**Supplementary Material for:**

**Feasibility and efficacy of a multidisciplinary palliative approach in patients with progressive interstitial lung disease. A pilot randomized controlled trial.**

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**Online Supplement Materials**

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**Section E1**

Thirty-one patients (15 in the control group and 16 in the intervention one) refused the anti-fibrotic treatment (18 were not fully convinced about the effectiveness of the medication because of the lack of a clear effect on mortality, 5 because of elevated level of alanine aminotransferase, aspartate aminotransferase or bilirubin, 5 because of fear of side effects, and finally 3 after consulting their GPs or relatives). The remaining 19 patients were initially treated with pirfenidone or nintedanib for 6 months. During the first 16 months of the study, our local Health Care Agency was approving the use of one of these two treatments under a “pay for performance” model, that means the suspension of the drug in the case of a drop in FVC>10% in this period of time. No additional treatments such as corticosteroids, NAC or immunosuppressive drugs were administered due to the lack of scientific evidences in these patients.

**Section E2**

Patients with IPF are typically prone to exertional dyspnoea and fatigue while performing motor activities. As such, is not uncommon observing an increase in respiratory rate particularly in those subject at an advanced stage of the disease. Although the assessment of the respiratory rate was visual, during exercise sessions, breathing exercises were primarily directed at illustrating to patients possible strategies to cope with the increased rhythm of breath. To this end, a relaxed, controlled breathing was explained and proposed particularly to those subjects experiencing exertional dyspnoea. In a meta-analysis conducted to investigate the efficacy and safety of pulmonary rehabilitation in patients with idiopathic pulmonary fibrosis, it has been found that deep breathing exercises and inspiratory muscle training were used in some pulmonary rehabilitation programsE4. Nevertheless, we believe that high inspiratory and deep inspiration might trigger incoercible cough in such a specific populationE5. Exercise could be interrupted with dyspnoea and fatigue scoring >4 modified Borg scale (somewhat hard), or heart rate increase >15-20 beats per minute beyond the baseline, or if patients reported subjective feeling of discomfort. All patients were encouraged to exercise at home following the instructions provided by the physiotherapist, who was available Monday to Friday for remote consulting (telephone call). In addition, caregivers and family members were encouraged to attend the rehabilitative sessions in order to familiarize with the instructed exercises. Patients were also provided with written and detailed instructions that described all the exercises executed during the rehabilitation program.

**Section E3**

During the visits, lasting 3 to 5 hours, all patients met the pulmonologist experienced in ILDs, and at the end, for “final” questions, all the team. The doctor performed the clinical assessment and discussed any clinical questions the patients wanted to ask, both for patients in the intervention group and patients in the usual care group. The psychologist, besides the administration of the anxiety and depression questionnaire, invited the patients to express any psychological concern, problem or difficulties, and thereafter was offering her counseling how to deal with those problems. The specialized nurses were mainly involved in assessing the compliance to medical treatments, the right comprehension of the timing of administration, and eventually to solve some bureaucratic issues. The palliative care doctor was in charge to discuss the control of symptoms and eventually titrate or initiate the opioids and in most of the case the end-of-life issues. The pulmonologists were not unblended for obvious reasons. The main outcomes measures like dyspnea, depression and anxiety, QoL and rehabilitation tests were however measured and collected by nurses, psychologists or FTs not aware of the study design.

**Section E4**

* The Borg scale developed by Gunnar Borg is a tool for measuring an individual’s effort and exertion, breathlessness and fatigue during physical workE6. It ranges from 0 (“no exertion dyspnoea at all”) to 10 (“maximal dyspnoea”).
* Cough VAS is a brief and simple measure of cough severity. We used a simple VAS made of a straight horizontal line of 100 mm. The ends are defined as the extreme limits of the cough orientated from the left (worst) to the right (best). Patients marks on the line the point that they feel represents their perception of their current stateE7: the close the point is to the left, the worst the cough.
* Maugeri Respiratory Failure questionnaire reduced form is used to evaluate the quality-of-life (QoL) impairment due to chronic respiratory failure and contain items on problems that patients with chronic respiratory failure experience regarding daily activities, cognition and invalidityE8. Higher scores indicate worse QoL.
* The Center for Epidemiological Studies-Depression (CES-D) is a 20-item measure that asks patients to rate how often over the past week they experienced symptoms associated with depression, such as restless sleep, poor appetite, and feeling lonely. Response options range from 0 to 3 for each item (0 = Rarely or None of the Time, 1 = Some or Little of the Time, 2 = Moderately or Much of the time, 3 = Most or Almost All the Time)E9, with high total scores indicating greater depressive symptoms.

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