, Evaluation, and Authorization of Chemicals) Tool

*Table E20 List Of Publications Reporting **Incidence of Silicosis**, Sorted By Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Incidence
Casey 2019	USA	Rtr	Medicare beneficiaries	Three case definitions were used to identify beneficiaries with silicosis: • Broad: Any claim that included ICD-9-CM code 502, pneumoconiosis due to other silica or silicates, listed in any position during 1999-2014 • Intermediate: Among broad definition cases those who used i) at least one inpatient, skilled nursing, or home health agency claim or ii) at least two outpatient provider claims within 365 days of each other. • Narrow: Among intermediate cases, a narrow definition applied included, that cases have a chest X-ray or CT scan 30 days before or 30 days after a silicosis claim.	4,99,23,987	Broad: 19,696	65-84 years: 80;19	32.1 per 100,000
						Interm: 11,469	65-84 years: 81;19	19.1 per 100,000
						Narrow: 10,026	65-84 years: 67;19	16.6 per 100,000
						Avg. annual		2.4-4.6 cases per 100 000

Duration of exposure for ILD patients is not reported for papers reporting Silicosis incidence

*Table E21 List of Publications Reporting **Prevalence of Asbestosis**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Exposure duration	Prevalence
Lee 2015	South Korea	CS	Residents from 5 villages that are within 2km from mines	• Chest radiographs were evaluated by radiologists • Reports were classified by ILO classification of pneumoconioses	35	27	Age (yr) 40-49: 0 50-59: 11% 60-69: 37% 70-79: 48% > 80: 4%; 48	Duration of exposure (yr) 10-19:1 (4) 20-29:2 (7) 30-39: 3 (11) 40-49: 6 (22) 50-59: 8 (30) 60-69: 7 (26)	77.1%
Wickram -atillake 2019	Sri Lanka	CS	Participants from 9 provinces where asbestos factories, tsunami clean-up, construction industry were located	• Chest radiographs were independently • Reports were classified by ILO classification of pneumoconioses	250	16	NR	13 out of 16 people were exposed to asbestos at work for more than 10 years	7%

*Table E22 List of Publications Reporting **Incidence of Asbestosis**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean/Median age(years); Female (%)	Prevalence
Szeszenia-Dąbrowska 2015	Poland	Rtr	Based on data obtained from former asbestos company records and the Central Register of Occupational Diseases, this study included 18 large state-owned asbestos processing enterprises	• Chest radiography and detection of the changes in the X-ray chest image are crucial in diagnosing asbestosis. • The diagnosis of asbestosis relies on detecting the presence of X-ray changes as small irregular s-, t-, u-type opacities with density starting from 1/0. It is in accordance with the radiological classification of pneumoconiosis developed by ILO.	43,650	2,160	NR	49.8 per 100,0 workers (4.9%)
DeBono 2021	Canada	Longitudinal	Workers employed in over 900 industry and occupation groups as part of ongoing surveillance program	• Cases were defined as those who had any of the following: (1) two or more physician visits with a diagnosis of ICD-9 code 501 (asbestosis), (2) two or more visits to an ambulatory care center with a main diagnosis of ICD-10 code J61 (pneumoconiosis due to asbestos and other mineral fibers), or (3) one or more hospital discharges with a main diagnosis of ICD-10 code J61.	1.76 million	737	66;44	0.042%
Thomsen 2021	Denmark	Longitudinal	This study took advantage of the new nationwide DOC*X Project research database, which has been approved by the Danish Data Protection Agency, self-reported	• On 1 January 1980, we ascertained all hospital contacts up to and including the year 2015 for asbestosis (ICD- 8 code 515.2; ICD- 10 code J61) • Pathological confirmation remains the gold standard for diagnosis,19 35 but lung biopsy is not routinely recommended in Denmark	138,276 (Vehicle mechanics)	47 (Number at risk: 138,226 Person-years at risk: 2,751,423)	NR	0.03%

*Table E23 List of Publications Reporting **Prevalence of Pneumoconiosis**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Prevalence
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• A MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	42	3.5 per 100,000
Simsek 2021	Turkey	CS	Workers from 19 workplaces that were randomly selected that use hard metal tools in metal machining processes in organized industrial zone	• CXRs were evaluated by two readers separately and independently according to the ILO international classification of radiographs of pneumoconiosis,	139	54	38.8% of study population

*Table E24 List of Publications Reporting **Incidence of Pneumoconiosis**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Exposure duration	Incidence
Cui 2015	China	Rtr	Workers registered in the selected 4 colliery groups in North China	• Qualified experts who were all members of the Pneumoconiosis Diagnosis Committee independently read the chest radiographs of CWP patients and other investigated workers • If there was difference among the experts on the diagnosis, the diagnosis judgment principle was that the minority should be subordinate to the majority	NR	2,873	**Datong**: 19.8 (7.2) years	Avg: 4.06% Cum (1980-1970): 6.6-14.1%
							Kailuan:24.9 (7.1) years	Avg: 4.9% Cum (1980-1970): 2.9-8.5%
							Fuxin: 23.5 (5.1) years	Avg: 1.4% Cum (1980-1970): 1.6-77.3%
							Tiefa: 20.5 (6.2) years	Avg: 0.3% Cum (1980-1970):0.4-3.6%
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• A MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	9	NR	0.8 per 100,000 per year

*Table E25 List of Publications Reporting **Prevalence of Other Occupational / Exposure Related ILD***

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Exposure duration	Prevalence
Choi 2015	South Korea	Longitudinal	Indium-handling workers from seven factories	• PFTs and HRCTs to confirm ILD	50	12	36;16	mean exposure duration was 44 (range 2–144) months. ILD diagnosed mean exposure 9.6 (4-17)	24% of Indium exposed workers

*Table E26 List of Publications Reporting **Prevalence of Pulmonary Sarcoidosis**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Prevalence
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• A MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined whe14.n a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	361	30.2 per 100,000
Coquart 2015	Guadeloupe	Rtr	2 hospitals	• Cases were identified from medical records using search term 'sarcoidosis'	72	49	68.1%; 14.4 per 100,000 inhabitants (95% CI, 10.8 to 17.8)

*Table E27 List of Publications Reporting **Incidence of Pulmonary Sarcoidosis**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Incidence (100,000 persons per year)
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals Community Pulmonologists and General Practitioners	• A MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	58	4.9
Jeon 2020	South Korea	Rtr	NHI linked to RID	• ICD/KCD diagnosis	402,345,679.01	1,955	0.48

*Table E28 List of Publications Reporting **Prevalence of Radiation -Induced ILD**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Prevalence
Radiation-induced pneumonitis							
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	7	0.6 per 100,000

Mean age, sex and exposure duration for ILD patients is not reported for papers reporting radiation induced ILD prevalence

*Table E29 List of Publications Reporting **Incidence of Radiation -Induced ILD**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age; Female (%)	Exposure duration	Incidence
Radiation induced BOOP									
Murofushi 2015	Japan	Prosp	Breast cancer patients treated with RT at a Japanese cancer institute hospital	• Routinely collected chest x-rays • In addition, when patients developed consistent respiratory symptoms or fever, lasting longer than 2 or more weeks, CT was performed	1,175	16	52;100	Median: 4.9 months (range, 2.3 to 8.6 months)	1.4% of patients who underwent breast cancer RT
Sato 2018	Japan	Rtr	Newly diagnosed breast cancer patients who received WBRT at Fukushima Medical University Hospital	• Puchest X-ray and/or chest CT	665	9	52;100	Median: 4 months (range, 2–12 months)	1.4% of patients who underwent breast cancer RT
Radiation induced pneumonitis									
Duchemann 2017	France	CS	Sources of case identification from separate sources of patients were used: • Public and private hospitals • Community Pulmonologists and General Practitioners	• A MDD of clinicians, radiologist and pathologists discussed each case, after a systematic review of medical charts, HRCT, and SLB, when applicable. • ILD aetiology was determined when a diagnosis could be attributed in consensus according to the current guidelines, including 2011 ATS/ERS/JRS/ALAT diagnostic criteria for IPF. • ILD aetiology remained undetermined when a diagnosis could not be established based on available investigations after MDD. • For unreviewable cases, information on the aetiological diagnosis was taken from the completed questionnaires or the ICDs-10 codes.	1,194,601	1	NR	NR	0.1 per 100,000 persons-years

*Table E30 List of Publications Reporting **Prevalence of Progressive Fibrosing ILD**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Mean age (yrs.); Female (%)	Prevalence (per 100,000 persons)
Olson 2021**	USA	Rtr	IBM MarketScan claims database	• ICD codes	37,565,644	NR	NR	70.3 (69.3-71.3)
Nasser 2021	France	Rtr	French healthcare database	• PF-ILD case definition was based on three algorithms modified from Olson et al. 2020 using diagnosis codes	538,472	14,413	68;48	6.6 -19.4 (18.9 – 19.8)

**Adjusted for age and sex

*Table E31 List of Publications Reporting **Incidence of Progressive Fibrosing ILD**, Sorted by Publication Year*

Author, year	Country	Study design	Study population description	ILD assessment	Study population (N)	No. of ILD cases	Incidence (per 100,000 persons)
Olson 2021**	USA	Rtr	IBM MarketScan claims database	• ICD codes	37,565,644	NR	32.6 (32 – 33.1)
Nasser 2021	France	Rtr	French healthcare database	• PF-ILD case definition was based on three algorithms modified from Olson et al. 2020 using diagnosis codes	538,472	14,119	4.0 to 4.7

**Adjusted for age and sex

Figure E6 Quality Assessment for Studies Reporting Incidence

ILD condition	Study author	Risk of Bias Assesment	Acertainment of ILD
Asbestosis	Thomsen 2021		
Asbestosis	Szeszenia-Dąbrowska 2015		
Asbestosis	DeBono 2021		
Asbestosis	DeBono 2021		
CTD ILD	Olaosebikan 2021		
Cystic Lung disease	Duchemann 2017		
HP	Duchemann 2017		
HP	Perez 2018		
IIP	Lee 2016		
IIP	Duchemann 2017		
IPF	Gjonbrataj 2015		
IPF	Harari 2016		
IPF	Hopkins 2016		
IPF	Lee 2016		
IPF	Raghu 2016		
IPF	Belbasis 2021		
IPF	Strongman 2018		
IPF	Lim 2019		
IPF	Zhang 2021		
MTCD ILD	Reiseter 2018		
Pneumoconiosis	Cui 2015		
Pneumoconiosis	Duchemann 2017		
PF ILD	Olson 2021		
PF ILD	Nasser 2021		
Pulmonary Sarcoid	Duchemann 2017		
Pulmonary Sarcoid	Jeon 2020		
Pulmonary Sarcoid	Coquart 2015		
RA ILD	Zhang 2017		
RA ILD	Raimundo 2019		
RA ILD	Sparks 2021		
Radiation Induced	Duchemann 2017		
Radiation Induced	Murofushi 2015		
Radiation Induced	Sato 2018		
Silicosis	Casey 2019		
Sjogren's Syndrome ILD	Roca 2017		
SSc ILD	Wangkaew 2016		
SSc ILD	Carton 2021		
SSc ILD	Li 2021		
Unclassifiable ILD	Duchemann 2017		

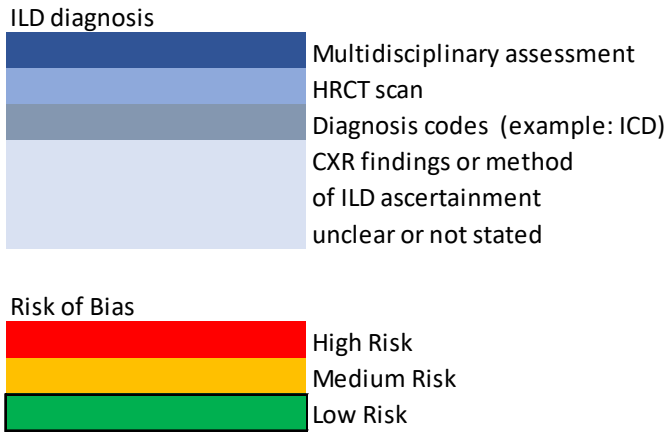

Figure E7 Quality Assessment for Studies Reporting Prevalence

ILD condition	Study author	Risk of Bias Assesment	Acertainment of ILD
Asbestosis	Wickramatillake2019		
Asbestosis	Lee 2015		
CTD ILD	Duchemann 2017		
CTD ILD	Olaosebikan 2021		
HP	Duchemann 2017		
HP	Perez 2018		
IIP	Lee 2016		
IIP	Duchemann 2017		
IPF	Harari 2016		
IPF	Hopkins 2016		
IPF	Kaunisto 2015		
IPF	Lee 2016		
IPF	Raghu 2016		
IPF	Raimundo 2016		
IPF	Strongman 2018		
IPF	Zhang 2021		
LAM	Duchemann 2017		
MCTD ILD	Reiseter 2018		
Myositis ILD	Ishizuka 2016		
Myositis ILD	Gomez 2021		
Myositis ILD	Huang 2021		
Other Exposure related ILD	Choi 2015		
PLCH	Duchemann 2017		
Pneumoconiosis	Simsek 2021		
Pneumoconiosis	Duchemann 2017		
Progressive fibrosing ILD	Nasser 2021		
Progressive fibrosing ILD	Olson 2021		
Pulmonary sarcoidosis	Duchemann 2017		
Pulmonary sarcoidosis	Coquart 2015		
RA ILD	McFarlane 2019		
RA ILD	Kim 2017		
RA ILD	Shin 2021		
RA ILD	Sakr 2018		
RA ILD	Ke 2021		
RA ILD	Kiely 2019		
RA ILD	Paulin 2021		
RA ILD	Raimundo 2019		
RA ILD	Duarte 2019		
RA ILD	Zhang 2017		
RA ILD	Samy 2021		
RA ILD	Kronzer 2021		
RA ILD	Sparks 2021		
RA ILD	Md Yosuf 2017		

ILD condition	Study author	Risk of Bias Assesment	Acertainment of ILD
Radiation induced ILD	Duchemann 2017		
Silicosis	Casey 2019		
Silicosis	Hoy 2021		
Silicosis	Knight 2015		
Silicosis	Poinen-Rughooputh 2021		
Silicosis	Requena-Mullor		
Silicosis	Silanum 2017		
Silicosis	Siribadda 2016		
Silicosis	Souza 2017		
Silicosis	Souza 2021		
Sjogrens ILD	Gao 2018		
Sjogrens ILD	Gao 2021		
Sjogrens ILD	Kam 2021		
Sjogrens ILD	Kampolis 2018		
Sjogrens ILD	Kvarnstorm 2015		
Sjogrens ILD	Manfredi 2017		
Sjogrens ILD	Nilsson 2021		
Sjogrens ILD	Omair 2021		
Sjogrens ILD	Roca 2017		
Sjogrens ILD	Wang 2018		
Sjogrens ILD	Zhao 2015		
SSc ILD	Janardana 2019		
SSc ILD	Sanchez-cano 2018		
SSc ILD	Morrisroe 2019		
SSc ILD	Noviani 2019		
SSc ILD	Bauer 2020		
SSc ILD	Fairley 2021		
SSc ILD	Jaafar 2021		
SSc ILD	Simeon-Aznar 2015		
SSc ILD	Tomiyama 2016		
SSc ILD	Wangkaew 2016		
SSc ILD	Li 2021		
SSc ILD	Pope 2021		
SSc ILD	Carton 2021		
Unclassifiable ILD	Duchemann 2017		