observed in the UK and Finland. Rates were also substantially higher in males with gender disparity increasing across the period.

**Interpretation**

Reported IPF mortality appears to be increasing across the EU, however there is substantial variation in mortality trends and overall reported mortality rates between countries. There are likely to be differences in coding practices and reporting levels between countries, particularly with specialist knowledge and equipment required to diagnose IPF.

**RESULTS**

In the UK, there was a significant decreasing trend in respiratory-related mortality between 1985 and 1991 with an estimated annual percentage change (EAPC) of -0.89 and -1.70, for men and women respectively. Between 1994 and 2013, there was a steady decline in ASDR with EAPC -2.06 and -0.85, for men and women, respectively. For EU15+ men, there was a decreasing trend in ASDR between until 1999 with EAPC -0.81 and from 1999 onwards the EAPC was -2.14. For EU15+ women, there was an increasing trend in ASDR until 2002 with EAPC of +1.48 which was followed by overall decreasing trend with EAPC -0.44 until 2013. After multivariable adjustment for pollution exposure and smoking prevalence in each country there was a persistent significant difference in ASDR with approximately 20% higher mortality in UK compared to EU15+ (p=0.009).

**Conclusion**

There was significantly greater mortality from respiratory-related illnesses in UK compared to EU15+ over the period from 1985 to 2013 after controlling for smoking and pollution exposure. System-level and population-level factors may contribute to this difference and additional investigations are necessary to further explain these differences.

**REFERENCE**