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KDIGO Clinical Practice Guideline for Glomerulonephritis

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KDIGO Clinical Practice Guideline for Glomerulonephritis



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Additional information in the form of supplementary materials can be found online at http://www.kdigo.org/clinical_practice_guidelines/GN.php

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NOMENCLATURE AND DESCRIPTION FOR RATING GUIDELINE RECOMMENDATIONS

Within each recommendation, the strength of recommendation is indicated as **Level 1**, **Level 2**, or **Not Graded**, and the quality of the supporting evidence is shown as **A**, **B**, **C**, or **D**.

Grade*	Implications		
	Patients	Clinicians	Policy
Level 1 "We recommend"	Most people in your situation would want the recommended course of action and only a small proportion would not.	Most patients should receive the recommended course of action.	The recommendation can be evaluated as a candidate for developing a policy or a performance measure.
Level 2 "We suggest"	The majority of people in your situation would want the recommended course of action, but many would not.	Different choices will be appropriate for different patients. Each patient needs help to arrive at a management decision consistent with her or his values and preferences.	The recommendation is likely to require substantial debate and involvement of stakeholders before policy can be determined.

*The additional category "Not Graded" was used, typically, to provide guidance based on common sense or where the topic does not allow adequate application of evidence. The most common examples include recommendations regarding monitoring intervals, counseling, and referral to other clinical specialists. The ungraded recommendations are generally written as simple declarative statements, but are not meant to be interpreted as being stronger recommendations than Level 1 or 2 recommendations.

Grade	Quality of evidence	Meaning
A	High	We are confident that the true effect lies close to that of the estimate of the effect.
B	Moderate	The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
C	Low	The true effect may be substantially different from the estimate of the effect.
D	Very Low	The estimate of effect is very uncertain, and often will be far from the truth.

CONVERSION FACTORS OF METRIC UNITS TO SI UNITS

Parameter	Metric units	Conversion factor	SI units
Albumin (serum)	g/dl	10	g/l
Creatinine (serum)	mg/dl	88.4	μmol/l
Creatinine clearance	ml/min	0.01667	ml/s
Cyclosporine (serum)	ng/ml	0.832	nmol/l
uPCR	mg/g	0.1	mg/mmol

Note: Metric unit × conversion factor = SI unit.

Abbreviations and Acronyms

ACE-I	Angiotensin-converting enzyme inhibitor(s)	IMN	Idiopathic membranous nephropathy
ACTH	Adrenocorticotrophic hormone	INR	International normalized ratio
AKI	Acute kidney injury	ISKDC	International Study of Kidney Disease in Children
ALMS	Aspreva Lupus Management Study	IU	International units
ANCA	Antineutrophil cytoplasmic antibody	KDIGO	Kidney Disease: Improving Global Outcomes
APOL1	Apolipoprotein L1	LN	Lupus nephritis
APS	Antiphospholipid antibody syndrome	MCD	Minimal-change disease
ARB	Angiotensin-receptor blocker	MDRD	Modification of Diet in Renal Disease
ATN	Acute tubular necrosis	MEPEX	Methylprednisolone or Plasma Exchange
BMI	Body mass index	MMF	Mycophenolate mofetil
CI	Confidence interval	MN	Membranous nephropathy
CKD	Chronic kidney disease	MPGN	Membranoproliferative glomerulonephritis
CNI	Calcineurin inhibitor	MPO	Myeloperoxidase
CrCl	Creatinine clearance	NCGN	Necrotizing and crescentic glomerulonephritis
eGFR	Estimated glomerular filtration rate	NS	Not significant
ERT	Evidence Review Team	OR	Odds ratio
ESRD	End-stage renal disease	PCR	Protein-creatinine ratio
FR	Frequently relapsing	p.o.	Oral(ly)
FRNS	Frequently relapsing nephrotic syndrome	PR3	Proteinase 3
FSGS	Focal segmental glomerulosclerosis	RAS	Renin-angiotensin system
GBM	Glomerular basement membrane	RAVE	Rituximab for the Treatment of Wegener's Granulomatosis and Microscopic Polyangiitis
GFR	Glomerular filtration rate	RCT	Randomized controlled trial
GN	Glomerulonephritis	RR	Relative risk
GRADE	Grading of Recommendations Assessment, Development and Evaluation	RRT	Renal replacement therapy
HAART	Highly active antiretroviral therapy	SCr	Serum creatinine
HBV	Hepatitis B virus	SD	Steroid-dependent
HCV	Hepatitis C virus	SLE	Systemic lupus erythematosus
HIVAN	Human immunodeficiency virus-associated nephropathy	SRNS	Steroid-resistant nephrotic syndrome
HR	Hazards ratio	SSNS	Steroid-sensitive nephrotic syndrome
HSP	Henoch-Schönlein purpura	TMA	Thrombotic microangiopathies
HSV	Herpes simplex virus	TTP	Thrombotic thrombocytopenic purpura
i.v.	Intravenous	uPCR	Urine protein:creatinine ratio
IgAN	Immunoglobulin A nephropathy		

Notice

Kidney International Supplements (2012) **2**, 139; doi:10.1038/kisup.2012.9

SECTION I: USE OF THE CLINICAL PRACTICE GUIDELINE

This Clinical Practice Guideline document is based upon systematic literature searches last conducted in January 2011, supplemented with additional evidence through November 2011. It is designed to provide information and assist decision-making. It is not intended to define a standard of care, and should not be construed as one, nor should it be interpreted as prescribing an exclusive course of management. Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every health-care professional making use of these recommendations is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation. The recommendations for research contained within this document are general and do not imply a specific protocol.

SECTION II: DISCLOSURE

Kidney Disease: Improving Global Outcomes (KDIGO) makes every effort to avoid any actual or reasonably perceived conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the Work Group. All members of the Work Group are required to complete, sign, and submit a disclosure and attestation form showing all such relationships that might be perceived or actual conflicts of interest. This document is updated annually and information is adjusted accordingly. All reported information will be printed in the final publication and are on file at the National Kidney Foundation (NKF), Managing Agent for KDIGO.

KDIGO gratefully acknowledges the following consortium of sponsors that make our initiatives possible: Abbott, Amgen, Belo Foundation, Coca-Cola Company, Dole Food Company, Genzyme, Hoffmann-LaRoche, JC Penney, NATCO—The Organization for Transplant Professionals, NKF-Board of Directors, Novartis, Robert and Jane Cizik Foundation, Roche, Shire, Transwestern Commercial Services, and Wyeth. KDIGO is supported by a consortium of sponsors and no funding is accepted for the development of specific guidelines.

Foreword

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It is our hope that this document will serve several useful purposes. Our primary goal is to improve patient care. We hope to accomplish this, in the short term, by helping clinicians know and better understand the evidence (or lack of evidence) that determines current practice. By providing comprehensive evidence-based recommendations, this guideline will also help define areas where evidence is lacking and research is needed. Helping to define a research agenda is an often neglected, but very important, function of clinical practice guideline development.

We used the GRADE system to rate the strength of evidence and the strength of recommendations. In all, there were only 4 (2%) recommendations in this guideline for which the overall quality of evidence was graded 'A', whereas 34 (20%) were graded 'B', 66 (40%) were graded 'C', and 63 (38%) were graded 'D'. Although there are reasons other than quality of evidence to make a grade 1 or 2 recommendation, in general, there is a correlation between the quality of overall evidence and the strength of the recommendation. Thus, there were 46 (28%) recommendations graded '1' and 121 (72%) graded '2'. There were 4 (2%) recommendations graded '1A', 24 (14%) were '1B', 15 (9%) were '1C', and 3 (2%) were '1D'. There were 0 (0%) graded '2A', 10 (6%) were '2B', 51 (31%) were '2C', and 60 (36%) were '2D'. There were 28 (14%) statements that were not graded.

Some argue that recommendations should not be made when evidence is weak. However, clinicians still need to make clinical decisions in their daily practice, and they often ask, "What do the experts do in this setting?" We opted to give guidance, rather than remain silent. These recommendations are often rated with a low strength of recommendation and a low strength of evidence, or were not graded. It is important for the users of this guideline to be cognizant of this (see Notice). In every case these recommendations are meant to be a place for clinicians to start, not stop, their inquiries into specific management questions pertinent to the patients they see in daily practice.

We wish to thank the Work Group Co-Chairs, Drs. Dan Cattran and John Feehally, along with all of the Work Group members who volunteered countless hours of their time developing this guideline. We also thank the Evidence Review Team members and staff of the National Kidney Foundation who made this project possible. Finally, we owe a special debt of gratitude to the many KDIGO Board members and individuals who volunteered time reviewing the guideline, and making very helpful suggestions.

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Abstract

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The 2011 Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline for Glomerulonephritis (GN) aims to assist practitioners caring for adults and children with GN. Guideline development followed an explicit process of evidence review and appraisal. The guideline contains chapters on various glomerular diseases: steroid-sensitive nephrotic syndrome in children; steroid-resistant nephrotic syndrome in children; minimal-change disease; idiopathic focal segmental glomerulosclerosis; idiopathic membranous nephropathy; membranoproliferative glomerulonephritis; infection-related glomerulonephritis; IgA nephropathy; Henoch-Schönlein purpura nephritis; lupus nephritis; pauci-immune focal and segmental necrotizing glomerulonephritis; and anti-glomerular basement membrane antibody glomerulonephritis. Treatment approaches are addressed in each chapter and guideline recommendations are based on systematic reviews of relevant trials. Appraisal of the quality of the evidence and the strength of recommendations followed the GRADE approach. Limitations of the evidence are discussed and specific suggestions are provided for future research.

Keywords: Clinical Practice Guideline; KDIGO; glomerulonephritis; nephrotic syndrome; evidence-based recommendation; systematic review

CITATION

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Summary of Recommendation Statements

Kidney International Supplements (2012) **2**, 143–153; doi:10.1038/kisup.2012.13

Chapter 3: Steroid-sensitive nephrotic syndrome in children

3.1: Treatment of the initial episode of SSNS

- 3.1.1: We recommend that corticosteroid therapy (prednisone or prednisolone)* be given for at least 12 weeks. (1B)
 - 3.1.1.1: We recommend that oral prednisone be administered as a single daily dose (1B) starting at 60 mg/m²/d or 2 mg/kg/d to a maximum 60 mg/d. (1D)
 - 3.1.1.2: We recommend that daily oral prednisone be given for 4–6 weeks (1C) followed by alternate-day medication as a single daily dose starting at 40 mg/m² or 1.5 mg/kg (maximum 40 mg on alternate days) (1D) and continued for 2–5 months with tapering of the dose. (1B)

3.2: Treatment of relapsing SSNS with corticosteroids

- 3.2.1: Corticosteroid therapy for children with infrequent relapses of SSNS:
 - 3.2.1.1: We suggest that infrequent relapses of SSNS in children be treated with a single-daily dose of prednisone 60 mg/m² or 2 mg/kg (maximum of 60 mg/d) until the child has been in complete remission for at least 3 days. (2D)
 - 3.2.1.2: We suggest that, after achieving complete remission, children be given prednisone as a single dose on alternate days (40 mg/m² per dose or 1.5 mg/kg per dose; maximum 40 mg on alternate days) for at least 4 weeks. (2C)
- 3.2.2: Corticosteroid therapy for frequently relapsing (FR) and steroid-dependent (SD) SSNS:
 - 3.2.2.1: We suggest that relapses in children with FR or SD SSNS be treated with daily prednisone until the child has been in remission for at least 3 days, followed by alternate-day prednisone for at least 3 months. (2C)
 - 3.2.2.2: We suggest that prednisone be given on alternate days in the lowest dose to maintain remission without major adverse effects in children with FR and SD SSNS. (2D)
 - 3.2.2.3: We suggest that daily prednisone at the lowest dose be given to maintain remission without major adverse effects in children with SD SSNS where alternate-day prednisone therapy is not effective. (2D)
 - 3.2.2.4: We suggest that daily prednisone be given during episodes of upper respiratory tract and other infections to reduce the risk for relapse in children with FR and SD SSNS already on alternate-day prednisone. (2C)

*Prednisone and prednisolone are equivalent, used in the same dosage, and have both been used in RCTs depending on the country of origin. All later references to prednisone in this chapter refer to prednisone or prednisolone. All later references to oral corticosteroids refer to prednisone or prednisolone.

3.3: Treatment of FR and SD SSNS with corticosteroid-sparing agents

- 3.3.1: We recommend that corticosteroid-sparing agents be prescribed for children with FR SSNS and SD SSNS, who develop steroid-related adverse effects. (1B)
- 3.3.2: We recommend that alkylating agents, cyclophosphamide or chlorambucil, be given as corticosteroid-sparing agents for FR SSNS. (1B) We suggest that alkylating agents, cyclophosphamide or chlorambucil, be given as corticosteroid-sparing agents for SD SSNS. (2C)
 - 3.3.2.1: We suggest that cyclophosphamide (2 mg/kg/d) be given for 8–12 weeks (maximum cumulative dose 168 mg/kg). (2C)
 - 3.3.2.2: We suggest that cyclophosphamide not be started until the child has achieved remission with corticosteroids. (2D)
 - 3.3.2.3: We suggest that chlorambucil (0.1–0.2 mg/kg/d) may be given for 8 weeks (maximum cumulative dose 11.2 mg/kg) as an alternative to cyclophosphamide. (2C)
 - 3.3.2.4: We suggest that second courses of alkylating agents not be given. (2D)

- 3.3.3: We recommend that levamisole be given as a corticosteroid-sparing agent. (1B)
- 3.3.3.1: We suggest that levamisole be given at a dose of 2.5 mg/kg on alternate days (2B) for at least 12 months (2C) as most children will relapse when levamisole is stopped.
- 3.3.4: We recommend that the calcineurin inhibitors cyclosporine or tacrolimus be given as corticosteroid-sparing agents. (1C)
- 3.3.4.1: We suggest that cyclosporine be administered at a dose of 4–5 mg/kg/d (starting dose) in two divided doses. (2C)
- 3.3.4.2: We suggest that tacrolimus 0.1 mg/kg/d (starting dose) given in two divided doses be used instead of cyclosporine when the cosmetic side-effects of cyclosporine are unacceptable. (2D)
- 3.3.4.3: Monitor CNI levels during therapy to limit toxicity. (Not Graded)
- 3.3.4.4: We suggest that CNIs be given for at least 12 months, as most children will relapse when CNIs are stopped. (2C)
- 3.3.5: We suggest that MMF be given as a corticosteroid-sparing agent. (2C)
- 3.3.5.1: We suggest that MMF (starting dose 1200 mg/m²/d) be given in two divided doses for at least 12 months, as most children will relapse when MMF is stopped. (2C)
- 3.3.6: We suggest that rituximab be considered only in children with SD SSNS who have continuing frequent relapses despite optimal combinations of prednisone and corticosteroid-sparing agents, and/or who have serious adverse effects of therapy. (2C)
- 3.3.7: We suggest that mizoribine not be used as a corticosteroid-sparing agent in FR and SD SSNS. (2C)
- 3.3.8: We recommend that azathioprine not be used as a corticosteroid-sparing agent in FR and SD SSNS. (1B)
- 3.4: *Indication for kidney biopsy*
- 3.4.1: Indications for kidney biopsy in children with SSNS are (Not Graded):
- late failure to respond following initial response to corticosteroids;
 - a high index of suspicion for a different underlying pathology;
 - decreasing kidney function in children receiving CNIs.
- 3.5: *Immunizations in children with SSNS*
- 3.5.1: To reduce the risk of serious infections in children with SSNS (Not Graded):
- Give pneumococcal vaccination to the children.
 - Give influenza vaccination annually to the children and their household contacts.
 - Defer vaccination with live vaccines until prednisone dose is below either 1 mg/kg daily (<20 mg/d) or 2 mg/kg on alternate days (<40 mg on alternate days).
 - Live vaccines are contraindicated in children receiving corticosteroid-sparing immunosuppressive agents.
 - Immunize healthy household contacts with live vaccines to minimize the risk of transfer of infection to the immunosuppressed child but avoid direct exposure of the child to gastrointestinal, urinary, or respiratory secretions of vaccinated contacts for 3–6 weeks after vaccination.
 - Following close contact with Varicella infection, give nonimmune children on immunosuppressive agents varicella zoster immune globulin, if available.

Chapter 4: Steroid-resistant nephrotic syndrome in children

4.1: *Evaluation of children with SRNS*

- 4.1.1: We suggest a minimum of 8 weeks treatment with corticosteroids to define steroid resistance. (2D)
- 4.1.2: The following are required to evaluate the child with SRNS (Not Graded):
- a diagnostic kidney biopsy;
 - evaluation of kidney function by GFR or eGFR;
 - quantitation of urine protein excretion.

4.2: Treatment recommendations for SRNS

- 4.2.1: We recommend using a calcineurin inhibitor (CNI) as initial therapy for children with SRNS. (1B)
- 4.2.1.1: We suggest that CNI therapy be continued for a minimum of 6 months and then stopped if a partial or complete remission of proteinuria is not achieved. (2C)
- 4.2.1.2: We suggest CNIs be continued for a minimum of 12 months when at least a partial remission is achieved by 6 months. (2C)
- 4.2.1.3: We suggest that low-dose corticosteroid therapy be combined with CNI therapy. (2D)
- 4.2.2: We recommend treatment with ACE-I or ARBs for children with SRNS. (1B)
- 4.2.3: In children who fail to achieve remission with CNI therapy:
- 4.2.3.1: We suggest that mycophenolate mofetil (2D), high-dose corticosteroids (2D), or a combination of these agents (2D) be considered in children who fail to achieve complete or partial remission with CNIs and corticosteroids.
- 4.2.3.2: We suggest that cyclophosphamide not be given to children with SRNS. (2B)
- 4.2.4: In patients with a relapse of nephrotic syndrome after complete remission, we suggest that therapy be restarted using any one of the following options: (2C)
- oral corticosteroids (2D);
 - return to previous successful immunosuppressive agent (2D);
 - an alternative immunosuppressive agent to minimize potential cumulative toxicity (2D).

Chapter 5: Minimal-change disease in adults

5.1: Treatment of initial episode of adult MCD

- 5.1.1: We recommend that corticosteroids be given for initial treatment of nephrotic syndrome. (1C)
- 5.1.2: We suggest prednisone or prednisolone* be given at a daily single dose of 1 mg/kg (maximum 80 mg) or alternate-day single dose of 2 mg/kg (maximum 120 mg). (2C)
- 5.1.3: We suggest the initial high dose of corticosteroids, if tolerated, be maintained for a minimum period of 4 weeks if complete remission is achieved, and for a maximum period of 16 weeks if complete remission is not achieved. (2C)
- 5.1.4: In patients who remit, we suggest that corticosteroids be tapered slowly over a total period of up to 6 months after achieving remission. (2D)
- 5.1.5: For patients with relative contraindications or intolerance to high-dose corticosteroids (e.g., uncontrolled diabetes, psychiatric conditions, severe osteoporosis), we suggest oral cyclophosphamide or CNIs as discussed in frequently relapsing MCD. (2D)
- 5.1.6: We suggest using the same initial dose and duration of corticosteroids for infrequent relapses as in Recommendations 5.1.2, 5.1.3, and 5.1.4. (2D)

*Prednisone and prednisolone are equivalent, used in the same dosage, and have both been used in RCTs depending on the country of origin. All later references to prednisone in this chapter refer to prednisone or prednisolone. All later references to oral corticosteroids refer to prednisone or prednisolone.

5.2: FR/SD MCD

- 5.2.1: We suggest oral cyclophosphamide 2–2.5 mg/kg/d for 8 weeks. (2C)
- 5.2.2: We suggest CNI (cyclosporine 3–5 mg/kg/d or tacrolimus 0.05–0.1 mg/kg/d in divided doses) for 1–2 years for FR/SD MCD patients who have relapsed despite cyclophosphamide, or for people who wish to preserve their fertility. (2C)
- 5.2.3: We suggest MMF 500–1000 mg twice daily for 1–2 years for patients who are intolerant of corticosteroids, cyclophosphamide, and CNIs. (2D)

5.3: Corticosteroid-resistant MCD

- 5.3.1: Re-evaluate patients who are corticosteroid-resistant for other causes of nephrotic syndrome. (Not Graded)

5.4: Supportive therapy

- 5.4.1: We suggest that MCD patients who have AKI be treated with renal replacement therapy as indicated, but together with corticosteroids, as for a first episode of MCD. (2D)
- 5.4.2: We suggest that, for the initial episode of nephrotic syndrome associated with MCD, statins not be used to treat hyperlipidemia, and ACE-I or ARBs not be used in normotensive patients to lower proteinuria. (2D)

Chapter 6: Idiopathic focal segmental glomerulosclerosis in adults

6.1: Initial evaluation of FSGS

- 6.1.1: Undertake thorough evaluation to exclude secondary forms of FSGS. (*Not Graded*)
- 6.1.2: Do not routinely perform genetic testing. (*Not Graded*)

6.2: Initial treatment of FSGS

- 6.2.1: We recommend that corticosteroid and immunosuppressive therapy be considered only in idiopathic FSGS associated with clinical features of the nephrotic syndrome. (*1C*)
- 6.2.2: We suggest prednisone* be given at a daily single dose of 1 mg/kg (maximum 80 mg) or alternate-day dose of 2 mg/kg (maximum 120 mg). (*2C*)
- 6.2.3: We suggest the initial high dose of corticosteroids be given for a minimum of 4 weeks; continue high-dose corticosteroids up to a maximum of 16 weeks, as tolerated, or until complete remission has been achieved, whichever is earlier. (*2D*)
- 6.2.4: We suggest corticosteroids be tapered slowly over a period of 6 months after achieving complete remission. (*2D*)
- 6.2.5: We suggest CNIs be considered as first-line therapy for patients with relative contraindications or intolerance to high-dose corticosteroids (e.g., uncontrolled diabetes, psychiatric conditions, severe osteoporosis). (*2D*)

*Prednisone and prednisolone are equivalent, used in the same dosage, and have both been used in RCTs depending on the country of origin. All later references to prednisone in this chapter refer to prednisone or prednisolone. All later references to oral corticosteroids refer to prednisone or prednisolone.

6.3: Treatment for relapse

- 6.3.1: We suggest that a relapse of nephrotic syndrome is treated as per the recommendations for relapsing MCD in adults (see Chapters 5.1 and 5.2). (*2D*)

6.4: Treatment for steroid-resistant FSGS

- 6.4.1: For steroid-resistant FSGS, we suggest that cyclosporine at 3–5 mg/kg/d in divided doses be given for at least 4–6 months. (*2B*)
- 6.4.2: If there is a partial or complete remission, we suggest continuing cyclosporine treatment for at least 12 months, followed by a slow taper. (*2D*)
- 6.4.3: We suggest that patients with steroid-resistant FSGS, who do not tolerate cyclosporine, be treated with a combination of mycophenolate mofetil and high-dose dexamethasone. (*2C*)

Chapter 7: Idiopathic membranous nephropathy

7.1: Evaluation of MN

- 7.1.1: Perform appropriate investigations to exclude secondary causes in all cases of biopsy-proven MN. (*Not Graded*)

7.2: Selection of adult patients with IMN to be considered for treatment with immunosuppressive agents (see 7.8 for recommendations for children with IMN).

- 7.2.1: We recommend that initial therapy be started only in patients with nephrotic syndrome *AND* when at least one of the following conditions is met:
 - Urinary protein excretion persistently exceeds 4 g/d *AND* remains at over 50% of the baseline value, *AND* does not show progressive decline, during antihypertensive and antiproteinuric therapy (see Chapter 1) during an observation period of at least 6 months; (*1B*)
 - the presence of severe, disabling, or life-threatening symptoms related to the nephrotic syndrome; (*1C*)
 - SCr has risen by 30% or more within 6 to 12 months from the time of diagnosis but the eGFR is not less than 25–30 ml/min/1.73 m² *AND* this change is not explained by superimposed complications. (*2C*)

7.2.2: Do not use immunosuppressive therapy in patients with a SCr persistently >3.5 mg/dl (>309 μ mol/l) (or an eGFR <30 ml/min per 1.73 m²) AND reduction of kidney size on ultrasound (e.g., <8 cm in length) OR those with concomitant severe or potentially life-threatening infections. (Not Graded)

7.3: Initial therapy of IMN

- 7.3.1: We recommend that initial therapy consist of a 6-month course of alternating monthly cycles of oral and i.v. corticosteroids, and oral alkylating agents (see Table 15). (1B)
- 7.3.2: We suggest using cyclophosphamide rather than chlorambucil for initial therapy. (2B)
- 7.3.3: We recommend patients be managed conservatively for at least 6 months following the completion of this regimen before being considered a treatment failure if there is no remission, unless kidney function is deteriorating or severe, disabling, or potentially life-threatening symptoms related to the nephrotic syndrome are present (see also Recommendation 7.2.1). (1C)
- 7.3.4: Perform a repeat kidney biopsy only if the patient has rapidly deteriorating kidney function (doubling of SCr over 1–2 month of observation), in the absence of massive proteinuria (>15 g/d). (Not Graded)
- 7.3.5: Adjust the dose of cyclophosphamide or chlorambucil according to the age of the patient and eGFR. (Not Graded)
- 7.3.6: We suggest that continuous daily (nonscyclical) use of oral alkylating agents may also be effective, but can be associated with greater risk of toxicity, particularly when administered for >6 months. (2C)

7.4: Alternative regimens for the initial therapy of IMN: CNI therapy

- 7.4.1: We recommend that cyclosporine or tacrolimus be used for a period of at least 6 months in patients who meet the criteria for initial therapy (as described in Recommendation 7.2.1), but who choose not to receive the cyclical corticosteroid/alkylating-agent regimen or who have contraindications to this regimen. (See Table 18 for specific recommendations for dosage during therapy.) (1C)
- 7.4.2: We suggest that CNIs be discontinued in patients who do not achieve complete or partial remission after 6 months of treatment. (2C)
- 7.4.3: We suggest that the dosage of CNI be reduced at intervals of 4–8 weeks to a level of about 50% of the starting dosage, provided that remission is maintained and no treatment-limiting CNI-related nephrotoxicity occurs, and continued for at least 12 months. (2C)
- 7.4.4: We suggest that CNI blood levels be monitored regularly during the initial treatment period, and whenever there is an unexplained rise in SCr ($>20\%$) during therapy. (Not Graded) (See Table 18 for specific CNI-based regimen dosage recommendations.)

7.5: Regimens not recommended or suggested for initial therapy of IMN

- 7.5.1: We recommend that corticosteroid monotherapy not be used for initial therapy of IMN. (1B)
- 7.5.2: We suggest that monotherapy with MMF not be used for initial therapy of IMN. (2C)

7.6: Treatment of IMN resistant to recommended initial therapy

- 7.6.1: We suggest that patients with IMN resistant to alkylating agent/steroid-based initial therapy be treated with a CNI. (2C)
- 7.6.2: We suggest that patients with IMN resistant to CNI-based initial therapy be treated with an alkylating agent/steroid-based therapy. (2C)

7.7: Treatment for relapses of nephrotic syndrome in adults with IMN

- 7.7.1: We suggest that relapses of nephrotic syndrome in IMN be treated by reinstatement of the same therapy that resulted in the initial remission. (2D)
- 7.7.2: We suggest that, if a 6-month cyclical corticosteroid/alkylating-agent regimen was used for initial therapy (see Recommendation 7.3.1), the regimen be repeated only once for treatment of a relapse. (2B)

7.8: Treatment of IMN in children

- 7.8.1: We suggest that treatment of IMN in children follows the recommendations for treatment of IMN in adults. (2C) (See Recommendations 7.2.1 and 7.3.1.)
- 7.8.2: We suggest that no more than one course of the cyclical corticosteroid/alkylating-agent regimen be given in children. (2D)

7.9: Prophylactic anticoagulants in IMN

- 7.9.1: We suggest that patients with IMN and nephrotic syndrome, with marked reduction in serum albumin (<2.5 g/dl [<25 g/l]) and additional risks for thrombosis, be considered for prophylactic anticoagulant therapy, using oral warfarin. (2C)

Chapter 8: Idiopathic membranoproliferative glomerulonephritis

8.1: Evaluation of MPGN

- 8.1.1: Evaluate patients with the histological (light-microscopic) pattern of MPGN for underlying diseases before considering a specific treatment regimen (see Table 20). (Not Graded)

8.2: Treatment of idiopathic MPGN

- 8.2.1: We suggest that adults or children with presumed idiopathic MPGN accompanied by nephrotic syndrome AND progressive decline of kidney function receive oral cyclophosphamide or MMF plus low-dose alternate-day or daily corticosteroids with initial therapy limited to less than 6 months. (2D)

Chapter 9: Infection-related glomerulonephritis

- 9.1: For the following infection-related GN, we suggest appropriate treatment of the infectious disease and standard approaches to management of the kidney manifestations: (2D)

- poststreptococcal GN;
- infective endocarditis-related GN;
- shunt nephritis.

9.2: Hepatitis C virus (HCV) infection-related GN

(Please also refer to the published KDIGO Clinical Practice Guidelines for the Prevention, Diagnosis, Evaluation, and Treatment of Hepatitis C in Chronic Kidney Disease.)

- 9.2.1: For HCV-infected patients with CKD Stages 1 or 2 and GN, we suggest combined antiviral treatment using pegylated interferon and ribavirin as in the general population. (2C) [based on KDIGO HCV Recommendation 2.2.1]

9.2.1.1: Titrate ribavirin dose according to patient tolerance and level of renal function. (Not Graded)

- 9.2.2: For HCV-infected patients with CKD Stages 3, 4, or 5 and GN not yet on dialysis, we suggest monotherapy with pegylated interferon, with doses adjusted to the level of kidney function. (2D) [based on KDIGO HCV Recommendation 2.2.2]

- 9.2.3: For patients with HCV and mixed cryoglobulinemia (IgG/IgM) with nephrotic proteinuria or evidence of progressive kidney disease or an acute flare of cryoglobulinemia, we suggest either plasmapheresis, rituximab, or cyclophosphamide, in conjunction with i.v. methylprednisolone, and concomitant antiviral therapy. (2D)

9.3: Hepatitis B virus (HBV) infection-related GN

- 9.3.1: We recommend that patients with HBV infection and GN receive treatment with interferon- α or with nucleoside analogues as recommended for the general population by standard clinical practice guidelines for HBV infection (see Table 23). (1C)

- 9.3.2: We recommend that the dosing of these antiviral agents be adjusted to the degree of kidney function. (1C)

9.4: Human Immunodeficiency virus (HIV) infection-related glomerular disorders

- 9.4.1: We recommend that antiretroviral therapy be initiated in all patients with biopsy-proven HIV-associated nephropathy, regardless of CD4 count. (1B)

9.5: Schistosomal, filarial, and malarial nephropathies

- 9.5.1: We suggest that patients with GN and concomitant malarial, schistosomal, or filarial infection be treated with an appropriate antiparasitic agent in sufficient dosage and duration to eradicate the organism. (*Not Graded*)
- 9.5.2: We suggest that corticosteroids or immunosuppressive agents not be used for treatment of schistosomal-associated GN, since the GN is believed to be the direct result of infection and the attendant immune response to the organism. (*2D*)
- 9.5.3: We suggest that blood culture for *Salmonella* be considered in all patients with hepatosplenic schistosomiasis who show urinary abnormalities and/or reduced GFR. (*2C*)
 - 9.5.3.1: We suggest that all patients who show a positive blood culture for *Salmonella* receive anti-*Salmonella* therapy. (*2C*)

Chapter 10: Immunoglobulin A nephropathy

10.1: Initial evaluation including assessment of risk of progressive kidney disease

- 10.1.1: Assess all patients with biopsy-proven IgAN for secondary causes of IgAN. (*Not Graded*)
- 10.1.2: Assess the risk of progression in all cases by evaluation of proteinuria, blood pressure, and eGFR at the time of diagnosis and during follow-up. (*Not Graded*)
- 10.1.3: Pathological features may be used to assess prognosis. (*Not Graded*)

10.2: Antiproteinuric and antihypertensive therapy

- 10.2.1: We recommend long-term ACE-I or ARB treatment when proteinuria is > 1 g/d, with up-titration of the drug depending on blood pressure. (*1B*)
- 10.2.2: We suggest ACE-I or ARB treatment if proteinuria is between 0.5 to 1 g/d (in children, between 0.5 to 1 g/d per 1.73 m^2). (*2D*)
- 10.2.3: We suggest the ACE-I or ARB be titrated upwards as far as tolerated to achieve proteinuria < 1 g/d. (*2C*)
- 10.2.4: In IgAN, use blood pressure treatment goals of $< 130/80$ mmHg in patients with proteinuria < 1 g/d, and $< 125/75$ mmHg when initial proteinuria is > 1 g/d (see Chapter 2). (*Not Graded*)

10.3: Corticosteroids

- 10.3.1: We suggest that patients with persistent proteinuria ≥ 1 g/d, despite 3–6 months of optimized supportive care (including ACE-I or ARBs and blood pressure control), and GFR > 50 ml/min per 1.73 m^2 , receive a 6-month course of corticosteroid therapy. (*2C*)

10.4: Immunosuppressive agents (cyclophosphamide, azathioprine, MMF, cyclosporine)

- 10.4.1: We suggest not treating with corticosteroids combined with cyclophosphamide or azathioprine in IgAN patients (unless there is crescentic IgAN with rapidly deteriorating kidney function; see Recommendation 10.6.3). (*2D*)
- 10.4.2: We suggest not using immunosuppressive therapy in patients with GFR < 30 ml/min per 1.73 m^2 unless there is crescentic IgAN with rapidly deteriorating kidney function (see Section 10.6). (*2C*)
- 10.4.3: We suggest not using MMF in IgAN. (*2C*)

10.5: Other treatments

- 10.5.1: Fish oil treatment
 - 10.5.1.1: We suggest using fish oil in the treatment of IgAN with persistent proteinuria ≥ 1 g/d, despite 3–6 months of optimized supportive care (including ACE-I or ARBs and blood pressure control). (*2D*)
- 10.5.2: Antiplatelet agents
 - 10.5.2.1: We suggest not using antiplatelet agents to treat IgAN. (*2C*)
- 10.5.3: Tonsillectomy
 - 10.5.3.1: We suggest that tonsillectomy not be performed for IgAN. (*2C*)

10.6: Atypical forms of IgAN

- 10.6.1: MCD with mesangial IgA deposits
 - 10.6.1.1: We recommend treatment as for MCD (see Chapter 5) in nephrotic patients showing pathological findings of MCD with mesangial IgA deposits on kidney biopsy. (*2B*)

10.6.2: AKI associated with macroscopic hematuria

10.6.2.1: Perform a repeat kidney biopsy in IgAN patients with AKI associated with macroscopic hematuria if, after 5 days from the onset of kidney function worsening, there is no improvement. (*Not Graded*)

10.6.2.2: We suggest general supportive care for AKI in IgAN, with a kidney biopsy performed during an episode of macroscopic hematuria showing only ATN and intratubular erythrocyte casts. (2C)

10.6.3: Crescentic IgAN

10.6.3.1: Define crescentic IgAN as IgAN with crescents in more than 50% of glomeruli in the renal biopsy with rapidly progressive renal deterioration. (*Not Graded*)

10.6.3.2: We suggest the use of steroids and cyclophosphamide in patients with IgAN and rapidly progressive crescentic IgAN, analogous to the treatment of ANCA vasculitis (see Chapter 13). (2D)

Chapter 11: Henoch-Schönlein purpura nephritis

11.1: *Treatment of HSP nephritis in children*

11.1.1: We suggest that children with HSP nephritis and persistent proteinuria, $> 0.5\text{--}1$ g/d per 1.73 m^2 , are treated with ACE-I or ARBs. (2D)

11.1.2: We suggest that children with persistent proteinuria, > 1 g/d per 1.73 m^2 , after a trial of ACE-I or ARBs, and GFR > 50 ml/min per 1.73 m^2 , be treated the same as for IgAN with a 6-month course of corticosteroid therapy (see Chapter 10). (2D)

11.2: *Treatment of crescentic HSP nephritis in children*

11.2.1: We suggest that children with crescentic HSP with nephrotic syndrome and/or deteriorating kidney function are treated the same as for crescentic IgAN (see Recommendation 10.6.3). (2D)

11.3: *Prevention of HSP nephritis in children*

11.3.1: We recommend not using corticosteroids to prevent HSP nephritis. (1B)

11.4: *HSP nephritis in adults*

11.4.1: We suggest that HSP nephritis in adults be treated the same as in children. (2D)

Chapter 12: Lupus nephritis

12.1: *Class I LN (minimal-mesangial LN)*

12.1.1: We suggest that patients with class I LN be treated as dictated by the extrarenal clinical manifestations of lupus. (2D)

12.2: *Class II LN (mesangial-proliferative LN)*

12.2.1: Treat patients with class II LN and proteinuria < 1 g/d as dictated by the extrarenal clinical manifestations of lupus. (2D)

12.2.2: We suggest that class II LN with proteinuria > 3 g/d be treated with corticosteroids or CNIs as described for MCD (see Chapter 5). (2D)

12.3: *Class III LN (focal LN) and class IV LN (diffuse LN)—initial therapy*

12.3.1: We recommend initial therapy with corticosteroids (1A), combined with either cyclophosphamide (1B) or MMF (1B).

12.3.2: We suggest that, if patients have worsening LN (rising SCr, worsening proteinuria) during the first 3 months of treatment, a change be made to an alternative recommended initial therapy, or a repeat kidney biopsy be performed to guide further treatment. (2D)

12.4: Class III LN (focal LN) and class IV LN (diffuse LN)—maintenance therapy

- 12.4.1: We recommend that, after initial therapy is complete, patients with class III and IV LN receive maintenance therapy with azathioprine (1.5–2.5 mg/kg/d) or MMF (1–2 g/d in divided doses), and low-dose oral corticosteroids (≤ 10 mg/d prednisone equivalent). (1B)
- 12.4.2: We suggest that CNIs with low-dose corticosteroids be used for maintenance therapy in patients who are intolerant of MMF and azathioprine. (2C)
- 12.4.3: We suggest that, after complete remission is achieved, maintenance therapy be continued for at least 1 year before consideration is given to tapering the immunosuppression. (2D)
- 12.4.4: If complete remission has not been achieved after 12 months of maintenance therapy, consider performing a repeat kidney biopsy before determining if a change in therapy is indicated. (Not Graded)
- 12.4.5: While maintenance therapy is being tapered, if kidney function deteriorates and/or proteinuria worsens, we suggest that treatment be increased to the previous level of immunosuppression that controlled the LN. (2D)

12.5: Class V LN (membranous LN)

- 12.5.1: We recommend that patients with class V LN, normal kidney function, and non-nephrotic-range proteinuria be treated with antiproteinuric and antihypertensive medications, and only receive corticosteroids and immunosuppressives as dictated by the extrarenal manifestations of systemic lupus. (2D)
- 12.5.2: We suggest that patients with pure class V LN and persistent nephrotic proteinuria be treated with corticosteroids plus an additional immunosuppressive agent: cyclophosphamide (2C), or CNI (2C), or MMF (2D), or azathioprine (2D).

12.6: General treatment of LN

- 12.6.1: We suggest that all patients with LN of any class are treated with hydroxychloroquine (maximum daily dose of 6–6.5 mg/kg ideal body weight), unless they have a specific contraindication to this drug. (2C)

12.7: Class VI LN (advanced sclerosis LN)

- 12.7.1: We recommend that patients with class VI LN be treated with corticosteroids and immunosuppressives only as dictated by the extrarenal manifestations of systemic lupus. (2D)

12.8: Relapse of LN

- 12.8.1: We suggest that a relapse of LN after complete or partial remission be treated with the initial therapy followed by the maintenance therapy that was effective in inducing the original remission. (2B)
 - 12.8.1.1: If resuming the original therapy would put the patient at risk for excessive lifetime cyclophosphamide exposure, then we suggest a non-cyclophosphamide-based initial regimen be used (Regimen D, Table 28). (2B)
- 12.8.2: Consider a repeat kidney biopsy during relapse if there is suspicion that the histologic class of LN has changed, or there is uncertainty whether a rising SCr and/or worsening proteinuria represents disease activity or chronicity. (Not Graded)

12.9: Treatment of resistant disease

- 12.9.1: In patients with worsening SCr and/or proteinuria after completing one of the initial treatment regimens, consider performing a repeat kidney biopsy to distinguish active LN from scarring. (Not Graded)
- 12.9.2: Treat patients with worsening SCr and/or proteinuria who continue to have active LN on biopsy with one of the alternative initial treatment regimens (see Section 12.3). (Not Graded)
- 12.9.3: We suggest that nonresponders who have failed more than one of the recommended initial regimens (see Section 12.3) may be considered for treatment with rituximab, i.v. immunoglobulin, or CNIs. (2D)

12.10: Systemic lupus and thrombotic microangiopathy

- 12.10.1: We suggest that the antiphospholipid antibody syndrome (APS) involving the kidney in systemic lupus patients, with or without LN, be treated by anticoagulation (target international normalized ratio [INR] 2–3). (2D)
- 12.10.2: We suggest that patients with systemic lupus and thrombotic thrombocytopenic purpura (TTP) receive plasma exchange as for patients with TTP without systemic lupus. (2D)

12.11: Systemic lupus and pregnancy

- 12.11.1: We suggest that women be counseled to delay pregnancy until a complete remission of LN has been achieved. (2D)

- 12.11.2: We recommend that cyclophosphamide, MMF, ACE-I, and ARBs not be used during pregnancy. (1A)
- 12.11.3: We suggest that hydroxychloroquine be continued during pregnancy. (2B)
- 12.11.4: We recommend that LN patients who become pregnant while being treated with MMF be switched to azathioprine. (1B)
- 12.11.5: We recommend that, if LN patients relapse during pregnancy, they receive treatment with corticosteroids and, depending on the severity of the relapse, azathioprine. (1B)
- 12.11.6: If pregnant patients are receiving corticosteroids or azathioprine, we suggest that these drugs not be tapered during pregnancy or for at least 3 months after delivery. (2D)
- 12.11.7: We suggest administration of low-dose aspirin during pregnancy to decrease the risk of fetal loss. (2C)

12.12: LN in children

- 12.12.1: We suggest that children with LN receive the same therapies as adults with LN, with dosing based on patient size and GFR. (2D)

Chapter 13: Pauci-immune focal and segmental necrotizing glomerulonephritis

13.1: Initial treatment of pauci-immune focal and segmental necrotizing GN

- 13.1.1: We recommend that cyclophosphamide and corticosteroids be used as initial treatment. (1A)
- 13.1.2: We recommend that rituximab and corticosteroids be used as an alternative initial treatment in patients without severe disease or in whom cyclophosphamide is contraindicated. (1B)

13.2: Special patient populations

- 13.2.1: We recommend the addition of plasmapheresis for patients requiring dialysis or with rapidly increasing SCr. (1C)
- 13.2.2: We suggest the addition of plasmapheresis for patients with diffuse pulmonary hemorrhage. (2C)
- 13.2.3: We suggest the addition of plasmapheresis for patients with overlap syndrome of ANCA vasculitis and anti-GBM GN, according to proposed criteria and regimen for anti-GBM GN (see Chapter 14). (2D)
- 13.2.4: We suggest discontinuing cyclophosphamide therapy after 3 months in patients who remain dialysis-dependent and who do not have any extrarenal manifestations of disease. (2C)

13.3: Maintenance therapy

- 13.3.1: We recommend maintenance therapy in patients who have achieved remission. (1B)
- 13.3.2: We suggest continuing maintenance therapy for at least 18 months in patients who remain in complete remission. (2D)
- 13.3.3: We recommend no maintenance therapy in patients who are dialysis-dependent and have no extrarenal manifestations of disease. (1C)

13.4: Choice of agent for maintenance therapy

- 13.4.1: We recommend azathioprine 1–2 mg/kg/d orally as maintenance therapy. (1B)
- 13.4.2: We suggest that MMF, up to 1 g twice daily, be used for maintenance therapy in patients who are allergic to, or intolerant of, azathioprine. (2C)
- 13.4.3: We suggest trimethoprim-sulfamethoxazole as an adjunct to maintenance therapy in patients with upper respiratory tract disease. (2B)
- 13.4.4: We suggest methotrexate (initially 0.3 mg/kg/wk, maximum 25 mg/wk) for maintenance therapy in patients intolerant of azathioprine and MMF, but not if GFR is < 60 ml/min per 1.73 m². (1C)
- 13.4.5: We recommend not using etanercept as adjunctive therapy. (1A)

13.5: Treatment of relapse

- 13.5.1: We recommend treating patients with severe relapse of ANCA vasculitis (life- or organ-threatening) according to the same guidelines as for the initial therapy (see Section 13.1). (1C)

13.5.2: We suggest treating other relapses of ANCA vasculitis by reinstating immunosuppressive therapy or increasing its intensity with agents other than cyclophosphamide, including instituting or increasing dose of corticosteroids, with or without azathioprine or MMF. (2C)

13.6: Treatment of resistant disease

13.6.1: In ANCA GN resistant to induction therapy with cyclophosphamide and corticosteroids, we recommend the addition of rituximab (1C), and suggest i.v. immunoglobulin (2C) or plasmapheresis (2D) as alternatives.

13.7: Monitoring

13.7.1: We suggest not changing immunosuppression based on changes in ANCA titer alone. (2D)

13.8: Transplantation

13.8.1: We recommend delaying transplantation until patients are in complete extrarenal remission for 12 months. (1C)

13.8.2: We recommend not delaying transplantation for patients who are in complete remission but are still ANCA-positive. (1C)

Chapter 14: Treatment of anti-glomerular basement membrane antibody glomerulonephritis

14.1: Treatment of anti-GBM GN

14.1.1: We recommend initiating immunosuppression with cyclophosphamide and corticosteroids plus plasmapheresis (see Table 31) in all patients with anti-GBM GN except those who are dialysis-dependent at presentation and have 100% crescents in an adequate biopsy sample, and do not have pulmonary hemorrhage. (1B)

14.1.2: Start treatment for anti-GBM GN without delay once the diagnosis is confirmed. If the diagnosis is highly suspected, it would be appropriate to begin high-dose corticosteroids and plasmapheresis (Table 31) while waiting for confirmation. (Not Graded)

14.1.3: We recommend no maintenance immunosuppressive therapy for anti-GBM GN. (1D)

14.1.4: Defer kidney transplantation after anti-GBM GN until anti-GBM antibodies have been undetectable for a minimum of 6 months. (Not Graded)

Chapter 1: Introduction

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SCOPE

This clinical practice guideline has been developed to provide recommendations for the treatment of patients already diagnosed with glomerulonephritis (GN). The emphasis is on the more common forms of immune-mediated glomerular disease in both children and adults. The scope includes histologic variants of GN restricted to the kidney, as well as the most common ones associated with systemic immune-mediated disease. This guideline does not cover diagnosis or prevention of GN.

The guideline addresses the following forms of GN:

- Steroid-sensitive nephrotic syndrome (SSNS) and steroid-resistant nephrotic syndrome (SRNS) in children;
- Minimal-change disease (MCD) and idiopathic focal segmental glomerulosclerosis (FSGS) in children and adults;
- Idiopathic membranous nephropathy (IMN);
- Idiopathic membranoproliferative GN;
- GN associated with infections;
- Immunoglobulin A (IgA) nephropathy and Henoch-Schönlein purpura (HSP) nephritis;
- Lupus nephritis (LN);
- Renal vasculitis;
- Antiglomerular basement membrane (anti-GBM) GN.

METHODOLOGY

The Work Group members defined the overall topics and goals for the guideline. Then, in collaboration with the evidence review team (ERT), the Work Group further developed and refined each systematic review topic, specified screening criteria, literature search strategies, and data extraction forms.

The ERT performed literature searches, organized the abstracts and article screening, coordinated the methodological and analytic processes of the report, defined and standardized the methodology relating to these searches and data extraction, and produced summaries of the evidence. Using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach, they created preliminary evidence profiles (described in the Methods for guideline development) that were subsequently reviewed and completed by the Work Group members. The ERT searches were updated to January 2011 and supplemented with additional studies known to the Work Group members through November 2011. Through an iterative process that involved all Work Group members, the chairs of the Work Group, and the ERT, the individual chapters were refined, reviewed, and finalized. All the details in the multiple steps involved in the

assessment of grade and strength of the evidence are detailed fully in the section, Methods for guideline development. The Work Group made two levels of recommendations (1 or 2) based on the strength of the evidence supporting the recommendation, the net medical benefit, values and preferences, and costs. Recommendations were also graded based on the overall quality of the evidence (A to D). Recommendations that provided general guidance about routine medical care (and related issues) were not graded.

The recommendations made in this guideline are directed by the available evidence to support the specific treatment options listed. When the published evidence is very weak or nonexistent no recommendations are made, although the reasons for such omissions are explained in the rationale in each chapter. There are, therefore, a number of circumstances in this guideline where treatments in wide use in current clinical practice are given only level 2 recommendations (i.e., suggested) or not included for lack of evidence.

The starting point for this guideline is that a morphological characterization of the glomerular lesion has been established by kidney biopsy or, in the case of some children with nephrotic syndrome, by characteristic clinical features. An important corollary is that the guideline does not provide recommendations on how to evaluate patients presenting with suspected glomerular disease nor when or in whom to perform a diagnostic kidney biopsy. We recognize these are relevant management issues in these patients but have chosen to begin the guideline at the point of an established diagnosis based on an adequate biopsy reviewed by a knowledgeable nephrologist. This has dictated the starting point of our evidence-based systematic reviews and subsequent recommendations.

INTENDED USERS

This guideline was written primarily for nephrologists, although it should also be useful for other physicians, nurses, pharmacists, and health-care professionals who care for patients with GN. It was not developed for health-care administrators or regulators *per se*, and no attempts were made to develop clinical performance measures. This guideline was also not written directly for patients or caregivers, though appropriately drafted explanations of guideline recommendations could potentially provide useful information for these groups.

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Chapter 2: General principles in the management of glomerular disease

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There are a number of general principles in the management of glomerular injury which apply to most or all of the histologic variants of GN covered by this guideline. In this chapter, we discuss these general principles to minimize repetition in the guideline. Where there are specific applications or exceptions to these general statements, an expansion and rationale for these variations and/or recommendations are made in each chapter.

Kidney Biopsy

Kidney biopsy is mandatory for diagnosis. It defines the morphologic patterns of GN that will be reviewed in this guideline. The single exception to this rule is SSNS in children. This entity has an operational clinical definition that is sufficiently robust to direct initial treatment, with the kidney biopsy reserved for identifying pathology only when the clinical response is atypical.

Adequacy of kidney biopsy. There are two components in terms of assessing adequacy of the tissue sample. The first relates to the size of biopsy necessary to diagnose or exclude a specific histopathologic pattern with a reasonable level of confidence, and the second concerns the amount of tissue needed for an adequate assessment of the amount of acute or chronic damage present.

In some cases a diagnosis may be possible from examination of a single glomerulus (e.g., membranous nephropathy), but generally a substantially larger specimen is required to ensure that the material reviewed by the nephropathologist adequately represents the glomerular, tubular, interstitial, and vascular compartments of the kidney. In addition, sufficient tissue is needed to perform not only an examination by light microscopy, but also immunohistochemical staining to detect immune reactants (including immunoglobulins and complement components), and electron microscopy to define precisely the location, extent and, potentially, the specific characteristics of the immune deposits. We recognize that electron microscopy is not routinely available in many parts of the world, but the additional information defined by this technique may modify and even change the histologic diagnosis, and may influence therapeutic decisions; hence, it is recommended whenever possible.

In some diseases, for example FSGS and necrotizing glomerulonephritis associated with antineutrophil cytoplasmic antibodies (ANCA), lesions are only seen in some segments of some glomeruli. In these cases, it is important

that the biopsy is examined by light microscopy at several levels if lesions are not to be missed. If a lesion that affects only 5% of glomeruli is to be detected or excluded with 95% confidence, then over 20 glomeruli are needed in the biopsy.¹ Although many biopsies will have fewer glomeruli, it is important to realize that this limits diagnostic accuracy, especially when the diagnostic lesions are focal and/or segmental.

An important component of kidney biopsy examination is the assessment of “activity”, that is lesions which are acute and potentially responsive to specific therapy, and “chronicity”, where they are not reversible or treatable. As glomeruli become scarred there is consequent atrophy of the rest of the nephron with interstitial fibrosis, and it is usually the case in GN that the degree of chronic irreversible damage is most easily assessed from the amount of tubular atrophy. The accuracy of this assessment is increased with larger biopsies. The assessment of chronic damage from the biopsy must always be interpreted together with the clinical data to avoid misinterpretation if the biopsy is taken from a focal cortical scar. The amount of information that can be derived from kidney pathology varies substantially in the different GN types; when of particular relevance, this is addressed specifically within the appropriate chapters.

Repeat kidney biopsy. Repeat kidney biopsy during therapy or following a relapse may be informative. There is no systematic evidence to support recommendations for when or how often a repeat biopsy is necessary, but given the invasive nature of the procedure and the low but unavoidable risks involved, it should be used sparingly. In general, a decision about the value of a repeat biopsy should be driven by whether a change in therapy is being considered. More specifically, a repeat biopsy should be considered:

- when an unexpected deterioration in kidney function occurs (not compatible with the natural history) that suggests there may be a change or addition to the primary diagnosis (e.g., crescentic GN developing in known membranous nephropathy or interstitial nephritis secondary to the drugs being used in the disease management);
- when changes in clinical or laboratory parameters suggest a change of injury pattern within the same diagnosis (e.g., conversion of membranous to diffuse proliferative LN);
- when the relative contributions to the clinical picture of disease activity and chronicity are unknown, creating therapeutic uncertainty in regards to intensifying, maintaining, or reducing therapy;

- to assist in defining a “point of no return” and to help define therapeutic futility (i.e., such extensive and irreversible kidney scarring that no response to available therapies can be expected).

Assessment of Kidney Function

Key outcome measures for the management of GN include assessment of kidney function, particularly measurement of proteinuria and glomerular filtration rate (GFR).

Proteinuria. Whether urine albumin or urine protein excretion is the preferred measurement to assess glomerular injury continues to be debated. However, 24-hour protein excretion remains the reference (“gold standard”) method for quantification of proteinuria in patients with GN. It averages the variation of proteinuria due to the circadian rhythm, physical activity, and posture. Almost all of the published clinical trials used in the development of this guideline utilized 24-hour measurement of proteinuria to assess responses. Although this method is subject to error due to over- or under-collection, the simultaneous measurement of urine creatinine helps to standardize the collection in terms of completeness, thereby improving its reliability.

Protein-creatinine ratio (PCR) or albumin-creatinine ratio on a random (“spot”) urine sample, or a first morning urine sample, is a practical alternative to 24-hour urine collection.² It is increasingly used in clinical practice because the sample is easy to obtain, is not influenced by variation in water intake or by urinary flow rate. There may still be gender and racial variations that are not accounted for, given these factors may modify creatinine generation. There is a correlation between the protein-creatinine ratio in a random urine sample and 24-hour protein excretion. Although the reliability of PCR for the monitoring of proteinuria during treatment is still not proven, it has practical clinical utility, especially in children. In some recent studies, urine samples have been collected over a longer period (e.g., 4 hours) to address the limitations of “spot” urine samples that can be influenced by activity and circadian rhythm, but without the problems associated with a 24-hour urine collections.³ The correlation of PCR with proteinuria from a 24-hour urine collection does improve steadily as the collection period is lengthened. However, there is currently insufficient evidence to preferentially recommend 24-hour, shorter-timed, or spot urine collections for proteinuria in the management of GN.

The conventional definition of nephrotic syndrome in the published literature is proteinuria >3.5 g per 24 hours (in children, >40 mg/m²/hr or PCR >2000 mg/g [>200 mg/mmol] or >300 mg/dl or 3+ on urine dipstick) plus hypoalbuminemia and edema. Nephrotic-range proteinuria is nearly always arbitrarily defined as proteinuria >3.5 g per 24 hours [uPCR >2000 mg/g [>200 mg/mmol] in children) in the absence of clinically overt nephrotic syndrome. Asymptomatic proteinuria, by definition without clinical symptoms, has variable levels of proteinuria in the range of 0.3–1.5 g per 24 hours (or equivalent). Treatment trials even

within the same pattern of GN have used a variety of entry criteria based on severity of proteinuria. This is only one of the issues that make direct comparison of trial outcomes difficult. Nevertheless, quantifying proteinuria (and perhaps even assessing its qualitative nature) is an important measure in the assessment of the patient with GN. This is relevant in almost all the primary and secondary glomerular diseases in this guideline. It is also important and necessary to define, within each of the specific GN types in the subsequent chapters, what levels and changes in proteinuria have been used to categorize both the risk of progression and the definition of response. These parameters are not uniform and vary widely across the spectrum of GN. There is insufficient evidence currently to recommend basing treatment decisions on more detailed qualitative analysis of proteinuria, such as measurement of fractional urinary excretion of immunoglobulin G (IgG), β -2 microglobulin, retinol-binding protein, or α -1 macroglobulin.

Estimation of GFR. Most of the available evidence for treatment of GN has been based on estimations of excretory kidney function using serum creatinine (SCr) or creatinine clearance (CrCl) requiring a 24-hour urine collection. Very few studies have reported gold standard measurements of GFR using inulin or radioisotope clearance techniques. Other techniques used in past studies include adjustment of SCr for age, weight, and sex using the Cockcroft-Gault formula and reciprocal or log transformation of SCr. Serum cystatin C, as an alternative to SCr has not been validated in subjects with GN. All these methods have limitations, but are informative when sequential measurements are made in each subject.

Recently, estimation of GFR using the Modification of Diet in Renal Disease (MDRD) 4 variable equation has gained increasing acceptance, although it has not been validated specifically in those with GN. Another estimating equation, CKD Epi has recently been proposed, which may be more accurate than the MDRD equation, especially at values >60 ml/min. Ethnicity may also influence estimated glomerular filtration rate (eGFR). There is no robust evidence to recommend the superiority of any of the available methods for estimating GFR in the management of GN. One particular limitation is that eGFR using creatinine-based formulas should be interpreted with caution in nephrotic syndrome, since tubular creatinine handling is altered in this condition. As a result, CrCl and eGFR may overestimate true GFR in nephrotic syndrome by 50% or more.⁴ GFR estimations are also unreliable during episodes of acute kidney injury (AKI).

In children, there are alternative validated formulas for eGFR, notably the Schwartz formula.

Outcome Measures

Complete remission, ESRD, mortality. A definitive assessment of the efficacy of a treatment for GN requires the demonstration that end-stage renal disease (ESRD) has been prevented, and mortality reduced. Very few studies in GN have been of sufficient duration or have analyzed sufficient

numbers of patients to accurately assess these outcomes. This is not surprising, given the slow natural history of many of the histologic variants of GN in this guideline. The other accepted outcome measure for many of these disorders is complete remission, assessed by the complete disappearance of abnormal proteinuria (<300 mg per 24 hours). However, most studies rely on other surrogates as predictors of clinical outcomes. These surrogate outcome measures include changes in proteinuria, e.g., partial remission of proteinuria, change in kidney function, “point of no return”, quality of life, and quality of health.

Changes in proteinuria. A quantitative change in proteinuria is presented in most studies. This is often categorized as complete remission, usually defined as proteinuria <0.3 g per 24 hours (uPCR <300 mg/g [<30 mg/mmol]) or partial remission defined as proteinuria >0.3 but <3.5 g per 24 hours or a decrease in proteinuria by at least 50% from the initial value and <3.5 g per 24 hours. However, definitions vary and are not used consistently even within a specific GN pattern. The variations in these definitions will be discussed in each chapter.

Changes in kidney function. Changes in kidney function are usually measured by changes in SCr or CrCl. These need to be substantial to indicate true disease progression, e.g., doubling of SCr, or halving of CrCl or eGFR. This is because most patients with GN have gradual changes in function and there are many factors that may modify the SCr value besides progression of kidney disease. These factors include changes in intravascular volume, intercurrent illness, comorbid conditions, and many drugs. In addition, there are specific issues related to the SCr value independent of the disease, such as the method used for its measurement, changes in muscle mass, and alterations in urine flow and level of kidney function that both alter the tubular secretion of creatinine. In more recent studies, changes over time in eGFR have been reported. In the absence of ESRD as a defined adverse outcome, slope of CrCl or slope of eGFR may be an adequate and reliable marker of change in kidney function, provided that sufficient data at sequential time points are available, and that the slope is sufficiently linear.⁵

Changes in GFR are often described qualitatively as “deteriorating” or “rapidly deteriorating” kidney function. Although these terms have no precise definitions, they are in common usage especially in certain histologic categories such as vasculitis and lupus nephritis. These are descriptive terms, and the value of a particular therapy can be properly evaluated only when compared to another group with similar clinical and histologic characterizations and in the setting of a randomized controlled trial (RCT). Where available, these will be presented in each chapter.

“Point of no return”. This concept has no precise definition, but describes a situation in the natural history of a chronic glomerular disease where loss of kidney function is accompanied by such extensive and irreversible kidney injury that any therapeutic strategy being tested cannot reasonably be expected to alter the natural history of progressive

deterioration in kidney function (therapeutic futility). The presumption is that such patients should be excluded from clinical trials, since they are expected to be “nonresponders” and therefore may dilute any treatment effect, and adversely affect the power of the study. Furthermore these subjects with reduced kidney function may be at higher risk of adverse effects of the therapies being tested. In the absence of precise definitions of the “point of no return” it is not possible to know, in most of the published trials, whether the inclusion or exclusion of such patients may have masked any therapeutic benefit.

Quality of life and quality of health. Patients’ own perceptions of their quality of life and quality of health, and their preferences are extremely important elements of the assessment of therapy, but are often an underappreciated and/or unmeasured parameter in the evaluation of many of the clinical trials reviewed in this guideline. This is particularly relevant when considering the risk-benefit analysis of interventions, which may include the short- and long-term risks of immunosuppressive treatments but often does not account for the patient’s perspective in relationship to real or perceived impact on their quality of life. These unassessed elements have the potential to significantly obfuscate outcomes (e.g., concerns about body image in young females treated with corticosteroids could impact adherence to therapy). The recent introduction of patient-related outcomes (PROMS) that allows a more rapid assessment has the potential to provide a more uniform quality-of-life determination that is standard across all chronic diseases.

The lack of such data is a substantial evidence gap in the evaluation of studies relating to the management of GN.

Impact of Age, Sex, Ethnicity, and Genetic Background

Published RCTs of treatment for GN remain few, and many are small, short in duration of follow-up, and of variable quality. This has resulted in uncertainty about generalizability, i.e., whether the demonstrated benefits (or lack of efficacy) of any treatments will still emerge if patients are then treated who come from different ethnic groups, and/or are of different age or sex, compared to those included in the published studies. The specific limitations of studies in this regard are discussed in later chapters but the following are examples of this issue: whether it is reasonable to extrapolate treatment recommendations from children to adults with MCD, and vice versa; whether the effectiveness of regimens for LN proven in Caucasians can be extended to those of other ethnicities; and whether the safety observed with a course of immunosuppression in the young applies equally to the elderly.

Furthermore few available RCTs are statistically powered to examine less-common adverse effects of therapy. It is not yet clear if new insights into these and other issues will emerge from a better understanding of the pharmacogenetic variations that can substantially alter the pharmacokinetics and/or pharmacodynamics of immunosuppressive and other agents. Although early evidence is suggestive that such

genetic traits may alter clinical outcome,⁶ the cost of such pharmacogenetic testing also needs consideration and, as yet, there is little robust evidence that these factors should modify the treatment of GN.

Management of Complications of Glomerular Disease

A number of complications of glomerular disease are a consequence of the clinical presentation rather than the specific histopathologic pattern. Active management of such complications—although not subject to evidence review in this guideline—should always be considered and may have a significant positive impact on the natural history of the disease. These include measures to treat blood pressure, reduce proteinuria, control edema, and address other metabolic and thrombophilic consequences of nephrotic syndrome, which can result in significant morbidity and even mortality. If successful, these relatively nontoxic therapies may prevent—or at least modulate—the need for immunosuppressive drugs with their potential adverse effects. Such supportive therapy is usually not necessary in steroid-sensitive MCD with rapid remission, or in patients with GN and only microscopic hematuria, preserved GFR, and neither proteinuria nor hypertension. The latter is a common scenario, for instance, in IgA nephropathy.

Hypertension. As in all chronic kidney disease (CKD), the aim of blood pressure control is both to protect against the cardiovascular risks of hypertension and to delay progressive loss of GFR. Lifestyle modification (salt restriction, weight normalization, regular exercise, and smoking cessation) should be an integral part of the therapy for blood pressure control.

The ideal goal for blood pressure is not firmly established but current recommendations suggest that 130/80 mm Hg should be the treatment goal. There are limited data to support a lower target of 125/75 mm Hg if there is proteinuria >1 g/d.⁷ This issue will be covered in a forthcoming KDIGO Guideline for the Management of Blood Pressure in Chronic Kidney Disease. There is no specific evidence in GN on which to base a recommendation about the preferential importance of systolic or diastolic blood pressure, or about timing of blood pressure measurements. There are strong theoretical and experimental reasons for angiotensin-converting enzyme inhibitors (ACE-I) and angiotensin-receptor blockers (ARB) to be first-choice therapy; this is now well-documented in clinical studies.⁸ Children with GN should have blood pressure controlled to below the 50th percentile for systolic and diastolic pressure for age and sex using published^{9,10} or locally available standards.

The evidence for blood pressure goals and choice of antihypertensive therapy in GN and other CKD has not been systematically evaluated for this guideline; it will be the subject of a forthcoming KDIGO Clinical Practice Guideline.

Proteinuria. Reduction in proteinuria is important, as it reflects control of the primary disease, reduction of glomerular hypertension, and also reduction of podocyte damage (a likely major factor in glomerular scarring).

Most studies suggest that the loss of kidney function in the progressive histologic patterns discussed in this guideline can largely be prevented if proteinuria can be reduced to levels below 0.5 g/d. The exceptions are MCD and SSNS where complete remission defines the disease. Proteinuria or factors present in proteinuric urine may also be toxic to the tubulointerstitium. In nephrotic syndrome, a reduction of proteinuria to a non-nephrotic range often results in an elevation to normal of serum proteins (particularly albumin). This elevation, in turn, alleviates many of the patient's symptoms as well as the metabolic complications of the nephrotic syndrome, thus improving quality of life.

The antiproteinuric agents of choice are ACE-I or ARB, which may reduce proteinuria by up to 40–50% in a dose-dependent manner, particularly if the patient complies with dietary salt restriction. There is little evidence to suggest that ACE-I differ from ARBs in this respect. However, the combination of the two may result in additive antiproteinuric activity, although there is conflicting evidence as to the risk-benefit ratio of this strategy, especially if GFR is significantly reduced. Since ACE-I and ARBs lower GFR, a 10–20% increase in SCr is often observed. Unless SCr continues to rise, this moderate increase reflects their effect on kidney hemodynamics and not worsening disease, and should not prompt withdrawal of the medication.

Recommendations on the dosing of these agents and the target levels of proteinuria are outside the scope of this introduction, but are addressed when there is available evidence for specific forms of GN in subsequent chapters.

Adequate dietary protein should be ensured in the proteinuric patient (0.8–1.0 g/kg daily) with a high carbohydrate intake to maximize utilization of that protein.

The evidence for the benefit of reducing proteinuria in CKD in general, and the choice of specific agents, has not been systematically evaluated for this guideline with the exception of the value of partial remission discussed in the relevant chapters. The evidence for renal protective therapy will be the subject of a forthcoming KDIGO Clinical Practice Guideline on Evaluation and Management of Chronic Kidney Disease.

Hyperlipidemia. Treatment of hyperlipidemia in patients with glomerular disease should usually follow the guidelines that apply to those at high risk for the development of cardiovascular disease. This is most relevant in the patients where the manifestations of the disease cannot be completely ameliorated, and when other risk factors for cardiovascular disease coexist, most commonly hypertension and proteinuria. Dietary restriction of fats and cholesterol alone has only modest effects on hyperlipidemia in glomerular disease, in particular in nephrotic syndrome. Statins (HMG CoA reductase inhibitors) are well tolerated and effective in correcting the lipid profile, although not proven to reduce cardiovascular events in nephrotic syndrome. It may also be that statin therapy protects from a decline in GFR, although this is not established. Care is needed when statins are used in combinations with other drugs, notably an

increased risk of myalgia/myositis when combined with calcineurin inhibitors.

Nephrotic edema. The mainstay of treatment is diuretics accompanied by moderate dietary sodium restriction (1.5–2 g [60–80 mmol] sodium per 24 hours). Nephrotic patients are often diuretic-resistant even if GFR is normal: oral loop diuretics with once- or twice-daily administration are usually preferred, given the ease of administration and longer therapeutic effect compared to i.v. therapy. However, in severe nephrotic syndrome, gastrointestinal absorption of the diuretic may be uncertain because of intestinal-wall edema, and i.v. diuretic, by bolus injection or infusion, may be necessary to provoke an effective diuresis. Alternatively, combining a loop diuretic with a thiazide diuretic or with metolazone is often an effective oral regimen that may overcome “diuretic resistance”. i.v. albumin infusions may be combined with diuretics to treat diuretic resistance, but are of unproven benefit. Occasionally, mechanical ultrafiltration is required for resistant edema.

Significant hypovolemia is not often a clinical problem, provided that fluid removal is controlled and gradual, but the pediatric and the elderly populations are at more risk of this complication. In the elderly, associated conditions such as diabetes mellitus and hypertension may increase the likelihood of hypovolemic shock and acute ischemic kidney injury.

Hypercoagulability. The risk of thrombotic events becomes progressively more likely as serum albumin values fall below 2.5 g/dl (25 g/l). Immobility as a consequence of edema, obesity, malignancy, intercurrent illness, or admission to hospital for surgery can further aggravate the risk. Prophylactic low-dose anticoagulation (e.g., heparin 5000 units subcutaneously twice daily) is common practice at times of high risk. Full-dose anticoagulation with low-molecular-weight heparin or warfarin is mandatory if an arterial or venous thrombosis, or pulmonary embolism, is documented. It should also be considered if serum albumin drops below 2.0–2.5 g/dl (20–25 g/l) with one or more of the following: proteinuria >10 g/d; body mass index (BMI) >35 kg/m²; family history of thromboembolism with documented genetic predisposition; New York Heart Association class III or IV congestive heart failure; recent abdominal or orthopedic surgery; or prolonged immobilization. Contraindications to prophylactic anticoagulation are: an uncooperative patient; a bleeding disorder; prior gastrointestinal bleeding; a central nervous lesion prone to hemorrhage (brain tumor, aneurysms); or a genetic abnormality influencing warfarin metabolism or efficacy.

During treatment with heparin, a significantly higher than average dose may be required because part of the action of heparin depends on antithrombin III, which may be lost in the urine in the nephrotic patient. Warfarin is the long-term treatment of choice but should be monitored with special care because of potential alterations in the protein binding of the drug with fluctuations in serum albumin in the nephrotic patient. A target international normalized ratio (INR) of 2–3

is usually recommended, although not supported by specific evidence.

Risk of infection. A high order of clinical vigilance for bacterial infection is vital in nephrotic patients. This is particularly important in nephrotic children with ascites, in whom the fluid should be examined microscopically and cultured for spontaneous bacterial peritonitis. Bacteremia can occur even if clinical signs are localized to the abdomen. Erythrocyte sedimentation rate is unhelpful, but an elevated C-reactive protein may be informative. Parenteral antibiotics should be started once cultures are taken and the regimen should include benzylpenicillin (to treat pneumococcal infection). If repeated infections occur, serum immunoglobulins should be measured. If serum IgG is less than 600 mg/dl (6 g/l), there is limited evidence that infection risk is reduced by monthly administration of i.v. immunoglobulin 10–15 g to keep serum IgG >600 mg/dl (>6 g/l).¹¹

Those with GN and nephrotic syndrome are at increased risk of invasive pneumococcal infection and should receive pneumococcal vaccination with the heptavalent conjugate vaccine (7vPCV) and the 23-valent polysaccharide vaccine (23vPPV) as well as the annual influenza vaccination. The response does not seem to be impaired by concurrent corticosteroid therapy. Vaccination with live vaccines (measles, mumps, rubella, varicella, rotavirus, yellow fever) is contraindicated while on immunosuppressive or cytotoxic agents, and should be deferred until prednisone dose is <20 mg/d and/or immunosuppressive agents have been stopped for at least 1–3 months. Exposure to varicella can be life-threatening, especially in children. Treatment should be given with zoster immune globulin if exposure does occur and antiviral therapy with acyclovir or valaciclovir begun at the first sign of chicken pox lesions¹² (See Chapter 3, SSNS, for additional details on management in children).

Use of Corticosteroids and Immunosuppressive Therapy

The chapters that follow will focus on the effectiveness of therapy based on current evidence in the most common histologic variants of GN.

The therapeutic decisions of the physician are predicated on the continuing need to balance the risks and benefits of treatment. Nothing stated in this guideline replaces the physician's assessment in this regard. The physician ideally seeks a treatment regimen that reduces immunosuppressive therapy exposure to the minimum, minimizes immediate morbidity (e.g., achieving remission of nephrotic syndrome), and prevents disease progression. However, physicians must also recognize that more prolonged treatment may be required, given the long-term threat that failure to prevent ESRD will shorten life expectancy and may only delay prolonged immunosuppressive drug exposure that would be required after kidney transplantation.

The focus in the management of chronic patterns of GN has shifted from cure to control, exemplified by recognition of the short- and long-term benefits of a reduction in proteinuria (in addition to the benefits known to accrue with

complete remission). This paradigm has translated into use of more extended (or repeated) treatment regimens with the corollary of more toxic drug exposure.

The specific adverse effects of the recommended immunosuppressive agents and the need for routine prophylactic measures are beyond the scope of this guideline, but are familiar in clinical practice, and have been reviewed.¹³ Specific regimens that potentially require prolonged exposure to these immunosuppressive agents are identified in the chapters to follow.

Adverse effects. The potential adverse effects of immunosuppressive therapy must always be discussed with the patient and family before treatment is initiated. This part of the management cannot be overemphasized. The risks of treatment with many of the agents are significant and may have a substantial latent period (e.g., cyclophosphamide). A balance must be struck between the potential risks of immunosuppressive treatment for GN, and the seriousness of the patient's condition. It is sometimes difficult to reconcile the immediate risks of immunosuppression, in the otherwise clinically well patient, vs. the potential for progression to ESRD. However, given that advanced CKD—and, particularly, ESRD—is associated with a significant shortening of life expectancy even with dialysis or transplantation, the balancing of risks and benefits over time must be considered. The physician must be aware of this conundrum and where the evidence for treatment is weak (but potentially life-altering) and the risk for harm strong, a full disclosure is mandatory. Individual patient perceptions of the acceptability of any adverse effect may strongly influence the decision (e.g., the possibility of hirsutism with cyclosporin therapy may be perceived as less tolerable in a young female than in an older male). What might be seen as an acceptable trade-off by the physician may not be viewed similarly by the patient, leading to an issue over compliance with therapy.

With more intensive immunosuppressive regimens, prophylaxis may be required to minimize possible adverse effects. Specific recommendations are beyond the scope of this guideline, and are without an evidence base specific to treatment of GN, but better evidenced when immunosuppression is used in kidney transplantation. Common examples are the use of prophylactic antimicrobials to minimize opportunistic infection, and H₂-receptor antagonists or proton pump inhibitors to prevent peptic ulceration. Two other important and more drug-specific examples are the use of bisphosphonates (except in the presence of kidney failure) to minimize loss of bone density during prolonged treatment with corticosteroids, and the need to offer the opportunity for sperm or ovum storage/preservation—where available—before treatment with the gonadotoxic agents, cyclophosphamide and chlorambucil.

Drug monitoring. Immunosuppressive agents with a narrow therapeutic index include the calcineurin inhibitors, cyclosporin and tacrolimus. There are no RCTs that compare response to treatment in GN and different achieved blood

levels of these agents. Dosing and target blood levels are based on established practice in kidney transplantation. The main goal of blood level monitoring is to avoid toxicity due to high drug levels, while still maintaining efficacy. The latter can often be assessed by proteinuria reduction, which can sometimes be achieved with trough blood levels of calcineurin inhibitors that would be considered subtherapeutic for solid-organ transplantation. The value of monitoring mycophenolic acid levels to guide dosing of mycophenolate has not been studied in GN.

Pregnancy in Women with GN

In women of child-bearing potential, the risks of pregnancy must be considered. A major predictor of pregnancy outcome is the GFR at time of conception. Other issues include the toxicity, especially in the first trimester, of immunosuppressive agents, ACE-I, and ARBs, and also the hazards to fetal and maternal outcome of pregnancy with uncontrolled proteinuric conditions. There is also a risk of relapse of LN both during and after pregnancy.

Treatment Costs and Related Issues

These guidelines have been developed with the goal of providing evidence-based treatment recommendations for GN that can be used by physicians in all parts of the world. Most of the medications recommended are available at low cost in many parts of the world. These include prednisone, azathioprine, and cyclophosphamide tablets. Monitoring (e.g., by regular checks of blood count) is also cheap and widely available.

The cost of some agents (e.g., calcineurin inhibitors and mycophenolate) remains high, but the development and marketing of generic agents and biosimilars is now rapidly reducing costs. However, care must be taken to ensure that variations in bioavailability with these less expensive generic agents do not compromise effectiveness or safety.

Plasmapheresis remains unavailable in some parts of the world, related not only to the high cost and limited availability of replacement fluids (including human albumin and fresh frozen plasma) but also to the equipment and staffing costs.

Some treatments suggested as potential “rescue” therapies in this guideline (e.g., rituximab) remain prohibitively expensive in most parts of the world. This is another indication of the urgent need for developing trials that will provide robust evidence of their efficacy. Uncertainty about the value of such high-cost agents would also be mitigated if there were comprehensive national or international registries collecting comprehensive observational data on their use, but unfortunately none exist.

Post-transplantation GN

Virtually all of the histologic variants discussed in this guideline (with the exception of MCD) may recur after transplantation. Recurrent disease is recognized as the third most common cause of kidney transplant failure. Currently

there are no proven strategies to prevent recurrent GN in kidney transplant recipients. Despite the high rate of recurrent disease, long-term graft survival is still very good and transplantation remains the best treatment option for patients with ESRD secondary to GN. Where there are specific recommendations in particular variants of GN that relate to management before transplantation, they will be discussed in each relevant chapter.

RESEARCH RECOMMENDATIONS

The evidence review underpinning this clinical practice guideline has confirmed the paucity of robust data from RCTs to support the treatment recommendations and suggestions that have been made. This raises the question of why there are so few RCTs of good design and sufficient power in GN, compared to many other areas of nephrology and internal medicine. The slowly progressive natural history of many patterns of GN means that trials designed to provide definitive outcome data (using ESRD or mortality) require long follow-up, significantly increasing their cost as well as effort for both the physician and the patient. Studies often employ “composite end-points” in order to enhance event rates. Furthermore, there are two competing elements in GN trial design. On the one hand, there is the recognition that most GN variants are uncommon; on the other hand, there is a need to acquire an adequate sample size within a reasonable time frame, an essential element for any successful study. This virtually mandates multicenter and multinational trial organization which, in turn, is challenging from both organizational and cost perspectives. These factors have

made trials in GN less attractive both to funding agencies and pharmaceutical companies, compared to more common and higher-profile clinical domains such as cardiovascular disease and cancer.

However there is an urgent need for such studies to be carried out. The costs—both to society, and to patients with GN and their families, if disease progression is not prevented—are often grossly underestimated. As an integral part of this guideline, we make recommendations in each chapter about the most pressing areas of uncertainty where RCTs and other areas of research would significantly inform clinical practice.

DISCLAIMER

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Chapter 3: Steroid-sensitive nephrotic syndrome in children

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INTRODUCTION

This chapter makes treatment recommendations for children aged 1 to 18 years with nephrotic syndrome, who respond to corticosteroid therapy by achieving complete remission (SSNS). The cost implications for global application of this guideline are addressed in Chapter 2. This chapter does not apply to children under 1 year of age in whom nephrotic syndrome is often associated with gene mutations and with histologies other than MCD.

3.1: Treatment of the initial episode of SSNS

3.1.1: We recommend that corticosteroid therapy (prednisone or prednisolone)* be given for at least 12 weeks. (1B)

3.1.1.1: We recommend that oral prednisone be administered as a single daily dose (1B) starting at 60 mg/m²/d or 2 mg/kg/d to a maximum 60 mg/d. (1D)

3.1.1.2: We recommend that daily oral prednisone be given for 4–6 weeks (1C) followed by alternate-day medication as a single daily dose starting at 40 mg/m² or 1.5 mg/kg (maximum 40 mg on alternate days) (1D) and continued for 2–5 months with tapering of the dose. (1B)

*Prednisone and prednisolone are equivalent, used in the same dosage, and have both been used in RCTs depending on the country of origin. All later references to prednisone in this chapter refer to prednisone or prednisolone. All later references to oral corticosteroids refer to prednisone or prednisolone.

BACKGROUND

Nephrotic syndrome affects 1–3 per 100,000 children below 16 years of age.¹⁴ Eighty percent of children respond to corticosteroid therapy.¹⁴ A kidney biopsy diagnosis is not required routinely at presentation because the International Study of Kidney Disease in Children (ISKDC) demonstrated that, while 93% of children with MCD responded to corticosteroids, 25–50% of children with mesangial proliferative glomerulonephritis (MPGN) or FSGS also responded to corticosteroids.¹⁵ The majority of children who relapse continue to respond completely to corticosteroids throughout their subsequent course, and the long-term prognosis, including maintenance of normal kidney function, is

good.^{16–18} In contrast, without treatment, nephrotic syndrome in children is associated with high risk of death, particularly from bacterial infection. Before the use of corticosteroids and antibiotics, 40% of children died, with half of these deaths being from infection.¹⁹ A recent study reports only one death (0.7%) associated with nephrotic syndrome among 138 children with SSNS presenting between 1970 and 2003.²⁰

The definitions used for nephrotic syndrome, complete remission, initial responder, initial and late steroid non-responders (steroid resistance), infrequent relapses, frequent relapses and steroid dependence are listed in Table 1. The likelihood of initial corticosteroid unresponsiveness is increased with increasing age at presentation,¹⁴ in African and African-American children,²¹ and in children with kidney pathologies other than MCD.¹⁵ The likelihood of late resistance to corticosteroids is associated with a shorter interval to the first relapse, and relapsing during the initial course of corticosteroid therapy.²²

RATIONALE

- There is moderate-quality evidence that administering prednisone for three months reduces the risk of relapse in children with the first episode of SSNS, with an increase in benefit seen with up to 6 months of treatment.
- There is moderate-quality evidence that corticosteroid therapy should be given as a single daily dose for at least 4 weeks, followed by alternate-day therapy for 2–5 months.
- The initial dose regimen of corticosteroid therapy is based on recommendations from the ISKDC, and has not been defined in RCTs.

Corticosteroid Use in the First Episode of SSNS in Children

With corticosteroid therapy, 80–90% of patients with childhood nephrotic syndrome achieve complete remission.^{14,17} However, 80–90% of these children have one or more relapses^{17,18} following the 2-month steroid regimen proposed by the ISKDC²³ and adapted by Arbeitsgemeinschaft für Pädiatrische Nephrologie.²⁴ Therefore, RCTs have evaluated the benefits of increased duration of therapy for the initial episode of SSNS. A meta-analysis²⁵ of six RCTs (422 children) demonstrated that the risk of relapse at 12–24 months was reduced by 30% (risk ratio of relapse 0.70; 95% confidence intervals [CI] 0.58–0.84) with 3 months or more of corticosteroid therapy compared to 2 months. There was

Table 1 | Definitions of nephrotic syndrome in children

Classification	Definition
<i>Nephrotic syndrome</i>	Edema, uPCR ≥ 2000 mg/g (≥ 200 mg/mmol), or ≥ 300 mg/dl, or 3+ protein on urine dipstick, hypoalbuminaemia ≤ 2.5 g/dl (≤ 25 g/l)
<i>Complete remission</i>	uPCR < 200 mg/g (< 20 mg/mmol) or $< 1+$ of protein on urine dipstick for 3 consecutive days
<i>Partial remission</i>	Proteinuria reduction of 50% or greater from the presenting value and absolute uPCR between 200 and 2000 mg/g (20–200 mg/mmol)
<i>No remission</i>	Failure to reduce urine protein excretion by 50% from baseline or persistent excretion uPCR > 2000 mg/g (> 200 mg/mmol)
<i>Initial responder</i>	Attainment of complete remission within initial 4 weeks of corticosteroid therapy
<i>Initial nonresponder/steroid resistance</i>	Failure to achieve complete remission after 8 weeks of corticosteroid therapy
<i>Relapse</i>	uPCR ≥ 2000 mg/g (≥ 200 mg/mmol) or $\geq 3+$ protein on urine dipstick for 3 consecutive days
<i>Infrequent relapse</i>	One relapse within 6 months of initial response, or one to three relapses in any 12-month period
<i>Frequent relapse</i>	Two or more relapses within 6 months of initial response, or four or more relapses in any 12-month period
<i>Steroid dependence</i>	Two consecutive relapses during corticosteroid therapy, or within 14 days of ceasing therapy
<i>Late nonresponder</i>	Persistent proteinuria during 4 or more weeks of corticosteroids following one or more remissions

uPCR, urine protein:creatinine ratio.

an inverse linear relationship between duration of treatment and risk of relapse seen when prednisone was given for up to 6 months (risk ratio = 1.26 -0.112 duration; $r^2 = 0.56$, $P = 0.03$).²⁵ Also a meta-analysis²⁵ of four RCTs (382 children) identified that treatment for 6 months significantly reduced the risk of relapse at 12–24 months compared to 3 months (RR 0.57; 95% CI 0.45–0.71). No significant differences in the incidence of adverse effects between treatment groups were demonstrated. However, individual trials were not designed specifically to study harm, and so were underpowered for the detection of side-effects of corticosteroids.²⁵

There are no RCTs examining different initial doses of corticosteroid for the first episode of childhood nephrotic syndrome. A dose of prednisone 60 mg/m²/d was recommended empirically by the ISKDC in 1979; this is roughly equivalent to 2 mg/kg. Although theoretical studies indicate that dosing for body weight results in a lower total dose compared to dosing for surface area, there are no data on whether this is of clinical relevance, so either method of calculating prednisone dose may be utilized.²⁶ Two RCTs have demonstrated that the mean time to remission did not differ significantly when daily corticosteroid therapy was given as a single daily dose compared to divided doses (weighted mean difference 0.04 days; 95% CI -0.98 – 1.06).²⁵

The majority (94%) of children respond to corticosteroids within 4 weeks of daily prednisone therapy.²⁷ To reduce the risk of relapse, prednisone should be given daily for at least 4 weeks in the initial episode of nephrotic syndrome. In an RCT, the risk of relapse was significantly higher at 6 months and 12 months when prednisone was given for 1 month compared to 2 months (RR 1.46; 95% CI 1.01–2.12 at 12 months).²⁸ Prednisone should be given on alternate days after 4 weeks of daily treatment rather than on 3 consecutive days out of 7 days, based on an RCT that showed the former had a lower risk of relapse.²⁹ Alternate-day (rather than daily) prednisone is suggested to maintain remission, because linear growth is less affected.³⁰ Although widely used particularly in France,³¹ there is no evidence to support the administration of high-dose i.v.

methylprednisolone to a child with nephrotic syndrome, who has not achieved remission after 4 weeks of daily corticosteroids, before labeling that child as steroid-resistant.

3.2: Treatment of relapsing SSNS with corticosteroids

3.2.1: Corticosteroid therapy for children with infrequent relapses of SSNS:

3.2.1.1: We suggest that infrequent relapses of SSNS in children be treated with a single-daily dose of prednisone 60 mg/m² or 2 mg/kg (maximum of 60 mg/d) until the child has been in complete remission for at least 3 days. (2D)

3.2.1.2: We suggest that, after achieving complete remission, children be given prednisone as a single dose on alternate days (40 mg/m² per dose or 1.5 mg/kg per dose; maximum 40 mg on alternate days) for at least 4 weeks. (2C)

3.2.2: Corticosteroid therapy for frequently relapsing (FR) and steroid-dependent (SD) SSNS:

3.2.2.1: We suggest that relapses in children with FR or SD SSNS be treated with daily prednisone until the child has been in remission for at least 3 days, followed by alternate-day prednisone for at least 3 months. (2C)

3.2.2.2: We suggest that prednisone be given on alternate days in the lowest dose to maintain remission without major adverse effects in children with FR and SD SSNS. (2D)

3.2.2.3: We suggest that daily prednisone at the lowest dose be given to maintain remission without major adverse effects in children with SD SSNS where alternate-day prednisone therapy is not effective. (2D)

3.2.2.4: We suggest that daily prednisone be given during episodes of upper respiratory tract and other infections to reduce the risk for relapse in children with FR and SD SSNS already on alternate-day prednisone. (2C)

BACKGROUND

Children with nephrotic syndrome who respond to corticosteroids have an 80–90% chance of having one or more relapses.^{17,18} Half of those that relapse have infrequent relapses and can be managed with short courses of prednisone. The remaining children have FR or SD SSNS.^{17,18} The risks of a child developing frequent relapses or becoming steroid-dependent are increased with shorter time to first relapse,³² the number of relapses in the first 6 months after initial treatment,^{15,18} younger age at the initial episode,^{33,34} in boys,³⁴ prolonged time to first remission,^{31,35} infection at first relapse,³² and hematuria in first episode.³⁵ The most consistent indicator for a frequently relapsing course is early relapse after initial treatment. Studies have not assessed whether the other factors are independent risk factors for predicting frequent relapses or steroid dependence. Children with FR or SD SSNS, and children whose first episode of SSNS occurred at a young age, have a longer duration of relapsing or SD nephrotic syndrome compared to children with infrequent relapses or older age of onset.^{16,33} Corticosteroids are needed to achieve remission, and low doses given on alternate days may maintain remission in patients with FR SSNS without recourse to corticosteroid-sparing agents. Low-dose daily or alternate-day corticosteroids may still be required to maintain remission in SD SSNS, despite receiving corticosteroid-sparing agents.

RATIONALE

- In children with infrequent relapses of SSNS, corticosteroid therapy regimens are based on empirical recommendations from the ISKDC and an RCT in children with FR SSNS.
- In children with FR and SD SSNS, there is low-quality evidence that increasing the duration of corticosteroid therapy increases the duration of remission.
- In children with SD SSNS, there is low-quality evidence that changing children from alternate-day to daily corticosteroids at onset of upper respiratory infections reduced the risk of relapse.
- In children with FR and SD SSNS, there is very low-quality evidence that low-dose alternate-day or daily corticosteroid therapy reduces the risk of relapse.

Corticosteroid Use in Relapses in Children with Infrequent Relapses of SSNS

There are no RCTs examining relapse regimens with corticosteroids in infrequently relapsing SSNS. In children with frequently relapsing SSNS, the ISKDC demonstrated that the number of relapses in the 7 months after treatment

did not differ significantly between children treated with 8 weeks of daily prednisone compared to daily prednisone till remission followed by 4 weeks of prednisone given on 3 consecutive days out of 7 days (further relapse by 9 months RR 1.07; 95% CI 0.77–1.50).²⁵ Based on these data we suggest that children with infrequently relapsing SSNS should receive daily corticosteroids only until remission followed by four weeks of alternate day prednisone.

Corticosteroid Therapy in Frequently Relapsing (FR) and Steroid-Dependent (SD) SSNS in Children

Approximately 40% of children with SSNS have FR or SD SSNS. A single RCT in children with relapsing nephrotic syndrome demonstrated that the risk of relapse at 12 and 24 months was significantly reduced with prednisone treatment for 7 months compared to 2 months of therapy.²⁵ These data, and the data on prednisone duration in the initial episode of SSNS, suggest that it is reasonable to treat a child with FR or SD SSNS with longer corticosteroid regimens than those suggested for children who relapse infrequently. Three RCTs have demonstrated that daily prednisone dose during upper respiratory tract and other infections reduced the risk for relapse in children with SD SSNS.^{25,36,37}

To maintain remission in children with SD SSNS, prednisone may be given on alternate days in the lowest dose possible to maintain remission. An observational study demonstrated that low-dose alternate-day prednisone (mean dose 0.48 mg/kg on alternate days) reduced the risk of relapse in FR SSNS compared to historical controls.³⁸ Guidelines from the British Association of Paediatric Nephrology recommend that children with SD SSNS receive 0.1–0.5 mg/kg on alternate days for at least 3–6 months before tapering.³⁹ Guidelines from the Indian Paediatric Nephrology Group recommend that the prednisone dose be tapered to 0.5–0.7 mg/kg on alternate days or lower, and continued for 9–18 months with careful monitoring of corticosteroid toxicity.⁴⁰ A nonrandomized comparator study indicated that low-dose daily prednisone (0.25 mg/kg) was more effective in maintaining remission compared to historical controls not treated with low-dose prednisone with a reduction in relapse rate from 2.25 per patient per year to 0.5 per patient per year.⁴¹

3.3: Treatment of FR and SD SSNS with corticosteroid-sparing agents

3.3.1: We recommend that corticosteroid-sparing agents be prescribed for children with FR SSNS and SD SSNS, who develop steroid-related adverse effects. (1B)

3.3.2: We recommend that alkylating agents, cyclophosphamide or chlorambucil, be given as corticosteroid-sparing agents for FR SSNS. (1B) We suggest that alkylating agents, cyclophosphamide or chlorambucil, be given as corticosteroid-sparing agents for SD SSNS. (2C)

- 3.3.2.1: We suggest that cyclophosphamide (2 mg/kg/d) be given for 8–12 weeks (maximum cumulative dose 168 mg/kg). (2C)
- 3.3.2.2: We suggest that cyclophosphamide not be started until the child has achieved remission with corticosteroids. (2D)
- 3.3.2.3: We suggest that chlorambucil (0.1–0.2 mg/kg/d) may be given for 8 weeks (maximum cumulative dose 11.2 mg/kg) as an alternative to cyclophosphamide. (2C)
- 3.3.2.4: We suggest that second courses of alkylating agents not be given. (2D)
- 3.3.3: We recommend that levamisole be given as a corticosteroid-sparing agent. (1B)
- 3.3.3.1: We suggest that levamisole be given at a dose of 2.5 mg/kg on alternate days (2B) for at least 12 months (2C) as most children will relapse when levamisole is stopped.
- 3.3.4: We recommend that the calcineurin inhibitors cyclosporine or tacrolimus be given as corticosteroid-sparing agents. (1C)
- 3.3.4.1: We suggest that cyclosporine be administered at a dose of 4–5 mg/kg/d (starting dose) in two divided doses. (2C)
- 3.3.4.2: We suggest that tacrolimus 0.1 mg/kg/d (starting dose) given in two divided doses be used instead of cyclosporine when the cosmetic side-effects of cyclosporine are unacceptable. (2D)
- 3.3.4.3: Monitor CNI levels during therapy to limit toxicity. (*Not Graded*)
- 3.3.4.4: We suggest that CNIs be given for at least 12 months, as most children will relapse when CNIs are stopped. (2C)
- 3.3.5: We suggest that MMF be given as a corticosteroid-sparing agent. (2C)
- 3.3.5.1: We suggest that MMF (starting dose 1200 mg/m²/d) be given in two divided doses for at least 12 months, as most children will relapse when MMF is stopped. (2C)
- 3.3.6: We suggest that rituximab be considered only in children with SD SSNS who have continuing frequent relapses despite optimal combinations of prednisone and corticosteroid-sparing agents, and/or who have serious adverse effects of therapy. (2C)
- 3.3.7: We suggest that mizoribine not be used as a corticosteroid-sparing agent in FR and SD SSNS. (2C)
- 3.3.8: We recommend that azathioprine not be used as a corticosteroid-sparing agent in FR and SD SSNS. (1B)

BACKGROUND

About half of the children with SSNS who relapse will have FR or SD SSNS.^{17,18} The long-term prognosis for most children with SSNS is for complete resolution of their disease over time and maintenance of normal kidney function. Therefore limiting the long-term adverse effects of treatment is an important objective. Children with FR or SD SSNS require prolonged corticosteroid therapy, which is associated with significant adverse effects, including impaired linear growth, behavioral changes, obesity, Cushing's syndrome, hypertension, ophthalmological disorders, impaired glucose tolerance, and reduced bone mineral density. Adverse effects may persist into adult life in young people, who continue to relapse after puberty.⁴² To reduce the risk of corticosteroid-related adverse effects, children with FR or SD SSNS may require other agents, including alkylating agents (cyclophosphamide, chlorambucil) and CNI (cyclosporine, tacrolimus). Adverse effects of these agents include increased risk of infection and reduced fertility (alkylating agents)^{42,43} and kidney dysfunction and hypertension (CNI).⁴⁴ CNIs and MMF are much more expensive than the other agents, and this may limit access to them in many countries.

RATIONALE

In children with FR and SD SSNS:

- There is moderate-quality evidence to support the use of alkylating agents (cyclophosphamide, chlorambucil), levamisole, and CNI (cyclosporine, tacrolimus).
- There is low-quality evidence to support the use of mycophenolate mofetil (MMF).
- There is very low-quality evidence to support the efficacy of rituximab.
- There is moderate-quality evidence to demonstrate that mizoribine and azathioprine are not effective.

Children with FR or SD SSNS often continue to relapse into adolescence or adulthood, and require prednisone in variable doses for long periods of time to achieve and maintain remission. Patients successfully treated with corticosteroid-sparing therapy have improved growth rates, reduced body mass index, reduction of Cushingoid features, and improvement in other corticosteroid-related adverse effects.^{45–48} In all cases when contemplating corticosteroid-sparing therapy, the adverse effects of such therapy must be assessed against the benefits, in terms of reducing both the relapse rate and adverse effects of corticosteroids.

Fourteen RCTs in children have compared cyclophosphamide (three trials), chlorambucil (two trials), levamisole (six trials), mizoribine (one trial), and azathioprine (two trials) to placebo, no specific treatment, or prednisone in children with FR and/or SD SSNS. Trials either did not differentiate between FR and SD SSNS, or included only SD SSNS patients. Cyclophosphamide, chlorambucil, and levamisole reduced the risk of relapse during short term follow up (6–12 months) by more than 50% (Table 2). Two RCTs demonstrated no significant differences in the risk of relapse

Table 2 | Meta-analyses of RCTs of corticosteroid-sparing agents in children with FR or SD SSNS

Agent	N of RCTs	N of patients	Risk ratio of relapse (95% CI)	Time of outcome (months)	Relative risk reduction
Cyclophosphamide ^a	3	102	0.44 (0.26,0.73)	6–12	56%
Chlorambucil ^b	2	32	0.13 (0.03,0.57)	12	87%
Levamisole ^{c,d}	5	269	0.43 (0.27,0.68)	4–12	57%
Mizoribine ^e	1	197	Relapse rate ratio ^f 0.81 (0.61, 1.05)	18	Not significant
Azathioprine ^g	2	60	0.90 (0.59,1.38)	6	Not significant

CI, confidence interval; FR, frequently relapsing; RCT, randomized controlled trial; SD, steroid-dependent; SSNS, steroid-sensitive nephrotic syndrome.

^aCyclophosphamide and prednisone vs. prednisone.

^bChlorambucil and prednisone vs. prednisone, or vs. placebo and prednisone.

^cLevamisole and prednisone vs. placebo and prednisone, levamisole and prednisone vs. prednisone, levamisole vs. prednisone, Levamisole vs. no specific therapy.

^dOne trial using much lower dose of levamisole was excluded (see text).

^eMizoribine and prednisone vs. placebo and prednisone.

^fRelapse risk ratio = [Total number of relapses ÷ observation period in treatment group] ÷ [Total number of relapses ÷ observation period in control group].

^gAzathioprine and prednisone vs. placebo and prednisone, azathioprine and prednisone vs. prednisone.

Data from Hodson *et al.*⁴⁹

between cyclosporine and cyclophosphamide, or between cyclosporine and chlorambucil during cyclosporine treatment. RCTs have identified no significant differences in the risk for relapse between levamisole and i.v. cyclophosphamide, and between oral cyclophosphamide and oral chlorambucil.⁴⁹

Alkylating Agents

Alkylating agents (cyclophosphamide, chlorambucil) may result in prolonged remission off all therapy, though they may have significant adverse effects. In RCTs with 6–12 months of follow-up, alkylating agents reduced the risk of relapse compared to prednisone, placebo, or no specific treatment by about 65% (RR 0.34; 95% CI 0.18–0.63)⁴⁹ (Table 2). In a systematic review of observational studies and RCTs, alkylating agents in FR SSNS resulted in remission rates of 72% after 2 years but sustained in only 36% after 5 years. These agents were less effective in SD SSNS with remission rates of 40% and 24% after 2 and 5 years, respectively.⁴³ Patients younger than 3 years at onset of SSNS⁵⁰ and those commencing cyclophosphamide before 3.8 years⁵¹ were less likely to achieve long-term remission with cyclophosphamide, while children aged over 7.5 years were more likely to achieve long-term remission.⁵¹ Eight weeks of cyclophosphamide therapy was significantly more effective in reducing the risk for relapse compared to 2 weeks (Table 3). In SD SSNS patients, there was no significant difference in the risk of relapse between 8 and 12 weeks of cyclophosphamide therapy in one RCT (Table 3). However, the Arbeitsgemeinschaft für Pädiatrische Nephrologie concluded that 12 weeks of cyclophosphamide was more effective compared to historical controls treated for 8 weeks.⁵² Cyclophosphamide is associated with hemorrhagic cystitis but this rarely occurs at the doses used. Nevertheless, where possible, cyclophosphamide should be administered when the child is in remission, with a good urine output, and can receive a high fluid intake. The i.v. route may be considered where nonadherence to therapy is likely. Two RCTs found no significant difference in the risk of relapse between oral and i.v. cyclophosphamide at 12–24 months follow-up. However,

at 6 months, significantly more children treated with monthly pulses of i.v. cyclophosphamide for 6 months were in remission, compared to oral treatment for 8–12 weeks (Table 3; Online Suppl Tables 1–3). Studies have demonstrated the efficacy of chlorambucil at doses of 0.1–0.2 mg/kg/d given for 8 weeks (cumulative dose 11.2 mg/kg) (Table 2). Higher doses did not increase efficacy and resulted in increased risks, particularly of hematological and infectious adverse effects.⁵³

It is suggested that second courses of alkylating agents not be given. Gonadal toxicity with alkylating agents is well documented, with males more affected than females. There is a dose-dependent relationship between the total dose of cyclophosphamide and probability of sperm counts below 10⁶/ml. A “safe” dose of cyclophosphamide remains unclear, but a maximum cumulative dose of 168 mg/kg (2 mg/kg/d for 12 weeks) in boys is below the total dose (>200–300 mg/kg) at which azoospermia has generally been reported.^{43,54} There are fewer data available on chlorambucil, but studies in patients treated for lymphoma found that azoospermia was associated with total doses of 10–17 mg/kg, suggesting that the margin between efficacy and toxicity is narrow for chlorambucil.⁵⁵ Studies have reported a higher risk of malignancy following chlorambucil use compared to cyclophosphamide.⁴³

Levamisole

Five of six RCTs have demonstrated a significant reduction in the risk for relapse during levamisole treatment compared to prednisone, placebo, or no specific treatment⁴⁹ (Table 2). In four of these five RCTs that involved children with FR or SD SSNS, levamisole was given at a dose of 2.5 mg/kg on alternate days. In the sixth trial, a smaller dose (2.5 mg/kg of levamisole on 2 consecutive days per week) did not reduce the risk of relapse compared to placebo.⁵⁶ Most children relapse when levamisole was discontinued. Observational studies have documented a more prolonged reduction in relapse frequency when it is used for 12–24 months.^{57–59} Adverse effects of levamisole are uncommon and minor, with mild leucopenia and gastrointest-

Table 3 | RCTs comparing corticosteroid-sparing agents in FR and SD SSNS

Agents	N of RCTs	N of patients	Risk ratio of relapse (95% CI)	Time of outcome (months)	Conclusion
Cyclophosphamide 8 wk vs. 2 wk	1	29	0.25 (0.07, 0.92)	12	8 wk significantly more effective
Cyclophosphamide 8 wk vs. 12 wk	1	73	0.98 (0.74, 1.28)	24	No significant difference
Cyclophosphamide 8 wk vs. chlorambucil 8 wk	1	50	1.15 (0.69, 1.94)	12	No significant difference
i.v. vs. oral cyclophosphamide	2	83	0.99 (0.76, 1.29)	12–24	No significant difference
Cyclophosphamide vs. cyclosporine	1	55	1.07 (0.48, 2.35)	9	No significant difference during therapy
Chlorambucil vs. cyclosporine	1	40	0.82 (0.44, 1.53)	6	No significant difference during therapy
i.v. cyclophosphamide vs. levamisole	1	40	1.00 (0.7, 1.43)	12	No significant difference
Mycophenolate vs. cyclosporine	1	24	5.0 (0.68, 36.66)	12	No significant difference (small numbers)
Cyclosporine 5 mg/kg vs. 2.5 mg/kg	1	44	Hazard ratio 0.37 (0.18, 0.79)	24	Higher dose significantly more effective

CI, confidence interval; FR, frequently relapsing; RCT, randomized controlled trial; SD, steroid-dependent; SSNS, steroid-sensitive nephrotic syndrome. Data from Hodson *et al.*⁴⁹

inal upsets described. Rare cases of cutaneous vasculitis have been described with levamisole therapy.⁶⁰ Levamisole is unavailable in many countries.

CNIs

Two RCTs have demonstrated no significant differences in the risk of relapse between cyclosporine during treatment and cyclophosphamide or chlorambucil during treatment.^{61,62} However, cyclosporine has a higher relapse rate compared to alkylating agents when assessed at 12–24 months after treatment. An RCT from Japan reported that 50% of 49 children treated with cyclosporine relapsed compared to 70% of 59 children treated with placebo during the 24 weeks of therapy.⁶³ In observational studies, cyclosporine maintains remission in 60–90% of children with SD SSNS, who had relapsed after alkylating-agent therapy.^{64–66} However, in children with SD SSNS due to biopsy-proven MCD, only 40% remained in remission after 2 years of therapy and all relapsed within a median of 26 days when cyclosporine was discontinued.⁶⁵ Most studies have used cyclosporine at 3–6 mg/kg/d in two divided doses targeting 12-hour trough levels of 80–150 ng/ml [67–125 nmol/l] with maintenance of lower levels after a child has been in stable remission for 3–6 months, aiming to minimize cyclosporine nephrotoxicity. In an RCT the sustained remission rate was significantly higher in children maintaining a 12-hour cyclosporine trough level of 60–80 ng/ml [50–67 nmol/l] (mean dose 4.7 mg/kg/d) compared to children treated with 2.5 mg/kg/d (Table 3, Online Suppl Tables 6–7).⁶⁷ Limited data suggest peak (C₂) levels rather than trough (C₀) levels can be used for monitoring.⁶⁸

Tacrolimus has not been studied in RCTs in children with SSNS. Tacrolimus is widely used in North America in children with FR and SD SSNS, because of the cosmetic side effects of cyclosporine. There are few data to support its use, though its efficacy would appear to be similar to that of cyclosporine based on an observational study in SD SSNS.⁶⁹ The tacrolimus dose is adjusted to maintain the 12-hour trough levels in the range of 5–10 ng/ml [6–12 nmol/l] initially based on data from kidney transplant studies.

The principal side-effects of cyclosporine are kidney dysfunction, hypertension, gum hypertrophy, and hypertrichosis. Hypertension and kidney dysfunction are reported in 5–10% of children.^{49,64,66} Hypertrichosis and gum hypertrophy develop in 70% and 30%, respectively, in children treated with cyclosporine for more than 1 year.⁶⁴ Tacrolimus also causes kidney dysfunction and hypertension, but significantly less hypertrichosis; tacrolimus-associated diabetes mellitus has been described in children with nephrotic syndrome.⁷⁰

In children receiving cyclosporine for 12 months or more, tubulointerstitial lesions on kidney biopsy are reported in 30–40% of cases. This increases to 80% after 4 or more years of treatment.⁷¹ Cyclosporine-associated arteriopathy is uncommon. The duration of safe therapy is controversial, with some authors suggesting that CNI therapy should be restricted to 2 years,⁷¹ while others have suggested that longer courses of cyclosporine can be tolerated.⁷²

Coadministration of ketoconazole with cyclosporine in children with SD SSNS resulted in a 48% reduction in mean dose of cyclosporine, equivalent to a net cost saving of 38% with no reduction in efficacy, in a nonrandomized comparator study.⁷³ This approach to therapy has been suggested in order to help offset the costs of this drug class.

MMF

To date, all studies of mycophenolic acid prodrugs in nephrotic syndrome have used MMF. In a small RCT, five of 12 children treated for 1 year with MMF relapsed compared to one of 12 treated with cyclosporine. Although this difference was not statistically significant, the patient numbers were too small to determine the relative efficacies of MMF and cyclosporine (Table 3, Online Suppl Tables 4–5).⁷⁴ GFR remained stable during MMF treatment but fell during cyclosporine treatment. In a prospective study of 33 children (26 with FR SSNS) treated with MMF for 6 months, 24 (75%) children remained in remission during therapy, with 12 remaining relapse-free for 6 months after the drug was ceased; eight of these 12 patients continued in remission during 18–30 months of follow-up.⁷⁵ In a retrospective study

Table 4 | Advantages and disadvantages of corticosteroid-sparing agents as first agent for use in FR or SD SSNS

Agent	Advantages	Disadvantages
Cyclophosphamide	Prolonged remission off therapy Inexpensive	Less effective in SD SSNS Monitoring of blood count during therapy Potential serious short- and long-term adverse effects Only one course should be given
Chlorambucil	Prolonged remission off therapy Inexpensive	Less effective in SD SSNS Monitoring of blood count during therapy Potential serious adverse effects Only one course should be given Not approved for SSNS in some countries
Levamisole	Few adverse effects Generally inexpensive	Continued treatment required to maintain remission Limited availability Not approved for SSNS in some countries
Cyclosporine	Prolonged remissions in some children with SD SSNS	Continued treatment often required to maintain remission Expensive Nephrotoxic Cosmetic side-effects
Tacrolimus	Prolonged remissions in some children with SD SSNS	Continued treatment often required to maintain remission Expensive Nephrotoxic Risk of diabetes mellitus Not approved for SSNS in some countries
Mycophenolate mofetil	Prolonged remissions in some children with FR and SD SSNS Few adverse effects	Continued treatment often required to maintain remission Probably less effective than CNIs Expensive Not approved for SSNS in some countries

FR, frequently relapsing; SD, steroid-dependent; SSNS, steroid-sensitive nephrotic syndrome.

of SD SSNS in 42 children, who were treated for at least 6 months, mean reduction in relapse rate was 3.8 per year.⁷⁶ MMF was generally well tolerated, with small numbers of children developing leucopenia and abdominal pain. In observational studies, MMF has been used for up to 45 months and has been well tolerated.⁷⁶ In most studies, MMF has been given in a dose of 1200 mg/m²/d or about 30 mg/kg/d in two divided doses. MMF has been used with cyclosporine in children with poorly controlled SD SSNS and has allowed reduction in cyclosporine dose.⁷⁷ Mycophenolate sodium may be an alternative if MMF is not tolerated because of adverse effects, but there are no data to support its use in nephrotic syndrome. In pediatric kidney transplant patients on cyclosporine, a single-dose pharmacokinetic study has demonstrated that 450 mg/m² mycophenolate sodium and 600 mg/m² of MMF provide similar mycophenolic acid exposure.⁷⁸ Recruitment has commenced for an RCT comparing MMF to cyclophosphamide (ClinicalTrials.gov identifier NCT01092962).

Choice of First Agent for FR or SD SSNS

There are no data from RCTs to determine which corticosteroid-sparing agent should be used as the first agent in a child with FR or SD SSNS. In Table 4, the advantages and disadvantages of alkylating agents, levamisole, CNIs, and MMF are presented. This table should help in the decision-making of the clinician and families in determining which agent a child with FR or SD SSNS should receive as their first corticosteroid-sparing agent.

Rituximab in SD SSNS

The place of rituximab in treatment of SD SSNS remains to be established. A single open-labeled RCT enrolling 54 children with SD SSNS dependent on prednisone and CNIs found that rituximab reduced the rate of relapse at 3 months significantly (18.5% and 48.1% in experimental and control arms, respectively) and increased the probability of being free of prednisone and CNI treatment.⁷⁹ These data confirm the results of case series that have reported prolonged remissions in 80% of children following rituximab, an anti CD20 monoclonal antibody, with doses of 375 mg/m² per dose given for up to four weekly doses.^{80,81} Rituximab caused acute reactions, such as fever, vomiting and diarrhea, skin rash, and bronchospasm in about one-third of patients in one series.⁸¹ Other reported serious side effects include *Pneumocystis jiroveci* pneumonia and pulmonary fibrosis.^{80,82} Patient recruitment has commenced for an RCT comparing rituximab to placebo in cyclosporine-dependent SD SSNS (ClinicalTrials.gov identifier NCT 01268033).

Other Medications

Mizoribine is widely used as a corticosteroid-sparing agent in Japan. A single RCT (197 patients) demonstrated that the relapse rate (measured as the ratio of the total number of relapses/duration of observation in the mizoribine-treated group and placebo group) did not differ significantly between treatment and placebo groups (relapse-rate ratio 0.81; 95% CI 0.61–1.05)⁶³ (Table 2).

It is recommended that azathioprine not be used as a corticosteroid-sparing agent in FR and SD SSNS, since two RCTs have demonstrated no significant difference in the risk of relapse between azathioprine and placebo (RR 0.90; 95% CI 0.59–1.38)⁴⁹ (Table 2).

3.4: Indication for kidney biopsy

3.4.1: Indications for kidney biopsy in children with SSNS are (Not Graded):

- late failure to respond following initial response to corticosteroids;
- a high index of suspicion for a different underlying pathology;
- decreasing kidney function in children receiving CNIs.

RATIONALE

Kidney biopsy is indicated in children with nephrotic syndrome who fail to respond to corticosteroids after one or more remissions (late nonresponder) to determine kidney pathology. There is no fixed upper age limit for treating children with nephrotic syndrome without prior kidney biopsy, particularly in Northern Europe and India where 40–50% adolescents have MCD.^{14,83,84} However, in populations with a much higher prevalence of FSGS and other pathologies, particularly African or African-American populations, it is reasonable to consider biopsy at the time of onset of nephrotic syndrome diagnosis before treatment.⁸⁵ While it is sometimes recommended that children with SSNS should undergo annual kidney biopsy if CNI therapy is continued beyond 2 years,⁷¹ there are no data to determine whether the benefits of regular biopsies exceed the harm. Biopsies should be considered in children with deteriorating kidney function, when this persists after CNI doses are reduced. Routine biopsies of children with FR or SD SSNS before using corticosteroid-sparing therapy are not indicated. Studies show that the most important predictor for kidney survival in childhood nephrotic syndrome is not kidney pathology, but the achievement and maintenance of remission following any therapy.⁸⁶

3.5: Immunizations in children with SSNS

3.5.1: To reduce the risk of serious infections in children with SSNS (Not Graded):

- Give pneumococcal vaccination to the children.
- Give influenza vaccination annually to the children and their household contacts.
- Defer vaccination with live vaccines until prednisone dose is below either 1 mg/kg daily (<20 mg/d) or 2 mg/kg on alternate days (<40 mg on alternate days).
- Live vaccines are contraindicated in children receiving corticosteroid-sparing immunosuppressive agents.

- Immunize healthy household contacts with live vaccines to minimize the risk of transfer of infection to the immunosuppressed child but avoid direct exposure of the child to gastrointestinal, urinary, or respiratory secretions of vaccinated contacts for 3–6 weeks after vaccination.
- Following close contact with Varicella infection, give nonimmune children on immunosuppressive agents varicella zoster immune globulin, if available.

RATIONALE

Children with nephrotic syndrome are at increased risk of invasive pneumococcal disease⁸⁷ and should receive pneumococcal immunization with the heptavalent conjugate vaccine (7vPCV) and the 23-valent polysaccharide vaccine (23vPPV) according to local recommendations for initial immunization and repeat immunization. Adequacy of response to the 7vPCV vaccine has not been studied in children with nephrotic syndrome. Serological response to 23vPPV was not different in children with active nephrotic syndrome on high-dose prednisone (60 mg/m²/d) compared to children who received the vaccine while on low-dose alternate day prednisone.⁸⁸ In most patients, antibody levels persisted for at least 36 months.⁸⁹ Children with SSNS and their household contacts should receive annual influenza vaccination.^{90,91}

Live Vaccines

Live vaccines (measles, mumps, rubella, varicella, rotavirus) are contraindicated in children on immunosuppressive or cytotoxic agents^{90,91} and should be deferred until:

- Prednisone dose is below 1 mg/kg/d (below 20 mg/d) or below 2 mg/kg on alternate days (below 40 mg on alternate days).
- The child has been off cytotoxic agents (cyclophosphamide, chlorambucil) for more than 3 months.
- The child has been off other immunosuppressive agents (CNIs, levarimazole, MMF) for more than 1 month.

Healthy siblings and household contacts of children with impaired immunity should be vaccinated with measles, mumps, rubella, varicella, and rotavirus vaccines (where indicated) to prevent them from infecting children with impaired immunity.⁹⁰ However, immunosuppressed children should avoid direct exposure to gastrointestinal, urinary, or respiratory secretions of vaccinated contacts for 3–6 weeks after vaccination.

Varicella Immunization

Varicella infection may lead to life-threatening disease in children receiving immunosuppressive medications. Varicella immunization is safe and effective in children with nephrotic

syndrome, including children on low-dose alternate-day prednisone.¹²

- Children with SSNS, who are not receiving immunosuppressive or cytotoxic agents other than low-dose daily or alternate-day prednisone, should be offered varicella immunization if nonimmune.^{90,91}
- Families of nonimmune children with SSNS, who are receiving immunosuppressive agents, should be asked to contact their physician as soon as possible if the child comes into close contact with another child with chicken pox, or an adult with herpes zoster, so that the child can receive zoster immune globulin (if available) within 72 hours of exposure.⁹⁰
- Aciclovir or valaciclovir should be administered to immunosuppressed children at the onset of chicken pox lesions.

RESEARCH RECOMMENDATIONS

Further information from RCTs is required:

- To determine the relative efficacies of alkylating agents, levamisole, MMF, CNIs in FR and SD SSNS.
- To determine the relative benefits and adverse effects of cyclosporine and tacrolimus in FR and SD SSNS.
- To determine the additional benefits and risks of mycophenolic acid when added to CNIs in SD SSNS.
- To determine the additional benefits and risks of rituximab in comparison or in addition to other corticosteroid-sparing agents in SD SSNS.

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SUPPLEMENTARY MATERIAL

Supplementary Table 1: Evidence profile of studies examining IV vs. p.o. Cyc treatment in children with frequently relapsing nephrotic syndrome.

Supplementary Table 2: Existing systematic review on IV vs. p.o. Cyc treatment in children with frequently relapsing nephrotic syndrome.

Supplementary Table 3: Summary tables of studies examining IV vs. p.o. Cyc treatment in children with frequently relapsing nephrotic syndrome (categorical outcomes).

Supplementary Table 4: Summary table of RCT examining MMF vs. CsA in frequently relapsing nephrotic syndrome in children (categorical outcomes).

Supplementary Table 5: Summary table of RCT examining MMF vs. CsA in frequently relapsing nephrotic syndrome in children (continuous outcomes).

Supplementary Table 6: Summary table of RCT examining low vs. fixed dose CsA treatment in children with frequently relapsing nephrotic syndrome (categorical outcomes).

Supplementary Table 7: Summary table of RCT examining low vs. fixed dose CsA treatment in children with frequently relapsing nephrotic syndrome (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 4: Steroid-resistant nephrotic syndrome in children

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INTRODUCTION

This chapter makes treatment recommendations for children aged 1 to 18 years with nephrotic syndrome, who do not achieve a complete remission with corticosteroid therapy, i.e., SRNS. This chapter does not apply to children with SRNS under 1 year of age, nor to SRNS due to histologic patterns of glomerular injury other than MCD, MPGN, or FSGS. The cost implications for global application of this guideline are addressed in Chapter 2.

4.1: Evaluation of children with SRNS

4.1.1: We suggest a minimum of 8 weeks treatment with corticosteroids to define steroid resistance. (2D)

4.1.2: The following are required to evaluate the child with SRNS (Not Graded):

- a diagnostic kidney biopsy;
- evaluation of kidney function by GFR or eGFR;
- quantitation of urine protein excretion.

BACKGROUND

SRNS generally, and FSGS specifically, is associated with a 50% risk for ESRD within 5 years of diagnosis if patients do not achieve a partial or complete remission.⁸⁶ Persistent nephrotic syndrome is associated with poor patient-reported quality of life, thromboembolic events, hypertension, peritonitis and other serious infections, persistent dyslipidemia, and death.^{92–95} Children reaching ESRD have a greatly reduced life expectancy, 19 years on average following initiation of dialysis, and approximately 40 years following transplantation.⁹⁶

The cumulative burden of ongoing disease-related complications must be measured against potential medication-associated toxicities due to corticosteroids and other immunosuppressive agents. These issues are discussed in Chapter 3, SSNS and in Chapter 1, Introduction.

The potential benefit of therapy includes disease cure, control of nephrotic syndrome, and/or or slowing the progression to ESRD. There are times when the nephrologist, with the child's family or caregivers, will have to accept that a point of futility has been reached, characterized by unremitting and progressive loss of kidney function, resistance to multiple drug therapies, or concern for cumulative drug-associated toxicities.

RATIONALE

- Management of children with SRNS requires confirmation of resistance to corticosteroids, usually defined by unresponsiveness to oral prednisone or prednisolone* for a minimum of 8 weeks.
- Kidney biopsy is necessary to exclude secondary causes of nephrotic syndrome, and assess the extent of interstitial and glomerular fibrosis.
- Kidney function, measured by eGFR, at presentation and its deterioration over time is associated with the long-term risk for kidney failure.
- Quantification of proteinuria is essential, since this provides the comparison for subsequent treatment responsiveness.

*Prednisone and prednisolone are equivalent, used in the same dosage, and have both been used in RCTs depending on the country of origin. All later references to prednisone in this chapter refer to prednisone or prednisolone. All later references to oral corticosteroids refer to prednisone or prednisolone.

Steroid Resistance

The minimum requirement of corticosteroid exposure to define resistance remains unclear. Variations in the definition of SRNS create difficulties in comparing therapeutic trials. Based upon the International Study of Kidney Disease in Children (ISKDC), 95% of children with SSNS will demonstrate resolution of proteinuria with 4 weeks of daily corticosteroid therapy and 100% after an additional 3 weeks of alternate-day therapy.²⁷ Subsequent studies have reported additional remissions after an extended exposure to steroids in low-dose prednisone control arms within RCTs and after high doses of i.v. or oral corticosteroids in observational studies.^{97,98} It is not clear if these late responses are due to the extended corticosteroid exposure, a late effect of prior therapy, or natural history of the disease. Consequently, we have elected to utilize one of the commonly used definitions of resistance, i.e., a minimum exposure of 8 weeks of prednisone 2 mg/kg/d or 60 mg/m²/d for 4 weeks followed by 1.5 mg/kg or 40 mg/m² per dose alternate-day for 4 weeks.⁹⁹ At this point, steroid resistance dictates the requirement for kidney biopsy to define the histopathology. Steroids may be continued for an additional 4 weeks, totaling 12 weeks, while awaiting histopathology results.

Kidney Biopsy

A kidney biopsy in the evaluation of SRNS is recommended. This evaluation—including light microscopy,

immunofluorescence, and electron microscopy—may indicate disorders that also result in the clinical features of the nephrotic syndrome, e.g., immunoglobulin A nephropathy (IgAN) or LN. The therapy is subsequently dictated by the underlying diagnosis. (See Chapters 10 and 12 for IgAN and LN, respectively.) Alternately, it may show pathologic lesions of FSGS or, despite steroid resistance, still show MCD. In Chapter 2 it was noted that 20 glomeruli are needed in a biopsy to confidently exclude lesions that are affecting only 5% of them; hence, there is a possibility of missing an FSGS lesion in many routine biopsies containing fewer than this number. The kidney biopsy will also provide information regarding the degree of interstitial and glomerular fibrosis, which will be utilized in the assessment of prognosis of children with SRNS. Results of the biopsy are also often used to explain to both patient and family why there has not been a response to therapy, and that the prognosis is likely to be substantially altered from the initial one.

Laboratory Assessment

Kidney function should be measured at the time a diagnosis of SRNS is made to inform prognosis and assessment of response to subsequent therapy. Despite the inaccuracies in eGFR determination in the presence of nephrotic syndrome, kidney function at the time of diagnosis is a predictor of the long-term risk for kidney failure. Proteinuria should be quantified by uPCR to allow subsequent treatment response to be defined as partial, complete, or no remission (Table 1, Chapter 3).^{86,100–103} The uPCR should be measured in a first morning void to prevent variation based upon orthostatic effects.¹⁰⁴ Measurements of 24-hour urine protein may also be used but such collections are impractical in young children who are not toilet-trained. Observational studies of patients with FSGS demonstrate a 5-year kidney survival of 90% in patients with a complete remission following any single or combination of tested therapies.^{86,103} Partial remission has been associated with an intermediate 5-year kidney survival of 80% in adults, although these data are not available for children.¹⁰³ Absence of remission predicts a 5-year kidney survival of approximately 50%.^{86,100,103}

Many genetic mutations have been identified in subjects with SRNS and FSGS. In children with SRNS over 1 year of age, podocin mutations have been reported in 0–30%. The significant variation in the prevalence of SRNS-associated mutations is exemplified by the absence of podocin mutations in an African-American cohort of 18 children with FSGS¹⁰⁵ and the findings of a 28% prevalence of podocin mutations in a European cohort of 25 children published by the same group of investigators.¹⁰⁶ Routine evaluation for genetic mutations is not recommended in this guideline due to the variable availability of genetic testing, significant cost, low to absent prevalence observed in some populations, and the lack of systematic studies of treatment response and prognosis relative to specific genetic polymorphisms.

4.2: Treatment recommendations for SRNS

4.2.1: We recommend using a calcineurin inhibitor (CNI) as initial therapy for children with SRNS. (1B)

4.2.1.1: We suggest that CNI therapy be continued for a minimum of 6 months and then stopped if a partial or complete remission of proteinuria is not achieved. (2C)

4.2.1.2: We suggest CNIs be continued for a minimum of 12 months when at least a partial remission is achieved by 6 months. (2C)

4.2.1.3: We suggest that low-dose corticosteroid therapy be combined with CNI therapy. (2D)

4.2.2: We recommend treatment with ACE-I or ARBs for children with SRNS. (1B)

4.2.3: In children who fail to achieve remission with CNI therapy:

4.2.3.1: We suggest that mycophenolate mofetil (2D), high-dose corticosteroids (2D), or a combination of these agents (2D) be considered in children who fail to achieve complete or partial remission with CNIs and corticosteroids.

4.2.3.2: We suggest that cyclophosphamide not be given to children with SRNS. (2B)

4.2.4: In patients with a relapse of nephrotic syndrome after complete remission, we suggest that therapy be restarted using any one of the following options: (2C)

- oral corticosteroids (2D);
- return to previous successful immunosuppressive agent (2D);
- an alternative immunosuppressive agent to minimize potential cumulative toxicity (2D).

BACKGROUND

The risk for kidney failure in patients with persistent nephrotic syndrome provides the rationale for utilizing an alternate therapy once steroid resistance has been established.

Both cyclosporine and corticosteroids have a direct effect on the podocyte cytoskeleton,¹⁰⁷ in addition to their immunomodulating properties, indicating these agents may have multiple beneficial mechanisms of action in nephrotic syndrome.

RATIONALE

- There is moderate-quality evidence that cyclosporine induces complete or partial remission in a majority of children with SRNS.
- There is low-quality evidence that tacrolimus has a similar impact on proteinuria control and may improve adherence to treatment, based upon lower risk for hypertrichosis and gingival hyperplasia compared to cyclosporine.

- There is moderate-quality evidence that treatment with renin-angiotensin system (RAS) blockade is associated with a reduction in proteinuria.
- The risk for kidney failure is significantly greater for patients who fail to achieve a partial or complete remission with any single or combination therapy.

CNI Therapy

Cyclosporine has been most widely studied for treatment of SRNS. In three RCTs with 49 patients, 26 treated with cyclosporine and 23 with placebo or control therapy^{108–110} (Table 5), cyclosporine resulted in a complete remission in 31% and partial remission in 38% during 6 months of therapy. The 69% cumulative complete and partial remission was significantly better than the 0–16% remission in the control arms of these randomized studies. In a single RCT of 138 children and adults comparing cyclosporine ($N=72$) to mycophenolate combined with high-dose oral dexamethasone ($N=66$), cyclosporine resulted in a 19.4% complete remission and 26.4% partial remission during 12 months of therapy.¹¹¹ Based upon case series, complete and partial remissions are less common in the presence of nephrotic syndrome associated with podocin mutations. However, remissions have been reported, and suggest that a trial of CNI therapy may induce at least a partial remission even in these patients.¹¹²

Tacrolimus has been compared to cyclosporine in one study with 41 total participants¹¹³ and showed no significant difference in control of proteinuria. In this trial, the frequency of nephrotoxicity, hypertension, and diabetes mellitus were not different between cyclosporine and tacrolimus. The only difference in these agents was in the side-effect profile of hypertrichosis (95% vs. 0%, $P < 0.001$) and gingival hyperplasia (60% vs. 5%, $P < 0.001$) cyclosporine vs. tacrolimus, respectively, which may significantly impact adherence to treatment recommendations.

The optimal duration of CNI therapy is unknown. Published RCTs in children have utilized 6- and 12-month treatment phases. Reduction in proteinuria has been documented to occur in 4.4 ± 1.8 weeks,¹⁰⁹ with median times to complete and partial remission of 8 and 12 weeks.¹¹³ Relapse

in up to 70% of those responding to CNI therapy has been documented after discontinuation of 6- and 12-month courses of therapy. Extension of therapy beyond 12 months to prevent relapse is common practice; however, the impact of this approach on relapse risk, long-term kidney function, and risk for nephrotoxicity has not been established. Drug level monitoring is common but optimal levels are unknown for SRNS.

No studies have evaluated cyclosporine alone vs. cyclosporine with low-dose prednisone. Consequently, the necessity of corticosteroids as an adjunct to CNI for SRNS is unknown. A low-dose corticosteroid is recommended here to be consistent with the majority of clinical trials. Tapering of the dose to the lowest level that maintains remission is recommended.

The impact of podocyte-altering genetic polymorphisms on response to immunomodulating therapy has been reported in small genetic SRNS cohort studies with response ranging from 7% to 80% of cohorts (ranging between 4 and 34 subjects).¹¹² No RCTs of SRNS have evaluated the impact of underlying genetic polymorphisms.¹¹⁴

RAS Blockade

RAS blockade in addition to CNI therapy is recommended to reduce proteinuria in SRNS. Two RCTs demonstrated a reduction in proteinuria with ACE-I therapy using enalapril¹¹⁵ and fosinopril.¹¹⁶ A dose-response reduction of proteinuria has been observed: a 33% reduction in proteinuria with a 0.2 mg/kg dose of enalapril, and a 52% reduction in proteinuria with a 0.6 mg/kg dose of enalapril.¹¹⁵

Epidemiologic evidence from retrospective cohort studies in adults and children with FSGS^{99,103} has demonstrated the risk for kidney failure is significantly greater for patients who fail to achieve a partial or complete remission of proteinuria. There are only two published RCTs that provide evidence of the combination of cyclosporine and RAS blockade in SRNS.

ALTERNATIVE THERAPIES TO CNIs

High-dose corticosteroids. There is very low-quality evidence that extended courses of oral or i.v. corticosteroids, following a traditional initial steroid regimen, may increase

Table 5 | CNI trials in SRNS

Author	N	Intervention	Control	Treatment duration (months)	Remission: complete or partial	RR for remission	Conclusion
Lieberman 1996 ¹⁰⁹	24	Cyclosporine	Placebo	6	12 (100%) vs. 2 (17%)	5.48 (1.95–15.44)	Remission cyclosporine > placebo
Ponticelli 1993 ¹¹⁰	17 ^a	Cyclosporine	Supportive therapy	12 ^b	6 (60%) vs. 0 (0%)	9.45 (0.62–1.51)	Remission cyclosporine > control
Garin 1988 ¹⁰⁸	8	Cyclosporine	None	2	0 (0%) vs. 0 (0%)	0 (0.0–0.0)	No significant difference
Choudhry 2009 ¹¹³	41	Tacrolimus + prednisone	Cyclosporine + prednisone	12	18 (86%) vs. 15 (75%)	1.14 (0.84–1.55)	No significant difference
Gipson 2011 ¹¹¹	138	Cyclosporine	MMF + Dexamethasone	12	33 (45.8%) vs. 22 (33%)	1.35 (0.90–2.10)	No significant difference

CNI, calcineurin inhibitor; SRNS, steroid-resistant nephrotic syndrome; RR, relative risk.

^aChildren.

^bSix months full dose followed by taper 25% every 2 months.

Table 6 | Remission in corticosteroid-treated control arms of SRNS randomized trials

Trial	Treatment	Remission outcome	Events	Total N	Response (%)
ISKDC 1974 ⁹⁷	Prednisone	Complete	6	13	46.2
Tarshish 1996 ⁹⁸	Prednisone	Complete or partial	12	21	57.1
Prednisone response		Complete or partial	18	34	52.9
Lieberman 1996 ¹⁰⁹	Placebo	Partial	2	12	16.7
Ponticelli 1993 ¹¹⁰	No Steroids	Complete or partial	0	7	0.0
Garin 1988 ¹⁰⁸	Placebo	Complete	0	4	0.0
No prednisone response		Complete or partial	2	23	8.7

ISKDC, International Study of Kidney Disease in Children; SRNS, steroid-resistant nephrotic syndrome.

Table 7 | Cytotoxic therapy in SRNS

Author	N	Intervention	Control	Remission complete or partial	RR for remission	Conclusion
ISKDC 1974 ⁹⁷	31	Cyclophosphamide p.o. + prednisone 3 mo	Prednisone 3 mo	10 (56%) vs. 6 (46%)	1.20 (0.59–2.47)	ND
Tarshish 1996 ⁹⁸	53	Cyclophosphamide po x 3 mo + prednisone 12 mo q.o.d.	Prednisone 12 mo q.o.d.	16 (50%) vs. 12 (57%)	0.88 (0.53–1.45)	ND

ISKDC, International Study of Kidney Disease in Children; ND, not determined; p.o., orally; q.o.d., every other day; SRNS, steroid-resistant nephrotic syndrome.

the likelihood of remission. In one study, children with SRNS, defined as resistant to 4 weeks daily and 4 weeks alternate day prednisone, received i.v. corticosteroids (methylprednisolone or dexamethasone) for 6 doses combined with oral prednisone, and the short-term outcome was assessed at the end of a 2-week regimen. Because only a minority of those randomized to methylprednisolone actually received that agent, the study is of very low quality. The remaining patients were treated with dexamethasone. Of the 81 subjects treated, 78 were evaluated in the results. The corticosteroid pulse therapy induced a 34% complete remission and 13% partial remission with no significant difference between methylprednisolone and dexamethasone treatment groups.¹¹⁷ The remission response rates from low-dose corticosteroids in small randomized studies in SRNS are summarized in Table 6, and suggest that up to 53% of patients with SRNS achieve remission with extended steroid therapy; 0–17% (mean 8%) achieve remission with no additional therapy.

MMF. A single RCT evaluated MMF in combination with oral dexamethasone vs. cyclosporine. Patients in the MMF arm of this trial had a 33% combined complete and partial remission rate with 12 months of therapy. The study did not demonstrate a significant difference between the treatment arms (see Table 5).¹¹¹ Similarly, observational studies involving children with SRNS who were treated for a minimum of 6 months with mycophenolate demonstrated a complete remission rate from 23% to 62%, a partial remission rate of 25% to 37% and no remission in 8% to 40%.^{116,118}

Cytotoxic agents. There is moderate evidence to suggest that cytotoxic agents in children with SRNS should not be

used, based upon two randomized controlled trials that show no evidence of benefit of these agents combined with prednisone, compared to corticosteroids alone. The evidence is of moderate quality due to the small sample size (Table 7).^{97,98} In the ISKDC trial, there was no significant difference in achieving a complete remission with cyclophosphamide therapy plus corticosteroids compared to corticosteroids alone with 10/18 vs. 6/13 achieving complete remission in the combined-therapy group vs. corticosteroids alone group and an increase in adverse events.¹¹⁹ Although imprecision may affect this risk estimate, the RR and CI are centered around 1. In the Tarshish trial comparing cyclophosphamide plus corticosteroids vs. corticosteroids alone, there was also no evidence of benefit with the addition of cyclophosphamide, i.e., 16/32 with combination vs. 12/21 monotherapy ($P = \text{NS}$). One additional randomized trial compared cyclophosphamide ($N = 17$) to cyclosporine ($N = 15$). The study was halted at week 12 according to predefined stopping rules, due to the significant difference between the combined complete and partial remission rates of 60% in cyclosporine group and 17% in the cyclophosphamide group ($P < 0.05$).¹²⁰ At the present time, the potential harm from cytotoxic agents—including serious infections, increased risk for late onset malignancy, reduced fertility, hemorrhagic cystitis, and alopecia—far exceeds any evidence of benefit (Online Suppl Table 14).⁴³

Rituximab. Rituximab is not recommended as a treatment option for SRNS due to the lack of RCTs and risk for serious adverse events, which may persist long after the discontinuation of the therapy.⁸² Although this may be a promising agent, prospective randomized studies are required.

Relapsing Disease

In SRNS patients with relapse after complete remission, we suggest that immunosuppressant therapy be reinstated. This recommendation is based upon the concern that uncontrolled SRNS is likely to lead both to complications from the persistent nephrotic state as well as a high risk for kidney failure. We have no evidence in the literature to support a specific treatment choice. Options are provided without prioritization, and include oral corticosteroids, a return to the previously effective immunosuppressant agent, or the selection of an alternate immunosuppressant agent to avoid potential toxicity. Assessment of risk vs. benefit needs reassessment and becomes more relevant with each relapse.

RESEARCH RECOMMENDATIONS

- RCTs are needed in resistant nephrotic syndrome comparing CNIs to alternate immunosuppressive and nonimmunosuppressive agents.
- Investigation of treatment options is needed for patients with nephrotic syndrome associated with genetic mutations.
- RCTs are needed examining rituximab therapy for SRNS.

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every effort is made to ensure that drug doses and other quantities are presented accurately, readers are advised that new methods and techniques involving drug usage, and described within this Journal, should only be followed in conjunction with the drug manufacturer's own published literature.

SUPPLEMENTARY MATERIAL

Supplementary Table 8: Evidence profile of RCTs examining CsA vs. placebo in steroid-resistant nephrotic syndrome in children.

Supplementary Table 9: Meta-analyses and systematic reviews on steroid-resistant nephrotic syndrome in children.

Supplementary Table 10: Evidence profile of studies examining CsA vs. Cyc treatment in children with steroid-resistant nephrotic syndrome.

Supplementary Table 11: Summary table of studies examining CsA vs. Cyc treatment in children with steroid-resistant nephrotic syndrome (categorical outcomes).

Supplementary Table 12: Evidence profile of RCTs examining ACE-I treatment for steroid-resistant nephrotic syndrome in children.

Supplementary Table 13: Summary table of RCTs examining ACE treatment for steroid-resistant nephrotic syndrome in children (continuous outcomes).

Supplementary Table 14: Evidence profile of studies examining p.o. Cyc plus steroid vs. steroid in steroid-resistant nephrotic syndrome and/or FSGS in children.

Supplementary Table 15: Summary table of studies examining p.o. Cyc plus steroid vs. steroid in children with SRNS or FSGS (categorical outcomes).

Supplementary Table 16: Summary table of studies examining p.o. Cyc plus steroid vs. steroid in children with SRNS or FSGS (continuous outcomes).

Supplementary Table 17: Summary table RCTs examining IV vs. p.o. Cyc treatment in children with steroid-resistant nephrotic syndrome (continuous outcomes).

Supplementary Table 18: Summary table of RCT examining TAC vs. CsA treatment in children with steroid-resistant nephrotic syndrome (categorical outcomes).

Supplementary Table 19: Summary table of RCT examining TAC vs. CsA treatment in children with steroid-resistant nephrotic syndrome (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 5: Minimal-change disease in adults

Kidney International Supplements (2012) **2**, 177–180; doi:10.1038/kisup.2012.18

INTRODUCTION

This chapter makes treatment recommendations for adults with MCD. The cost implications for global application of this guideline are addressed in Chapter 2.

5.1: Treatment of initial episode of adult MCD

- 5.1.1: We recommend that corticosteroids be given for initial treatment of nephrotic syndrome. (1C)
- 5.1.2: We suggest prednisone or prednisolone* be given at a daily single dose of 1 mg/kg (maximum 80 mg) or alternate-day single dose of 2 mg/kg (maximum 120 mg). (2C)
- 5.1.3: We suggest the initial high dose of corticosteroids, if tolerated, be maintained for a minimum period of 4 weeks if complete remission is achieved, and for a maximum period of 16 weeks if complete remission is not achieved. (2C)
- 5.1.4: In patients who remit, we suggest that corticosteroids be tapered slowly over a total period of up to 6 months after achieving remission. (2D)
- 5.1.5: For patients with relative contraindications or intolerance to high-dose corticosteroids (e.g., uncontrolled diabetes, psychiatric conditions, severe osteoporosis), we suggest oral cyclophosphamide or CNIs as discussed in frequently relapsing MCD. (2D)
- 5.1.6: We suggest using the same initial dose and duration of corticosteroids for infrequent relapses as in Recommendations 5.1.2, 5.1.3, and 5.1.4. (2D)

*Prednisone and prednisolone are equivalent, used in the same dosage, and have both been used in RCTs depending on the country of origin. All later references to prednisone in this chapter refer to prednisone or prednisolone. All later references to oral corticosteroids refer to prednisone or prednisolone.

BACKGROUND

MCD refers to the occurrence of nephrotic syndrome with no glomerular lesions by light microscopy (or only minimal mesangial prominence), no staining on immunofluorescence microscopy (or low-intensity staining for C3 and IgM), and foot process effacement but no electron-dense deposits on electron microscopy.¹²¹

Although spontaneous remission can occur in MCD,^{122–125} untreated nephrotic syndrome is associated with significant

morbidity due to accelerated atherosclerosis, in part due to dyslipidemia,¹²⁶ infections,^{125,127} and thromboembolic events.¹²⁸ Therefore, specific treatment should be given with the goal of achieving remission. The cornerstone of treatment has been corticosteroids. MCD in children is exquisitely sensitive to corticosteroids; however, adults tend to respond more slowly, with responses occurring as late as 3–4 months after starting therapy. The response to corticosteroids is also less predictable in adults, as only about 75% of adults with MCD are steroid-responsive (Table 8). Also, in contrast to children, there is a paucity of well-designed RCTs investigating the treatment of MCD in adults.

Although AKI is common in adults with MCD (up to 20–25%),^{129,130} progressive CKD is not part of the natural history of adults with MCD, and its occurrence suggests underlying FSGS.

More than half of adult MCD patients will experience relapses, and up to a third of patients may become frequent relapsers or corticosteroid-dependent.^{130–133} Furthermore, a 40% relapse rate has been reported in adults who had MCD as children,¹⁶ and these patients continue to relapse. Secondary etiologies associated with MCD are uncommon, but should be considered. They include Hodgkin's disease, lithium therapy, and nonsteroidal anti-inflammatory drugs.¹³⁴

Corticosteroids are generally well-tolerated, but drug-related adverse effects are common with prolonged/repeated courses in SD or FR patients.

Disease Definitions

Definitions of proteinuria outcomes are as listed in Table 10, Chapter 6. Partial remissions in proteinuria are not seen in MCD.

RATIONALE

- There is only low-quality evidence to recommend corticosteroids in the treatment of adult MCD. This recommendation is based largely on extrapolation from RCTs in children, as well as small RCTs and observational studies in adults.
- There is only low-quality evidence to define the optimal dose and duration of corticosteroids in adults, but a high dose until remission is achieved followed by a slow taper to minimize relapse is usually prescribed.
- There is very low-quality evidence suggesting that alternate-day is equivalent to daily corticosteroids in adult MCD.
- MCD in adults may take a longer time to remit compared to MCD in children.

Table 8 | Dosage regimens in MCD

Drug and dosing scheme
Initial treatment
Prednisone
Daily single dose of 1 mg/kg (maximum 80 mg) or alternate-day single dose of 2 mg/kg (maximum 120 mg)
–until complete remission (minimum 4 weeks to a maximum of 16 weeks)
–after complete remission, tapered slowly over 6 months
FR or SD MCD
1. Cyclophosphamide (oral) single course 2–2.5 mg/kg/d as tolerated for 8 weeks
2. Relapsed despite cyclophosphamide, or patients of childbearing age
a. Cyclosporine starting dose 3–5 mg/kg/d (in two equally divided doses)
b. Tacrolimus 0.05–0.1 mg/kg/d (in two equally divided doses) Following 3 months of stable remission, tapered to reach the minimum dosage that maintains remission, for 1–2 years
3. Intolerant to corticosteroids, cyclophosphamide, and/or CNIs
a. Mycophenolate mofetil 500–1000 mg twice daily for 1–2 years

FR, frequently relapsing; MCD, minimal-change disease; SD, steroid-dependent.

Corticosteroids have been studied in several large prospective RCTs in children^{99,135} and observational studies in children and adults.^{129–133} In a very early multicenter controlled study of corticosteroids compared to no treatment in 125 nephrotic adults (including 31 MCD patients defined by light microscopy alone), those treated with at least 20 mg/d prednisone for at least 6 months showed an early and rapid decrease in proteinuria compared to the control group. However, by two and a half years, there was no difference in proteinuria or serum albumin in the two groups.¹²³ Similarly, in one small RCT of 28 adult MCD patients that compared prednisone 125 mg every other day for 2 months with placebo, there was no difference in overall remission rates over 77 months follow-up, although a significant percentage of the placebo arm ended up being treated with prednisone over this time frame. However, patients treated with prednisone went into remission more rapidly; 12 of 14 treated patients were in complete remission before 2 months, compared to 6 of 14 controls.^{124,136}

Although there are no controlled trials comparing daily vs. alternate-day corticosteroids in adults, observational studies have not shown any difference in response rates.¹³⁰ Corticosteroid therapy leads to complete remission in over 80% of adults with MCD. The time course to a complete remission is delayed compared to children, with 50% responding by 4 weeks but the remaining 10–25% requiring 12–16 weeks of therapy.^{129,130} It is known that, in children, 6 months of corticosteroid treatment is associated with a lower relapse rate than 3 months of therapy.¹³⁵ The optimal method to taper corticosteroids in adults is not known, but corticosteroids are commonly tapered by 5–10 mg/wk or less after achieving remission, for a total period of corticosteroid exposure of at least 24 weeks.^{125,129,130}

Only a few patients have been treated at the time of initial presentation with steroid-free regimens (e.g., cyclophosphamide^{132,137,138} or cyclosporine¹³⁹). In this very limited experience, the typical response rate of 75% is comparable to corticosteroids.

For infrequent relapses, repeat courses of corticosteroids may be used as in the first episode of MCD. There are no RCTs to guide the therapy of relapse in adult MCD. Reinstitution of prednisone usually results in a remission.

5.2: FR/SD MCD

5.2.1: We suggest oral cyclophosphamide 2–2.5 mg/kg/d for 8 weeks. (2C)

5.2.2: We suggest CNI (cyclosporine 3–5 mg/kg/d or tacrolimus 0.05–0.1 mg/kg/d in divided doses) for 1–2 years for FR/SD MCD patients who have relapsed despite cyclophosphamide, or for people who wish to preserve their fertility. (2C)

5.2.3: We suggest MMF 500–1000 mg twice daily for 1–2 years for patients who are intolerant of corticosteroids, cyclophosphamide, and CNIs. (2D)

RATIONALE

- There is low-quality evidence to suggest the value of alkylating agents in adult FR/SD MCD. Support for this approach comes from RCTs in children, and observational studies in adults.
- There is low-quality evidence to suggest that CNIs can induce complete or partial remission in adult MCD, but relapse rates may be higher than with alkylating agents after cessation of CNIs.
- There is very low-quality evidence to suggest the use of MMF as a corticosteroid or CNI-sparing agent.

In observational studies, treatment with cyclophosphamide leads to remission in a significant number of adults.^{129,130,132} The relapse-free interval appears to be longer than with cyclosporine (see below). In an observational study, the initial response rates with cyclophosphamide in SD adults appeared excellent (all nine patients were able to be weaned off steroids in one study);¹²⁹ however, five of these patients relapsed. In this study FR MCD patients appeared to fare better than SD MCD, with 80% of patients showing sustained remission at a mean follow-up of 9.1 years. Similarly, SD children may be less responsive to cyclophosphamide than frequent relapsers.⁴³ In another study, 21 of 36 adults with FR/SD MCD attained remission within 8 weeks and four more patients (total of 25/31 or 69%) within 16 weeks. The addition of prednisone to cyclophosphamide did not appear to provide added benefit. Remissions appeared to be more durable with cyclophosphamide compared to steroids.¹³² In another study, 55% of 20 patients treated with cyclophosphamide (for FR or SD MCD) had a complete or partial remission.¹³⁰ There is one report of the effectiveness of regimens using i.v. cyclophosphamide in adults.¹⁴⁰

Many observational studies have reported the efficacy of cyclosporine with remission rates of 70-90%.^{130,141} In an RCT of 73 adults and children with FR/SD nephrotic syndrome (31 with MCD; 42 with FSGS), treatment was given with either cyclophosphamide (2.5 mg/kg/d) for 8 weeks or cyclosporine (5 mg/kg/d) for 9 months, followed by a 3-month taper to withdrawal. At 9 months, remission rate did not differ significantly: 64% (18/28) of patients on cyclophosphamide and 74% (26/35) of patients on cyclosporine maintained remission. However, at 2 years, 25% of patients assigned to cyclosporine vs. 63% of patients assigned to cyclophosphamide were still in remission.⁶² Another RCT of 52 patients noted that remission was achieved sooner in patients treated with cyclosporine plus 0.8 mg/kg/d prednisone compared to patients receiving only 1 mg/kg/d prednisone, suggesting an additional benefit of lower exposure to corticosteroids (Online Suppl Tables 20, 21).¹⁴²

The optimal dose and duration of cyclosporine therapy is unknown. In an RCT of adults and children with FR/SD nephrotic syndrome, cyclosporine was dosed at 5 mg/kg/d for 9 months followed by a taper over 3 months.⁶² The possibility of cyclosporine dependency is high when treatment is abruptly stopped after achieving complete remission. However, prolonged treatment in 36 adult patients for a mean of 26 months, followed by slow withdrawal, led to sustained remissions without steroids in 11 of 14 patients and with low doses of corticosteroids in three patients. In 20% of patients, who remained cyclosporine-dependent, doses of <3 mg/kg/d were sufficient to maintain remission. The cumulative rate of remissions appears to reach a plateau by 6 months.^{143,144}

Tacrolimus, administered for 24 weeks was compared to i.v. cyclophosphamide in a small RCT in SD patients with achieved response rates similar to cyclosporine. All patients in this study were able to discontinue corticosteroids.¹⁴⁰

There are insufficient data to suggest a therapeutic level for CNI in adult MCD patients. After starting the drug with the suggested dosing regimen in Table 8 and achieving remission, the CNI dose should be progressively reduced to the lowest level that will maintain the remission. Many patients will be able to come off corticosteroids completely¹⁴⁰ and every effort should be made to reduce and stop corticosteroids after starting CNI.

In children with MCD, MMF has been used as a steroid-sparing agent (see Recommendation 3.3.5). The experience with MMF in adults has been limited to case reports.¹⁴⁵⁻¹⁴⁷

5.3: Corticosteroid-resistant MCD

5.3.1: Re-evaluate patients who are corticosteroid-resistant for other causes of nephrotic syndrome. (Not Graded)

RATIONALE

- Corticosteroid-resistant MCD suggests FSGS.

An estimated 10% of adult MCD patients are steroid-resistant (failed 16 weeks of daily or alternate-day corticosteroids as

outlined previously). Steroid resistance may be due to undetected FSGS (which may not be seen in a biopsy specimen because it is a focal lesion). A repeat biopsy could be considered and may show FSGS, which is associated with a worse prognosis than MCD. There are no RCTs and very few observational data on treatment strategies of steroid-resistant MCD in adults. Treatment strategy as outlined in Chapter 6 is suggested.

5.4: Supportive therapy

5.4.1: We suggest that MCD patients who have AKI be treated with renal replacement therapy as indicated, but together with corticosteroids, as for a first episode of MCD. (2D)

5.4.2: We suggest that, for the initial episode of nephrotic syndrome associated with MCD, statins not be used to treat hyperlipidemia, and ACE-I or ARBs not be used in normotensive patients to lower proteinuria. (2D)

RATIONALE

- AKI may accompany MCD in adults. This is usually reversible with continued steroid therapy. Supportive care, including renal replacement therapy, may be temporarily required. Proteinuria in adult MCD will typically remit with corticosteroids. As a consequence, the accompanying hyperlipidemia will remit with resolution of proteinuria, negating the need for statin therapy.
- Proteinuria in adult MCD will typically remit with corticosteroids, and statins and RAS blockade to help reduce proteinuria are not necessary if early remission is achieved.

AKI, sometimes severe enough to require dialysis, can occur in patients with MCD. Risk factors include older age, hypertension, severe nephrotic syndrome, and underlying arteriosclerosis of the kidney.^{130,148} Kidney function typically recovers even in the most severely affected patients, although patients who have experienced kidney failure may have residual chronic renal impairment.¹³⁰ Careful attention to volume status, as well as continued therapy with corticosteroids, and other supportive therapy for AKI are suggested.

There is only one small study of 40 adults who had relapsing nephrotic syndrome as children. This study did not show a higher incidence of cardiovascular disease, implying that long-term cardiovascular risk was not increased by intermittent hyperlipidemia during nephrotic relapses in childhood.¹⁴⁹ The use of antihyperlipidemic agents and ACE-I or ARBs may be considered on a case-by-case basis in FR/SD MCD adults in whom rapid remission is not achieved. It is important to note that adding an ACE-I or ARB in a severely nephrotic patient who is being aggressively diuresed may precipitate AKI.¹⁵⁰

Economic Considerations

Prednisone and cyclophosphamide are less costly than CNIs and MMF. Cost factors need to be considered in patients who are not able to afford or access the more expensive medications.¹⁵¹ The addition of ketoconazole is safe and can lead

to significant reduction in costs associated with CNIs, but drug levels need to be assessed to avoid nephrotoxicity.⁷³

RESEARCH RECOMMENDATIONS

- RCTs should investigate the use of CNIs or MMF as alternatives to corticosteroids for the first episode of adult MCD.
- RCTs are needed to compare CNIs to cyclophosphamide in FR/SD MCD, and to establish if cyclosporine or tacrolimus should be the preferred CNI.
- RCTs are needed to study the role of rituximab in FR/SD MCD.
- RCTs are needed to study the role of levamisole in FR/SD MCD.
- Evidence should be collected in these RCTs to evaluate the long-term cardiovascular, metabolic, infectious, and bone risk of FR/SD MCD, and corresponding treatment.

DISCLAIMER

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SUPPLEMENTARY MATERIAL

Supplementary Table 20: Summary table of RCT examining CsA vs. steroid treatment after first relapse in adults with minimal change disease (categorical outcomes).

Supplementary Table 21: Summary table of RCT examining CsA vs. steroid treatment after first relapse in adults with minimal change disease (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 6: Idiopathic focal segmental glomerulosclerosis in adults

Kidney International Supplements (2012) **2**, 181–185; doi:10.1038/kisup.2012.19

INTRODUCTION

This chapter makes treatment recommendations for adults with biopsy-proven, idiopathic FSGS. The cost implications for global application of this guideline are addressed in Chapter 2.

6.1: Initial evaluation of FSGS

6.1.1: Undertake thorough evaluation to exclude secondary forms of FSGS. (Not Graded)

6.1.2: Do not routinely perform genetic testing. (Not Graded)

BACKGROUND

The classical description of FSGS includes segmental increase of mesangial matrix with obliteration of the capillaries, sclerosis, hyalinosis, foam cells, and segmental scarring, and adhesion between the glomerular tuft and Bowman's capsule. A recently proposed pathology classification has pointed to the existence of nonsclerotic forms of FSGS.¹⁵² There has been a marked increase in the number of known underlying causes for the lesion of FSGS over the last 10–20 years. Perhaps a consequence of this has been that the incidence, the age of onset, and the clinical presentation have also dramatically altered over this timeframe. FSGS is now one of the most common patterns of glomerular injury encountered in human kidney biopsies,^{153,154} and it is the most common cause of proteinuria in the African-American and US Hispanic populations.

RATIONALE

- FSGS should be classified as idiopathic (primary) FSGS or secondary FSGS. This is not merely semantic, but has therapeutic implications. Idiopathic FSGS is defined by exclusion of any other identifiable cause of secondary FSGS.¹⁵⁵ Secondary causes of FSGS are listed in Table 9, and should be evaluated by detailed examination of the patient, including medical history, physical examination, family history, kidney imaging, and kidney pathology, including electron microscopy studies.¹⁵⁶
- There are no good data to support genetic testing in adults with FSGS, even in cases of steroid resistance. In the absence of a family history of FSGS, mutations of *NPHS1* (nephrin), *NPHS2* (podocin), *alpha-actinin-4*, *CD2AP*, and *TRPC-6* are detected in only 0–3% of adults with FSGS.^{105,157–163} In addition, some patients with a genetic abnormality have responded to therapy,

suggesting that the results of genetic analysis should not change treatment decisions.

- African-Americans with FSGS are likely to have mutations in the apolipoprotein L1 (*APOL1*) gene.¹⁶⁴ Most patients will present with non-nephrotic proteinuria. The therapeutic implications of this mutation are currently unknown, so this guideline does not suggest routine testing for *APOL1* mutations.

6.2: Initial treatment of FSGS

6.2.1: We recommend that corticosteroid and immunosuppressive therapy be considered only in idiopathic FSGS associated with clinical features of the nephrotic syndrome. (1C)

6.2.2: We suggest prednisone* be given at a daily single dose of 1 mg/kg (maximum 80 mg) or alternate-day dose of 2 mg/kg (maximum 120 mg). (2C)

6.2.3: We suggest the initial high dose of corticosteroids be given for a minimum of 4 weeks; continue high-dose corticosteroids up to a maximum of 16 weeks, as tolerated, or until complete remission has been achieved, whichever is earlier. (2D)

6.2.4: We suggest corticosteroids be tapered slowly over a period of 6 months after achieving complete remission. (2D)

6.2.5: We suggest CNIs be considered as first-line therapy for patients with relative contraindications or intolerance to high-dose corticosteroids (e.g., uncontrolled diabetes, psychiatric conditions, severe osteoporosis). (2D)

*Prednisone and prednisolone are equivalent, used in the same dosage, and have both been used in RCTs depending on the country of origin. All later references to prednisone in this chapter refer to prednisone or prednisolone. All later references to oral corticosteroids refer to prednisone or prednisolone.

BACKGROUND

Patients with FSGS and persistent proteinuria are at increased risk of progressive CKD and its accompanying cardiovascular morbidity and mortality. Risks are dependent on the level of proteinuria and kidney function.

The potential benefit of therapy includes disease cure, control, and/or slowing the progression to ESRD. In FSGS,

Table 9 | Causes of FSGS

Idiopathic (primary) FSGS	
Secondary FSGS	
1.	Familial <ol style="list-style-type: none"> Mutations in α-actinin 4 Mutations in <i>NPHS1</i> (nephrin) Mutations in <i>NPHS2</i> (podocin) Mutations in <i>WT-1</i> Mutations in <i>TRPC6</i> Mutations in <i>SCARB2</i> (LIMP2) Mutations in <i>INF2</i> (formin) Mutations in CD2-associated protein Mitochondrial cytopathies
2.	Virus associated <ol style="list-style-type: none"> HIV-associated nephropathy Parvovirus B19
3.	Medication <ol style="list-style-type: none"> Heroin-nephropathy Interferon-α Lithium Pamidronate/alendronate Anabolic steroids
4.	Adaptive structural-functional responses likely mediated by glomerular hypertrophy or hyperfiltration
4.1	Reduced kidney mass <ol style="list-style-type: none"> Oligomeganephronia Unilateral kidney agenesis Kidney dysplasia Cortical necrosis Reflux nephropathy Surgical kidney ablation Chronic allograft nephropathy Any advanced kidney disease with reduction in functioning nephrons
4.2	Initially normal kidney mass <ol style="list-style-type: none"> Diabetes mellitus Hypertension Obesity Cyanotic congenital heart disease Sickle cell anemia
5.	Malignancy (lymphoma)
6.	Nonspecific pattern of FSGS caused by kidney scarring in glomerular disease <ol style="list-style-type: none"> Focal proliferative glomerulonephritis (IgAN, LN, pauci-immune focal necrotizing and crescentic GN) Hereditary nephritis (Alport syndrome) Membranous glomerulopathy Thrombotic microangiopathy

FSGS, focal segmental glomerulosclerosis; GN, glomerulonephritis; HIV, Human immunodeficiency virus; IgAN, immunoglobulin A nephropathy; LN, lupus nephritis. Adapted from Deegens JK, Steenberg EJ, Wetzels JF. Review on diagnosis and treatment of focal segmental glomerulosclerosis. *Neth J Med* 2008; 66: 3–12 with permission from Van Zuiden Communications B.V.;¹⁵⁵ accessed <http://www.njmonline.nl/getpdf.php?t=a&id=10000260>.

outcome parameters can be divided into kidney and proteinuric events. Disease cure and control are defined primarily by changes in proteinuria (see Table 10).

In most cases of idiopathic FSGS, the natural history of the disease is prolonged, with even complete remitters having a relapse rate of up to 40%. Those with partial remissions still have a risk of slowly progressive loss of kidney function.

There is also a significant minority with no response to therapy; hence, the potential benefits of treatment must be constantly weighed against the risks of the chosen immunosuppressive therapy.¹³

Prognosis in patients with idiopathic FSGS is predicted by the severity and persistence of proteinuria. Patients with non-nephrotic proteinuria have a good prognosis, with kidney survival rates of more than 95% after a mean follow-up of 6.5 to 9.3 years,^{165–167} even in older studies when few patients, if any, were treated with RAS blockade. The conclusion still seems to be valid, since a very recent study concluded that even partial remission (reduction to non-nephrotic range proteinuria) was associated with significant improvement in kidney survival (80% vs. 40%) compared to no remission.¹⁰³

Many observational studies have demonstrated that remission of proteinuria, whether spontaneous or induced by therapy, is associated with a good outcome.^{103,168–171} Many studies have shown, in univariate and multivariate analyses, that development of a remission was associated with prednisone treatment.^{103,172–174}

The natural history of primary FSGS with nephrotic syndrome is quite variable. Important predictors are the magnitude of proteinuria, the level of kidney function, and the amount of tubulo-interstitial injury.^{101,165,175} Resistance to corticosteroids and immunosuppressive therapy is now considered the strongest predictor of ESRD.^{166,176} Prognosis is poor in patients who do not achieve remission, with 5-year kidney survival averaging 65% (60–90%) and 10-year kidney survival 30% (25–56%).^{165–167,177}

RATIONALE

- Most patients that progress have persistent nephrotic-range proteinuria; patients with non-nephrotic proteinuria are at low risk for progressive kidney failure and ESRD.
- Those with sustained non-nephrotic proteinuria are at increased risk of cardiovascular morbidity and mortality. Those risks should be managed, including treatment of proteinuria with RAS blockade and control of blood pressure.
- There is low-quality evidence to recommend corticosteroid or immunosuppressive therapy in primary FSGS when accompanied by nephrotic syndrome.
- There is no evidence to suggest corticosteroid or immunosuppressive therapy in secondary FSGS.

RAS Blockade and Blood Pressure Control

Optimal conservative management of patients with FSGS should follow guidelines for patients with persistent proteinuria (see Chapter 2). RAS blockade should be routine; however, it may be delayed in nephrotic syndrome to see if there is a response to initial corticosteroid therapy. This is particularly relevant if the nephrotic syndrome is severe, since the risk of developing AKI due to hypoperfusion and acute tubular necrosis (ATN) is increased in this setting.^{148,178}

Table 10 | Definitions of nephrotic syndrome in adults with FSGS

Classification	Definition
Complete remission	Reduction of proteinuria to <0.3 g/d or <300 mg/g (<30 mg/mmol), urine creatinine and normal serum creatinine and serum albumin >3.5 g/dl (35 g/l)
Partial remission ^a	Reduction of proteinuria to 0.3–3.5 g/d (300–3500 mg/g [30–350 mg/mmol]), urine creatinine and stable serum creatinine (change in creatinine <25%) or Reduction of proteinuria to 0.3–3.5 g/d (300–3500 mg/g [30–350 mg/mmol]), urine creatinine and a decrease >50% from baseline, and stable serum creatinine (change in creatinine <25%)
Relapse	Proteinuria >3.5 g/d or >3500 mg/g (>350 mg/mmol) urine creatinine after complete remission has been obtained
Frequent relapse	Not defined in adults
Steroid-dependent	Two relapses during or within 2 weeks of completing steroid therapy
Steroid-resistant	Persistence of proteinuria despite prednisone 1 mg/kg/d or 2 mg/kg every other day for >4 months

FSGS, focal segmental glomerulosclerosis; GFR, glomerular filtration rate.

^aBoth definitions of partial remission have been used in the literature.

Corticosteroids

Corticosteroid therapy should only be considered for patients with idiopathic FSGS associated with nephrotic syndrome. There are no data to support treatment with corticosteroids in patients without nephrotic-range proteinuria and, although there are no RCTs, there are numerous observational studies to support the use of corticosteroids in FSGS when associated with nephrotic-range proteinuria.

Prior to 1985, idiopathic FSGS was considered a steroid-resistant disease with poor outcome.¹⁶⁵ In contrast, observational studies conducted after 1985 have reported better outcomes and suggested that this improvement in response was associated with a higher initial dose and longer duration of treatment with corticosteroids.

Treatment routines have varied with durations from 4 to 24 months, and prednisone dosing from 0.3 to 1.5 mg/kg/d, reported complete remission rates range from 28% to 74%, and partial remission rates from 0% to 50%. The average time to complete remission is 3–4 months, with a range up to 8 months.^{166,168,169,171}

The timing of prednisone therapy initiation has been debated. Spontaneous remissions do occur, with reported rates varying from 5% to 23%. Spontaneous remissions are more likely to occur in patients with tip lesions, with preserved kidney function, and lower grades of proteinuria.¹⁷⁹ In such patients, prednisone treatment could be delayed to see if spontaneous remission occurs with RAS blockade and other conservative approaches, but no studies have investigated this approach, or systematically analyzed its risks and benefits.

In the absence of any evidence specific for FSGS, we suggest that the guidelines for adult MCD are used to direct further therapy in steroid-responsive primary FSGS (see Chapter 5).

There is no evidence to support the use of corticosteroids in secondary FSGS and, in current practice, such patients are not treated with immunosuppressive therapy.¹⁸⁰

Other Immunosuppressive Agents

Adult patients may tolerate poorly the sustained corticosteroid regimen recommended for primary FSGS, but there are

no RCTs to support the use of alternative immunosuppressive agents as first-line therapy.

A retrospective observational study compared high-dose oral prednisone (1 mg/kg/d) for at least 4 months and tapering thereafter, with low-dose prednisone (0.5 mg/kg/d) in combination with cyclosporine (3 mg/kg/d initial dose, tapering to 50 mg/d) or azathioprine (2 mg/kg/d initial dose, tapering to 0.5 mg/kg/d). Average duration of treatment was 20 months. Low-dose prednisone was given to 16 patients with obesity, bone disease, or mild diabetes. Remission rates were comparable; 63% for prednisone ($n=9$), 80% for prednisone plus azathioprine ($n=6$), and 86% for prednisone plus cyclosporine ($n=10$).¹⁷² Another study used tacrolimus as initial therapy in six patients and noted a remission in all.¹⁸¹

A randomized study in adult patients with FSGS and persistent nephrotic syndrome after 6 months of RAS blockade compared MMF (2 g/d for 6 months) plus low-dose prednisone (0.5 mg/kg/d for 8–12 weeks) to high-dose prednisone (1 mg/kg/d for 12–24 weeks, followed by tapering over 8 weeks). Similar remission rates were observed in the two regimens, 71% (12/17 patients) vs. 69% (11/16 patients).¹¹¹ These limited data suggest that patients who do not tolerate prolonged high-dose prednisone might benefit from alternative immunosuppressive agents, alone or in combination with a lower dose of prednisone. A CNi is favored in view of the evidence derived from studies in patients with steroid-resistant FSGS (see below).

6.3: Treatment for relapse

6.3.1: We suggest that a relapse of nephrotic syndrome is treated as per the recommendations for relapsing MCD in adults (see Chapters 5.1 and 5.2). (2D)

RATIONALE

- There is very low-quality evidence to guide treatment of relapses in steroid-responsive FSGS. We suggest that the guidelines for relapsing MCD are followed (see Chapter 5.2).

6.4: Treatment for steroid-resistant FSGS

- 6.4.1: For steroid-resistant FSGS, we suggest that cyclosporine at 3–5 mg/kg/d in divided doses be given for at least 4–6 months. (2B)
- 6.4.2: If there is a partial or complete remission, we suggest continuing cyclosporine treatment for at least 12 months, followed by a slow taper. (2D)
- 6.4.3: We suggest that patients with steroid-resistant FSGS, who do not tolerate cyclosporine, be treated with a combination of mycophenolate mofetil and high-dose dexamethasone. (2C)

BACKGROUND

There is no agreement in the literature regarding the duration of prednisone therapy that defines steroid-resistance. Some authors advise the use of alternative immunosuppressive therapy after only 4–8 weeks of prednisone, whereas others define resistance as persistent nephrotic syndrome after 4 months prednisone in a dose of 1 mg/kg/d.^{144,170,182,183} We suggest that prednisone be given for 4 months before defining resistance to therapy.

RATIONALE

Cyclosporine is effective in inducing remission of proteinuria in patients with steroid-resistant FSGS. Remissions can develop slowly, and may take 3–6 months after start of therapy.

- A partial remission provides a substantial outcome benefit.
- Relapses are very frequent after withdrawal of cyclosporine. More prolonged treatment may lead to more persistent remissions. Relapses occur frequently when using cyclosporine for a 6-month period. A longer duration of therapy and slow tapering strategy in cyclosporine-responsive patients can be used in FSGS (Table 11) similar to that advised in adults with MCD.
- There is limited evidence to support the efficacy of other regimens in patients with steroid-resistant proteinuria.

CNIs

Two RCTs have shown that cyclosporine is more effective than no treatment in inducing remission of proteinuria in FSGS with SRNS.^{110,184,185} In one of the two studies, cyclosporine was combined with low-dose prednisone. These are summarized in Online Suppl Tables 14–16. Remission in the two studies occurred in 60% and 69%, but relapse after cyclosporine withdrawal occurred in 69% and 61%, respectively. An additional benefit to cyclosporine treatment was an attenuated deterioration of kidney function in one study, with doubling of SCr in 25% of treated vs. 52% of control patients. An additional, but low-quality, controlled trial (Online Suppl Tables 14–16) as well as various uncontrolled studies have confirmed that treatment with cyclosporine reduces proteinuria in patients with FSGS.^{141,186–189} These

Table 11 | Treatment schedules

Drug and dosing scheme
Initial treatment
<i>Prednisone*</i> 1 mg/kg/d in patients (up to a maximum of 80 mg/d) or alternate-day prednisone 2 mg/kg (up to 120 mg) for at least 4 weeks and for a maximum of 4 months; in case of a complete remission, taper prednisone: e.g., reduce dose by 10 mg per 2 weeks down to 0.15 mg/kg/d, then taper dose every 2–4 weeks by 2.5 mg. In SR FSGS patients, taper off prednisone over 6 weeks.
Therapy for SR FSGS
<i>Cyclosporine</i> 3–5 mg/kg/d: in two divided doses (initial target levels 125–175 ng/ml [104–146 nmol/l]); in case of a remission continue treatment for 1 year then try to slowly taper cyclosporine: reduce cyclosporine dose by 25% every 2 months. If no remission by 6 months, discontinue cyclosporine treatment.
Or
<i>Tacrolimus</i> 0.1–0.2 mg/kg/d in two divided doses (initial target levels 5–10 ng/ml [6–12 nmol/l]); in case of remission see advice for cyclosporine.
And
<i>Prednisone</i> 0.15 mg/kg/d for 4–6 months, then taper off over 4–8 weeks.

FSGS, Focal segmental glomerulosclerosis; SR, steroid-resistant.

observational studies reported remission rates of 10–75%. The variation in reported remission rates may depend on the definition of steroid resistance, the prior use of alkylating agents, and the concomitant use of low-dose prednisone. Remissions usually develop within 2–3 months, but may take longer (4–6 months). All studies report high relapse rates (60–80%). Patients who respond within 6 months to cyclosporine can sometimes be maintained for periods of years without untoward effects on kidney function; however, deterioration of kidney function may occur, even if proteinuria has remitted.¹⁸⁸ Deterioration of kidney function is more likely in patients who use high-dose cyclosporine (> 5.5 mg/kg/d), in patients with pre-existing reduced GFR (< 60 ml/min per 1.73 m²) and pre-existent tubulointerstitial fibrosis.¹⁴⁴

There are no RCTs using tacrolimus. Uncontrolled studies suggest that tacrolimus may be an alternative to cyclosporine.^{181,190} Segarra *et al.*¹⁹⁰ treated 25 patients with cyclosporine-resistant or cyclosporine-dependent FSGS. Tacrolimus was used in a dose of 0.15 mg/kg/d and targeted to trough levels of 5–10 µg/l; there was a 100% remission rate in the cyclosporine-dependent patients, 100% in patients who had developed resistance to cyclosporine, and 62% in patients with resistance to the initial treatment with cyclosporine. These limited observational studies suggest tacrolimus may be an alternative in patients intolerant of cyclosporine.

Other Immunosuppressive Agents

A recent RCT compared cyclosporine to the combination of MMF and high-dose dexamethasone in children and young adults with steroid-resistant FSGS.¹¹¹ There was no statistically significant difference in remission rates. The study was largely underpowered, and inferiority of the MMF regimen could not be excluded. Case reports and small observational studies have reported response to alkylating agents, sirolimus, and rituximab, but there is insufficient evidence to support the use of any of these agents in patients with steroid-resistant FSGS.

RESEARCH RECOMMENDATIONS

- An RCT is needed of corticosteroid therapy at presentation compared to delayed corticosteroid therapy.
- An RCT is needed to evaluate the comparative efficacy of CNIs, alkylating agents, and MMF in steroid-resistant FSGS.
- Validation studies are needed on the most recent classification of FSGS¹⁵² to test its reproducibility, impact on outcome, and capacity to predict response to corticosteroids and immunosuppressive agents.

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SUPPLEMENTARY MATERIAL

Supplementary Table 14: Evidence profile of studies examining p.o. Cyc plus steroid vs. steroid in steroid-resistant nephrotic syndrome and/or FSGS in children.

Supplementary Table 15: Summary table of studies examining p.o. Cyc plus steroid vs. steroid in children with SRNS or FSGS (categorical outcomes).

Supplementary Table 16: Summary table of studies examining p.o. Cyc plus steroid vs. steroid in children with SRNS or FSGS (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 7: Idiopathic membranous nephropathy

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INTRODUCTION

This chapter makes treatment recommendations for patients with biopsy-proven membranous nephropathy (MN) believed to be of unknown cause (IMN). The treatment of secondary forms of MN will not be covered in this chapter, except for MN associated with hepatitis B and C. The cost implications for global application of this guideline are addressed in Chapter 2.

7.1: Evaluation of MN

7.1.1: Perform appropriate investigations to exclude secondary causes in all cases of biopsy-proven MN. (Not Graded)

BACKGROUND

The diagnosis of MN is made on kidney biopsy. Diagnostic features include capillary wall thickening, normal cellularity, IgG and C3 along capillary walls on immunofluorescence, and subepithelial deposits on electron microscopy. MN is often seen in association with an underlying disorder (secondary MN).^{191–193} Secondary MN is more common in children (75%) than adults (25%) (Table 12). The diagnosis of IMN is made by exclusion of secondary causes, using history, physical exam, and appropriate laboratory tests (e.g., serology, imaging) and by careful examination of the kidney biopsy by light, immunofluorescence, and electron microscopy. In IMN, deposition of the IgG4 subclass of IgG is dominant, whereas other IgG subclasses dominate in secondary forms of MN.^{194,195} Distinguishing secondary MN from IMN is very important, since the therapy in the former must be directed at the underlying cause and some of the treatments for IMN are potentially toxic both to the patient and the kidney.

RATIONALE

MN is due to a clinically recognizable underlying disorder in a variable percentage of cases, depending on age and geography.^{191–193,196,197,199–202} The recognition of the underlying disorder responsible for MN has important implications for prognosis and therapy.

MN is typically a disease of adults (fewer than 3% of cases are found in children). The frequency and etiology of secondary causes varies in different geographic areas^{191–193,196,197,199–203} (Table 12). IMN is often a “diagnosis of exclusion”. A recent study²⁰⁰ has shown that about 70–80% of IMN patients exhibit circulating antibodies of IgG4 subtype against a conformation-dependent epitope in the

M-type phospholipase A2 receptor. Such autoantibodies appear to be absent or very uncommon in patients with secondary MN. If the absence of autoantibodies to phospholipase A2 receptor in secondary MN is validated and a sensitive and specific assay for autoantibodies becomes available, it could become a valuable marker to positively identify (“rule in”) IMN. The IgG4 subclass dominates in the deposits of IMN, while IgG1, IgG2, and/or IgG3 dominate in secondary forms of MN.^{194,195}

The most important secondary causes include systemic lupus (in younger women), chronic hepatitis B infection (especially in East Asia¹⁹⁶), drugs (such as nonsteroidal anti-inflammatory agents, gold and mercury compounds) and malignancy (especially in patients presenting over the age of 65 years). Specific evaluations should exclude secondary causes of MN before specific immunosuppressive therapy is considered. Detailed morphological studies show mesangial deposits by electron microscopy and prominent IgG1, 2, or 3 subclass deposits by immunofluorescence in secondary MN. These features can be helpful in suspecting a secondary form of MN (see also Table 13 for a detailed listing of causes of MN).

RESEARCH RECOMMENDATIONS

- Studies are needed to validate the utility of antibody against M-type phospholipase A2 receptor in terms of its accuracy in separating primary from secondary MN.
- Studies are needed to determine the most cost-effective panel of investigations for screening an underlying (covert) malignancy in the older patient with MN.

7.2: Selection of adult patients with IMN to be considered for treatment with immunosuppressive agents (see 7.8 for recommendations for children with IMN)

7.2.1: We recommend that initial therapy be started only in patients with nephrotic syndrome AND when at least one of the following conditions is met:

- urinary protein excretion persistently exceeds 4 g/d AND remains at over 50% of the baseline value, AND does not show progressive decline, during antihypertensive and antiproteinuric therapy (see Chapter 1) during an observation period of at least 6 months; (1B)
- the presence of severe, disabling, or life-threatening symptoms related to the nephrotic syndrome; (1C)

Table 12 | Reported causes of secondary MN (% in adults)

Cause	China Zeng <i>et al.</i> ¹⁹⁶ (n=390)	Japan Abe <i>et al.</i> ¹⁹¹ (n=137)	France Cahen <i>et al.</i> ¹⁹² (n=82)	Finland Honkanen ¹⁹⁷ (n=82)	United States Ehrenreich <i>et al.</i> ¹⁹⁸ (n=167)
IMN	31.8	65.0	79.3	69.8	62.3
Secondary MN	68.2	35.0	20.7	30.2	37.7
Autoimmune diseases	50.0	25.5	6.1	17.7	7.2
Infections	12.0	5.1	2.5		2.4
Tumors	3.1	1.5	4.9	2.1	1.8
Drugs or toxins	3.1	2.2	6.1	10.4	4.2

IMN, idiopathic membranous nephropathy; MN, membranous nephropathy.

Abe *et al.*, Cahen *et al.*, and Ehrenreich *et al.* also reported diabetes as a secondary cause of MN, accounting for 0.7%, 1.2%, and 16.8% of secondary MN cases, respectively. Reprinted from Zeng CH, Chen HM, Wang RS *et al.* Etiology and clinical characteristics of membranous nephropathy in Chinese patients. *Am J Kidney Dis* 2008; 52: 691–698 with permission from National Kidney Foundation;¹⁹⁶ accessed [http://www.ajkd.org/article/S0272-6386\(08\)01058-5/fulltext](http://www.ajkd.org/article/S0272-6386(08)01058-5/fulltext).

- SCr has risen by 30% or more within 6 to 12 months from the time of diagnosis but the eGFR is not less than 25–30 ml/min per 1.73 m² AND this change is not explained by superimposed complications. (2C)

7.2.2: Do not use immunosuppressive therapy in patients with a SCr persistently >3.5 mg/dl (>309 μmol/l) (or an eGFR <30 ml/min per 1.73 m²) AND reduction of kidney size on ultrasound (e.g., <8 cm in length) OR those with concomitant severe or potentially life-threatening infections. (Not Graded)

BACKGROUND

The commonest presentation of IMN is nephrotic syndrome with preserved kidney function. About 50% of patients with persistent high-grade proteinuria eventually progress to ESRD, often after many years of observation. Complete remission of nephrotic syndrome predicts excellent long-term kidney and patient survival. A partial remission also significantly reduces the risk of progression to ESRD (see Table 14 for definitions of complete and partial remission used in this chapter). The primary aims of treatment, therefore, are to induce a lasting reduction in proteinuria. All currently used treatment modalities have significant toxicity; therefore, selecting patients at high risk of progression is important so that exposure to treatment-related adverse events is minimized. The degree and persistence of proteinuria during a period of observation helps in selecting patients for this therapy. There is no agreed definition of the “point of no return” in the evolution of IMN after which the risks of immunosuppressive drugs become unacceptable and futile. However, the presence of severe tubular interstitial fibrosis, tubular atrophy, and glomerular obsolescence on biopsy, accompanied by persistent elevation of SCr >3.5 mg/dl (>309 μmol/l) (or eGFR <30 ml/min per 1.73 m²), and reduction in kidney size on ultrasound may be such indicators.

RATIONALE

- There is low- to moderate-quality evidence to support a recommendation that patients with time-averaged

proteinuria <4.0 g/d or those who achieve a complete or partial remission have an excellent long-term prognosis.

- Observational studies of the natural history of IMN have shown that male gender, persistent heavy proteinuria, and elevated SCr at diagnosis predict the risk of later progressive decline in kidney function, although these factors may not all be independent risks.
- About 30–35% of patients with IMN eventually undergo spontaneous remission of nephrotic syndrome; therefore, it is reasonable to delay specific therapy for at least 6 months utilizing supportive therapy, including RAS blockade (see Chapter 1 for details) unless the patient has unexplained rapid deterioration in kidney function or there are complications related to uncontrolled nephrotic syndrome. However, the frequency of spontaneous remissions is lower with higher grades of proteinuria at presentation.
- It may be difficult to define precisely the time of onset of a partial remission, since some patients experience a slow reduction in proteinuria, even in the absence of specific treatment, to non-nephrotic levels over several years.
- There is support for the use of predictive models for determining risk of progression in IMN (i.e., persistent proteinuria >4 g/d and/or decline in kidney function over a 6-month period of observation).
- There is low-quality evidence to support a recommendation that the period of observation may be extended in patients who exhibit a consistent progressive decline in proteinuria during observation, have stable kidney function, and no complications related to the nephrotic state.

About 80% of adults with IMN have nephrotic syndrome at presentation²⁰⁶ and the remainder have subnephrotic proteinuria (see definitions in Chapter 1). The disease course may be punctuated with spontaneous remissions and relapses.^{197,207–214} In about 20% of patients, there is spontaneous complete remission of the nephrotic syndrome, and another 15–20% undergo partial remission. Remission may be delayed for as long as 18–24 months. In a recent

Table 13 | Reported causes of secondary MN

Autoimmune	Infections
Autoimmune diseases	Hepatitis B
Systemic lupus erythematosus	Hepatitis C
Rheumatoid arthritis	Human immunodeficiency virus
Mixed connective tissue disease	Malaria
Dermatomyositis	Schistosomiasis
Ankylosing spondylitis	Filariasis
Systemic sclerosis	Syphilis
Myasthenia gravis	Enterococcal endocarditis
Bullous pemphigoid	Hydatid disease
Autoimmune thyroid disease	Leprosy
Sjögren's syndrome	
Temporal arteritis	
Crohn's disease	
Graft-versus-host disease	
Malignancies	
<i>Carcinomas</i>	<i>Noncarcinomas</i>
Lung	Hodgkin's lymphoma
Esophageal	Non-Hodgkin's lymphoma
Colon	Leukemia (chronic lymphocytic leukemia)
Breast	Mesothelioma
Stomach	Melanoma
Renal	Wilm's tumor
Ovary	Hepatic adenoma
Prostate	Angiolymphatic hyperplasia
Oropharynx	Schwannoma
	Neuroblastoma
	Adrenal ganglioneuroma
Drugs/Toxins	Miscellaneous
Gold	Diabetes mellitus (association or cause?)
Penicillamine	Sarcoidosis
Bucillamine	Sickle cell disease
Mercury compounds	Polycystic kidney disease
Captopril	α 1-antitrypsin deficiency
Probenicid	Weber-Christian disease
Trimethadione	Primary biliary cirrhosis
Nonsteroidal anti-inflammatory drugs	Systemic mastocytosis
Cyclooxygenase-2 inhibitors	Guillain-Barre syndrome
Clopidogrel	Urticarial vasculitis
Lithium	Hemolytic-uremic syndrome
Formaldehyde	Dermatitis herpetiformis
Hydrocarbons	Myelodysplasia

study, the mean time to remission was 14.7 ± 11.4 months following presentation.²¹⁵ About 15–30% suffer one or more relapses, leaving about 50% of the patients with persistent nephrotic syndrome. Data from natural history studies and placebo arms of intervention studies show that about 30–40% of the patients with persistent nephrotic syndrome progress to ESRD over 10 years.^{208,216} Those with a persistent nephrotic syndrome are also exposed to the related complications, including infections, thromboembolic events, and accelerated atherosclerotic cardiovascular disease.

The likelihood of spontaneous remission and progression is dependent upon the age, gender, degree of proteinuria, and kidney function at presentation.^{216,217} The risk of progression is highest in those with proteinuria > 8 g/d, persistent for

Table 14 | Definitions of complete and partial remission in IMN

Complete Remission: Urinary protein excretion < 0.3 g/d (uPCR < 300 mg/g or < 30 mg/mmol), confirmed by two values at least 1 week apart, accompanied by a normal serum albumin concentration, and a normal SCr.

Partial Remission: Urinary protein excretion < 3.5 g/d (uPCR < 3500 mg/g or < 350 mg/mmol) **and** a 50% or greater reduction from peak values; confirmed by two values at least 1 week apart, accompanied by an improvement or normalization of the serum albumin concentration and stable SCr.

MN, membranous nephropathy; uPCR, urine protein:creatinine ratio.

See also Chapter 1.

Based on previously published information, Jha *et al.* and Passerini *et al.*^{204,205}

6 months. A validated algorithm allowed creation of a model based on time-averaged proteinuria over 6 months, CrCl at diagnosis, and the slope of CrCl over 6 months that correctly identified patients at risk of progression with 85–90% accuracy.²¹⁸ Based on this model, patients at low risk for progression present with a normal CrCl, proteinuria consistently < 4 g/d, and have stable kidney function over a 6-month observation period. Patients at medium risk for progression (~ 50 –55% probability of developing progressive CKD over 10 years) have normal kidney function that remains unchanged during 6 months of observation, but continue to have proteinuria between 4 and 8 g/d. Those classified as high risk for progression (65–80% probability of progression to advanced CKD within 10 years from diagnosis) have persistent proteinuria > 8 g/d, independent of the degree of kidney dysfunction.^{219,220} Treatment-induced remissions are associated with an improved prognosis.^{221,222} The 10-year survival free of kidney failure is about 100% in complete remission, 90% in partial remission, and 50% with no remission. Patients with complete or partial remission have a similar rate of decline in CrCl: -1.5 ml/min/y for complete remission, and -2 ml/min/y for partial remission. Although spontaneous remissions are *less common* in those with higher baseline proteinuria, they are not unknown; a recent report²¹⁵ showed spontaneous remission in 26% among those with baseline proteinuria 8–12 g/d and 22% among those with proteinuria > 12 g/d. Treatment with RAS blockade, and a 50% decline of proteinuria from baseline during the first year of follow-up, were significant independent predictors for remission. Most reported natural history studies were performed in an era before drugs that act on the RAS became available. The long-term value of RAS blockade in management of IMN has been assessed largely by observational studies and has been observed only in those patients with proteinuria (< 10 g/d) at baseline. A recent small RCT ($n = 27$) compared an ACE-I (lisinopril, up to 10 mg/d) to an ARB (losartan, up to 100 mg/d) in patients with IMN and variable-range proteinuria (2.5–7 g/d). Both agents were of comparable efficacy, reducing proteinuria on average by 2.5 g/d by 12 months. The absence of a placebo control and the failure to include patents with higher-grade

proteinuria (>8–10 g/d) weaken the impact of the study.²²³ There is only low-quality evidence to support the value of other predictors, such as hypertension, histologic evidence of interstitial fibrosis and tubular atrophy, persistently elevated urinary C5b-9, and excretion of increased quantities of low- or high-molecular-weight proteins (β 2-microglobulin and IgG) in urine.^{224,225} Staging of MN by histologic criteria has limited utility for prediction of outcomes or response to therapy in IMN.

7.3: Initial therapy of IMN

- 7.3.1:** We recommend that initial therapy consist of a 6-month course of alternating monthly cycles of oral and i.v. corticosteroids, and oral alkylating agents (see Table 15). (1B)
- 7.3.2:** We suggest using cyclophosphamide rather than chlorambucil for initial therapy. (2B)
- 7.3.3:** We recommend patients be managed conservatively for at least 6 months following the completion of this regimen before being considered a treatment failure if there is no remission, unless kidney function is deteriorating or severe, disabling, or potentially life-threatening symptoms related to the nephrotic syndrome are present (see also Recommendation 7.2.1). (1C)
- 7.3.4:** Perform a repeat kidney biopsy only if the patient has rapidly deteriorating kidney function (doubling of SCr over 1–2 month of observation), in the absence of massive proteinuria (>15 g/d). (Not Graded)
- 7.3.5:** Adjust the dose of cyclophosphamide or chlorambucil according to the age of the patient and eGFR. (Not Graded)
- 7.3.6:** We suggest that continuous daily (noncyclical) use of oral alkylating agents may also be effective, but can be associated with greater risk of toxicity, particularly when administered for >6 months. (2C)

BACKGROUND

Three RCTs have shown that monotherapy with oral corticosteroids is not superior to symptomatic therapy alone in IMN. Orally administered alkylating agents (cyclophosphamide or chlorambucil), most commonly in conjunction with steroids, are effective in inducing remission and preventing ESRD (Online Suppl Tables 22–25). The toxicity profile suggests that cyclophosphamide might be preferred to chlorambucil.

RATIONALE

- There is moderate-quality evidence to recommend a 6-month cyclical regimen of alternating alkylating agents (cyclophosphamide or chlorambucil) plus i.v. pulse and oral corticosteroids (see Table 15 for description of regimen) for initial therapy of IMN meeting the criteria

Table 15 | Cyclical corticosteroid/alkylating-agent therapy for IMN (the “Ponticelli Regimen”)

Month 1: i.v. methylprednisolone (1 g) daily for three doses, then oral methylprednisolone (0.5 mg/kg/d) for 27 days
Month 2: Oral chlorambucil (0.15–0.2 mg/kg/d) or oral cyclophosphamide (2.0 mg/kg/d) for 30 days ^a
Month 3: Repeat Month 1
Month 4: Repeat Month 2
Month 5: Repeat Month 1
Month 6: Repeat Month 2

IMN, idiopathic membranous nephropathy.

^aMonitor every 2 weeks for 2 months, then every month for 6 months, with serum creatinine, urinary protein excretion, serum albumin, and white blood cell count. If total leukocyte count falls to <3500/mm³, then hold chlorambucil or cyclophosphamide until recovery to >4000/mm³.

in Recommendation 7.2.1 above. This evidence indicates this treatment is superior to supportive therapy alone in inducing remissions and preventing long-term decline of kidney function, including the need for dialysis, in patients with IMN and persisting nephrotic syndrome. The risks and adverse events associated with the use of cyclophosphamide in IMN are summarized in Table 16.

- Other combined regimens of cyclophosphamide and corticosteroids have also been used. Some omit i.v. methylprednisolone, others use alkylating agent and corticosteroids concurrently, rather than cyclically, for a longer duration.^{226–228} However, the long-term efficacy and safety of these regimens are less well-established than the cyclical regimen.²²⁹ The safety and efficacy of i.v. cyclophosphamide-based regimens for treatment of IMN have not been sufficiently evaluated to warrant any recommendations. One small (underpowered) controlled trial in progressive IMN was negative.²³⁰ The evidence is insufficient to make any recommendations regarding the use of i.v. compared to oral cyclophosphamide.
- A complete or partial remission of nephrotic syndrome is associated with an excellent long-term prognosis; therefore, persisting remission of the nephrotic state is an acceptable surrogate end-point to assess overall efficacy of treatment.
- Treated patients may continue to enter complete or partial remission for as long as 12–18 months following completion of the regimen, so it is reasonable to wait this period of time before deciding whether the initial treatment has been unsuccessful (see Recommendations 7.6.1 and 7.6.2), providing that serum albumin levels or kidney function are not deteriorating, and that morbid events have not supervened. During the period of observation, patients should continue to receive ACE-I or ARBs, other antihypertensives, and other supportive therapies as clinically indicated. In comparative studies, cyclophosphamide has a superior safety profile compared to chlorambucil. There is low-quality evidence that cyclophosphamide can lead to more frequent and longer remissions than chlorambucil. Cumulative toxicities of

Table 16 | Risks and benefits of the cyclical corticosteroid/alkylating-agent regimen in IMN

Risks	Benefits
Enhanced risk of opportunistic infection	Prevention of CKD and ESRD
Reactivation of viral hepatitis	Avoidance of complications of nephrotic syndrome (thrombosis, accelerated atherogenesis)
Alopecia	Prolongation of life; improved quality of life
Gonadal damage (aspermatozoa, ovulation failure)	
Hemorrhagic cystitis (cyclophosphamide only)	
Neoplasia (myelodysplastic syndrome, acute myelogenous leukemia)	
Transitional cell carcinoma of the bladder, ureter or pelvis	
Toxic hepatitis	

CKD, chronic kidney disease; ESRD, end-stage renal disease; MN, membranous nephropathy.

alkylating agents can be significant and require careful monitoring by the treating physician. A recent study of the use of cyclophosphamide- or chlorambucil-based regimens in IMN has raised concerns regarding safety, given a reported adverse-event rate that exceeded 80%.²³¹ This is in contrast to the older long-term RCT of cyclical alkylating agents and steroids, where the regimens were well-tolerated with an acceptably low frequency of serious adverse events.^{229,232,233} Risks of this regimen are now known to be increased if alkylating agents are used in patients with reduced renal function, older age, and/or concomitant comorbidities as evidenced in this recent report.

- Since the decline in GFR in IMN is often very gradual, especially in the absence of massive proteinuria, any acceleration of the rate of decline indicates the possibility of a superimposed disease process (such as crescentic glomerulonephritis or acute interstitial nephritis, which is often drug-related) that might dictate a change in treatment approach. A repeat kidney biopsy is necessary to identify these conditions.
- Relapses of nephrotic syndrome occur in about 25% of patients treated with the “Ponticelli” regimen. A similar fraction of patients with spontaneous remissions also will relapse (see treatment of relapses in IMN in Section 7.7).

An open-label RCT utilizing a 6-month course of chlorambucil and steroids in alternating monthly cycles was initiated in the 1980s (see Table 15 for the description of the regimen).^{229,232,233} After 10 years of follow-up, 92% of the treated ($n=42$) and 60% of the control ($n=39$) patients were alive with normal kidney function ($P=0.0038$). There was remission in 61% (40% complete remission) and 33% (5% complete remission) in the two groups. In another RCT,²³⁴ this same regimen was compared to one where steroids alone were used for the entire 6-month period (chlorambucil was substituted with oral prednisolone 0.5 mg/kg/d). A significantly higher proportion of patients in the chlorambucil arm were in remission in the first 3 years. The difference was lost at 4 years, probably because of a small number of at-risk cases. The duration of remission was also longer in those treated with chlorambucil. Another RCT²³⁵ compared the same combination of chlorambucil and

steroids to one in which chlorambucil had been replaced with oral cyclophosphamide (2.5 mg/kg/d). Remission of nephrotic syndrome was noted with equal frequency in the two arms (82% vs. 93%; $P=0.116$) (Online Suppl Tables 22–25). However, severe adverse effects leading to discontinuation of therapy occurred more frequently in the chlorambucil group compared to the cyclophosphamide group (12% vs. 4%). Other small trials and several meta-analyses and systematic reviews have indicated that the alkylating agents are associated with a higher remission rate, although the long-term benefits on kidney function could not be demonstrated.^{204,236–240}

A more recent open-label study²⁰⁴ gave similar results to the initial trials of Ponticelli. Quality of life, as measured by a visual analog scale, was significantly better in the treatment group throughout the follow-up period. The complication rate was not different in the two groups.

One small open-label RCT ($N=29$) examined the efficacy of cyclophosphamide for 12 months plus moderate-dose steroids in IMN patients considered to be at high risk of progression (based on urinary IgG and urine β_2 microglobulin levels) that previously indicated these patients would have an increase in SCr levels by >25%, and reach a SCr >1.5 mg/dl (>133 $\mu\text{mol/l}$) or have an increase of >50% from baseline. The study compared an early-start group (urinary abnormalities at baseline) vs. the group started only after SCr had risen by >25–50%. They found a more rapid remission in proteinuria in early-start patients, but no differences between the two groups in overall remission rates, SCr levels, average proteinuria, relapse rates, or adverse events after 6 years.²⁴¹ This study agrees with earlier observational studies from the same authors, and supports an initial conservative treatment approach in IMN patients. However, toxicity with this specific approach has been reported to be substantially increased by both prolonging its duration and by selecting patients with impaired kidney function (SCr >1.5 mg/dl [$>133 \mu\text{mol/l}$]). The overall evidence for this approach is moderate.^{241–243} The adverse effects of alkylating-cytotoxic agents are substantial, and include gonadal toxicity, bladder carcinoma, bone marrow hypoplasia, leukemogenesis, and serious opportunistic infections (Table 16). The balance of risk and benefit may be altered by patient-dependent factors, such as age and comorbidities. Table 17 lists some of the contraindications to

Table 17 | Contraindications to the use of the cyclical corticosteroid/alkylating-agent regimen in IMN

Untreated infection (HIV, hepatitis B and C, tuberculosis, fungal infection, etc.)
Neoplasia (lung, skin [except squamous cell]), breast, colon, etc.
Urinary retention
Inability to comply with monitoring
Pre-existing leukopenia (<4000 leukocytes/mm ³)
SCr >3.5 mg/dl (>309 μmol/l)

HIV, human immunodeficiency virus; MN, membranous nephropathy; SCr, serum creatinine.

the use of the cyclical alkylating-agent/steroid regimen. Cyclophosphamide has a more favorable side-effect profile compared to chlorambucil. The available evidence does not suggest a beneficial effect of i.v. cyclophosphamide on the course of IMN, and its use is not recommended. Based on limited pharmacokinetic data, the dose of alkylating agents should be reduced when GFR declines, in order to avoid bone-marrow toxicity. Azathioprine does not favorably influence the course of IMN, either alone or with corticosteroids.²⁴⁴⁻²⁴⁶

Evidence from studies of immunosuppressed patients with diseases other than IMN indicates that patients on corticosteroids should receive prophylaxis for *Pneumocystis jiroveci* with trimethoprim-sulfamethoxazole. Those at risk for osteoporosis (e.g., elderly or postmenopausal females) should also receive bisphosphonates, unless these are contraindicated, such as an eGFR <30 ml/min per 1.73 m² (see also Chapter 1).

Deterioration of kidney function in IMN is usually slow, and development of advanced CKD most often takes several years of persistent high-level proteinuria. A rapid deterioration of kidney function in the absence of massive proteinuria (e.g., >15 g/d) usually indicates the superimposition of another pathologic process, such as acute bilateral renal-vein thrombosis, a superimposed crescentic GN, or acute interstitial nephritis. A repeat kidney biopsy is the most appropriate tool to identify any pathology changes that may require a change in treatment. In patients with severe proteinuria (>10–15 g/d), however, an acute decline in kidney function (<50% reduction in GFR) can be seen, possibly as a result of hemodynamic changes. This usually reverses with remission of the nephrotic state, and hence does not require a change in the therapeutic approach.

Prospective controlled studies of the use of immunosuppressive agents for treatment of patients with IMN and impaired renal function (e.g., eGFR 30–60 ml/min per 1.73 m²) are very limited. The current evidence is insufficient to make any specific recommendation in this group of patients. The hematological toxicity of alkylating agents can be heightened in subjects with impaired renal function, and the nephrotoxicity of CNI in those with already impaired renal function remains a concern. These agents should be

used with caution in patients with IMN and chronically reduced renal function.

RESEARCH RECOMMENDATIONS

- Clinical, pathological, and biological markers are needed to identify patients who will benefit most from therapy, and also to avoid unnecessary drug exposure risk to the rest. There is a lack of evidence to guide ideal dosing to minimize drug toxicity, especially the gonadal and bladder toxicity of cyclophosphamide.
- RCTs are needed to compare alkylating agents or CNIs to MMF, rituximab, or adrenocorticotropic hormone (ACTH) as initial therapy of IMN with nephrotic syndrome (with or without impaired renal function at diagnosis).
- Studies are needed to determine the value of renal pathology and urinary biomarkers in predicting prognosis and/or treatment responsiveness.
- Serial anti-PLA2R antibodies and urinary biomarkers (such as urinary IgG, β2-microglobulin) should be measured in natural history studies, and in all future treatment trials for IMN, in order to assess their value in determining spontaneous remission, response to treatment, and prognosis.

7.4: Alternative regimens for the initial therapy of IMN: CNI therapy

- 7.4.1:** We recommend that cyclosporine or tacrolimus be used for a period of at least 6 months in patients who meet the criteria for initial therapy (as described in Recommendation 7.2.1), but who choose not to receive the cyclical corticosteroid/alkylating-agent regimen or who have contraindications to this regimen. (See Table 18 for specific recommendations for dosage during therapy.) (1C)
- 7.4.2:** We suggest that CNIs be discontinued in patients who do not achieve complete or partial remission after 6 months of treatment. (2C)
- 7.4.3:** We suggest that the dosage of CNI be reduced at intervals of 4–8 weeks to a level of about 50% of the starting dosage, provided that remission is maintained and no treatment-limiting CNI-related nephrotoxicity occurs, and continued for at least 12 months. (2C)
- 7.4.4:** We suggest that CNI blood levels be monitored regularly during the initial treatment period, and whenever there is an unexplained rise in SCr (>20%) during therapy. (Not Graded) (See Table 18 for specific CNI-based regimen dosage recommendations.)

RATIONALE

There is low- to moderate-quality evidence to support a recommendation for CNI therapy (cyclosporine or

Table 18 | CNI-based regimens for IMN

Cyclosporine: 3.5–5.0 mg/kg/d given orally in two equally divided doses 12 hours apart, with prednisone 0.15 mg/kg/d, for 6 months. We suggest starting at the low range of the recommended dosage and gradually increasing, if necessary, to avoid acute nephrotoxicity (Sandimmune[®], Neoral[®], and generic cyclosporin considered equivalent).

Tacrolimus: 0.05–0.075 mg/kg/d given orally in two divided doses 12 hours apart, without prednisone, for 6–12 months. We suggest starting at the low range of the recommended dosage and gradually increasing, if necessary, to avoid acute nephrotoxicity.

IMN, idiopathic membranous nephropathy.

Note: Monitoring of blood levels during therapy is discussed in the text.

tacrolimus) as an alternative to cyclical corticosteroid/alkylating-agent therapy in IMN (Online Suppl Tables 28–31). There is low-quality evidence to suggest that a minimum of 6 months therapy with CNI should be employed, which should be continued for at least 6–12 months if there is a beneficial effect on proteinuria, based on the high relapse rates if therapy is discontinued early. The suggested dosage regimens for CNIs in IMN are given in Table 18.

Cyclosporine

Early uncontrolled studies suggested an initial benefit, but a high relapse rate, with cyclosporine in IMN.^{247,248} In a single-blind, randomized controlled study, 51 patients with steroid-resistant MN were treated with low-dose prednisone plus cyclosporine and compared to placebo plus prednisone.²⁴⁹ Complete and partial remissions in proteinuria were seen in 69% of the patients, but the relapse rate when cyclosporine was discontinued was high, approximately 45% of the end of 1 year. Observational data from the German Cyclosporine in NS Study Group suggests that prolonging cyclosporine treatment for 1 year results in higher (34%) complete remission at 1 year, and more sustained rate of remissions.¹⁴⁴ Current recommendations, for patients who respond to cyclosporine, are to continue treatment for at least 1 year.¹⁸² Prolonged low-dose cyclosporine (~1.5 mg/kg/d) could be considered for long-term maintenance of patients who achieve a complete or partial remission, especially in patients at high risk for relapse.²⁵⁰ Regular monitoring of cyclosporine blood concentration as well as kidney function is often recommended, according to data accumulated from experiences in kidney transplantation. There is no evidence in patients with IMN to indicate optimal cyclosporine blood levels. Cyclosporine levels usually regarded as nontoxic are 125–175 ng/ml [104–146 nmol/l] (C₀, trough level) or 400–600 ng/ml [333–500 nmol/l] (C₂, 2-hour post-dose level).¹⁸² Online Suppl Tables 28–31 summarize studies using cyclosporine.^{208,247,251–253}

There has been only one small RCT using cyclosporine in patients with high-grade proteinuria and progressive kidney failure.²⁵¹ At the time of initiation of treatment, mean

CrCl was 55 ml/min, and mean proteinuria 11 g/d. After 12 months of treatment with cyclosporine, there was a significant reduction in proteinuria, and the rate of loss of kidney function decreased from –2.4 to –0.7 ml/min/mo, whereas, in those receiving placebo, there was no change: –2.2 to –2.1 ml/min/mo ($P < 0.02$). This improvement was sustained in ~50% of the patients for up to 2 years after cyclosporine was stopped.^{208,247,251–253}

Tacrolimus

In an RCT using tacrolimus monotherapy in IMN, patients with normal kidney function ($n = 25$) and mean proteinuria (~8 g per 24 hours) received tacrolimus (0.05 mg/kg/d) over 12 months with a 6-month taper, and were compared to conservatively treated controls ($n = 23$).²⁵⁴ After 18 months, the probability of remission was 94% in the tacrolimus group but only 35%, in the control group. Six patients in the control group and only one in the tacrolimus group reached the secondary end-point of a 50% increase in SCr.²⁵⁴ Almost half of the patients relapsed after tacrolimus was withdrawn, similar to patients treated with cyclosporine. There is only low-quality evidence to support prolonged use of low-dose tacrolimus to maintain remission; the safety of this approach is uncertain.^{226,227,229,230,233–235,238,240,242,243,255–258}

Comparison Studies of CNIs vs. Alkylating Agents

An RCT in IMN patients of Asian ancestry has compared tacrolimus ($n = 39$) for 6–9 months to oral cyclophosphamide ($n = 34$) for 4 months (both groups received prednisone tapered off over 8 months).²⁵⁹ The results indicated no difference between treatments in terms of partial or complete remission of proteinuria (79% vs. 69%), or adverse events at 12 months of follow-up. Relapses occurred in approximately 15% of both groups. These data support the use of tacrolimus, short-term (with or without concomitant steroids) as an alternative to an oral alkylating-agent regimen.²⁵⁴ However, the long-term efficacy of a tacrolimus-based regimen for IMN remains uncertain.²⁵⁹

Use of CNIs in Patients with Reduced Renal Function

The nephrotoxicity of CNIs can be enhanced in the presence of pre-existing renal functional impairment. Cyclophosphamide-based regimens may be preferred in this situation, but dose reduction of the alkylating agent is advisable. There is weak evidence for preferring CNI or alkylating agent-based regimens in this group of patients. An RCT examining this controversial area is in progress (ISRCTN99959692). The use of other agents, including rituximab, MMF, and/or ACTH in this group of subjects is worthy of further study, but the evidence is currently insufficient to make any specific recommendations. The evidence concerning the value of quantification of the degree of interstitial fibrosis and/or tubular atrophy in renal biopsy as a guide for the choice of treatment regimens for IMN is presently insufficient to make any recommendations.

RESEARCH RECOMMENDATIONS

- RCTs are needed in IMN to assess the efficacy, safety, and risks of long-term CNI therapy.
- Studies are needed to determine the value of monitoring blood levels of CNIs during therapy of IMN.

7.5: Regimens not recommended or suggested for initial therapy of IMN

7.5.1: We recommend that corticosteroid monotherapy not be used for initial therapy of IMN. (1B)

7.5.2: We suggest that monotherapy with MMF not be used for initial therapy of IMN. (2C)

BACKGROUND

A number of treatments, other than combined therapy of corticosteroid/alkylating agents or CNIs, have been tried as initial therapy in IMN (meeting the criteria outline in Recommendation 7.2.1). However, none of these have been shown in appropriately sized RCTs to be consistently effective and safe, and therefore are not recommended as “first-line” initial therapy in IMN.

RATIONALE**Corticosteroid Monotherapy**

There is moderate-quality evidence to recommend not using corticosteroid monotherapy for inducing remissions or delaying the onset of progressive CKD in IMN. An early study reported that a 2- to 3-month course of high-dose, alternate-day prednisone resulted in a significant reduction compared to placebo in progression to kidney failure, although there was no sustained effect on proteinuria.²⁶⁰ A subsequent RCT in patients with IMN, using an identical corticosteroid regimen vs. placebo, showed no improvement during drug exposure, or over a 3-year follow-up in either proteinuria or kidney function (SCr). An additional RCT comparing a 6-month course of prednisone given on alternate days ($n=81$) to no specific treatment ($n=77$) showed no significant benefit of corticosteroid treatment alone, in either induction of remission or preservation of kidney function, even after the data were adjusted to include only patients with proteinuria at entry >3.5 g per 24 hours.²⁶¹ Nevertheless, retrospective studies conducted in subjects of Asian (Japanese) ancestry have suggested possible benefits for steroid monotherapy.²⁶² These analyses could be confounded by unmeasured variables and failure to subject patients to an observation period prior to initiation of therapy. The negative RCTs mentioned included too few Asian subjects for subanalysis.

MMF (Online Suppl Tables 32–34)

MMF as initial therapy in IMN has not been shown in RCTs to be consistently effective for inducing remissions or delaying the onset of progressive CKD. Thirty-two patients with IMN and impairment of kidney function (SCr >1.5 mg/dl [>133 $\mu\text{mol/l}$]) were treated with oral MMF

1g twice daily for 12 months, in combination with corticosteroids, and compared to 32 patients—historical controls treated for the same duration with oral cyclophosphamide in combination with corticosteroids (cyclophosphamide; 1.5 mg/kg/d).²⁶³ Cumulative incidences of remission of proteinuria at 12 months were 66% with MMF vs. 72% with cyclophosphamide ($P=0.3$). Adverse effects occurred at a similar rate in the two groups, but relapses were very much more common with MMF, and relapses were noted even while on treatment.²⁶³

There have been two small RCTs that have compared MMF plus steroids to the Ponticelli regimen of an alkylating agent (cyclophosphamide or chlorambucil) plus steroids.

In one study of 20 low risk-of-progression adults that were all drug-naïve with nephrotic syndrome due to IMN, the efficacy of a regimen of MMF plus corticosteroids was compared to a modified Ponticelli regimen (with chlorambucil).²⁶⁴ There was no significant difference in the proportion of patients achieving remission: 64% with MMF, 67% with the modified Ponticelli regimen. The frequency of relapses and incidence of infections were similar in both groups. There was more leucopenia with the modified Ponticelli regimen, compared to MMF. In the other small RCT^{264A} 21 drug naïve IMN patients, MMF plus steroids was compared to the Ponticelli regimen. The complete or partial response rate was 64% (7/11) in the MMF versus 80% (8/10) with the alkylating/steroid regimen. In a short follow-up period no patient relapsed in the MMF group and only one in the Ponticelli regimen (NS).

By contrast, in a pilot RCT in a low risk-of-progression adults that were all drug naïve with nephrotic syndrome due to IMN, the efficacy of a MMF based monotherapy regimen (no concomitant steroids) was compared to conservative therapy alone. This study randomized 36 patients with IMN and nephrotic syndrome to conservative therapy (RAS blockade, statins, low-salt and low-protein diet, and diuretics) plus MMF (2g/d, without concomitant steroids) ($n=19$) or conservative therapy alone ($n=17$) for 12 months.²⁶⁵ The probability of a complete or partial remission did not differ between the two groups after 12 months.

Thus, while a regimen of MMF plus steroids might have comparable efficacy to the standard regimen of cyclical alkylating agents and steroids, the present evidence is conflicting, of low quality, and only short-term. The high frequency of relapses with MMF substantially reduces enthusiasm regarding this approach to therapy of IMN.²⁶³ Monotherapy with MMF appears to be ineffective.²⁶⁵

Rituximab

As yet, there are no RCTs using rituximab for initial therapy of IMN, although large observational studies have provided encouraging data. A pilot study used four weekly doses of rituximab (375 mg/m²) in eight nephrotic patients with IMN and followed them for 1 year.^{266,267} Proteinuria significantly decreased at 12 months, and kidney function remained stable

in all patients. Adverse effects were reported as mild. An observational study from the same investigators suggested that rituximab is likely to be most effective in patients with minimal degrees of tubulointerstitial injury.²⁶⁸

A prospective observational study in 15 patients with IMN and proteinuria >4 g per 24 hours—despite ACE-I/ARB use for >3 months and systolic blood pressure <130 mm Hg—has been reported.²⁶⁹ At 6 months, patients who remained with proteinuria >3 g per 24 hours, and in whom total CD19+ B-cell count was >15 cells/ μ l, received a second identical course of rituximab. Baseline proteinuria of 13.0 ± 5.7 g per 24 hours (range 8.4–23.5) decreased to 9.1 ± 7.4 g, 9.3 ± 7.9 g, 7.2 ± 6.2 g, and 6.0 ± 7.0 g per 24 hours (range 0.2–20) at 3, 6, 9, and 12 months, respectively (mean \pm SD). The mean decline in proteinuria from baseline to 12 months was 6.2 ± 5.1 g/d and was statistically significant ($P=0.002$). Rituximab was well-tolerated, and was effective in reducing proteinuria in some patients with IMN. The complete and partial remission rate was almost 60%, higher than would have been expected based on known spontaneous remission rates.

Another observational study used circulating B-cell counts to guide dosing, significantly reducing total dose of rituximab.²⁷⁰ At 1 year, the proportion of patients who achieved disease remission was identical to that of 24 historical patients who were given a standard rituximab protocol of four weekly doses of 375 mg/m².

More recently, another prospective observational study in 20 patients with IMN and baseline persistent proteinuria >5.0 g/d received rituximab (375 mg/m² weekly for four doses), with retreatment at 6 months regardless of proteinuria response.²⁷¹ Baseline proteinuria of 11.9 g/d decreased to 4.2 g/d and 2.0 g/d at 12 and 24 months, respectively, while CrCl increased from 72.4 to 88.4 ml/min per 1.73 m² at 24 months. Among 18 patients who completed 24 months of follow-up, four achieved complete remission, 12 achieved partial remission (complete plus partial remission of 80%). One patient relapsed during follow-up. More than 50% of the patients in this pilot trial had not responded to prior therapy. No short-term toxicity of rituximab was observed. This study also reinforced the observation, made with alkylating agent/corticosteroid therapy that proteinuria declines gradually, and many months may be required for proteinuria to reach its nadir.

An RCT is needed to confirm these encouraging results, but the findings indicate a high probability that rituximab has beneficial actions on the disease process. The long-term relapse rate is unknown but in the short term, it appears to be low.²⁷¹ Due to the lack of RCTs, no specific recommendations can be made regarding the use of rituximab for initial therapy of IMN.

ACTH (Online Suppl Tables 26–27)

One observational study and one small RCT provide preliminary, low-quality evidence for the use of long-acting ACTH as initial therapy in IMN.

Depot synthetic ACTH (Synacthen[®]) administered for 1 year in an observational study decreased proteinuria in patients with IMN.^{272,273} More recently, a small open-label pilot RCT compared i.v. methylprednisolone and oral corticosteroids plus a cytotoxic agent ($n=16$) vs. synthetic ACTH ($n=16$) as initial therapy in IMN, and found them to be of similar efficacy, at least over short-term follow-up.²⁷⁴ Side-effects associated with the use of synthetic ACTH included dizziness, glucose intolerance, diarrhea, and the development of bronze-colored skin, which resolved after the end of therapy. Larger, more-powerful RCTs are required before synthetic ACTH can be recommended for initial therapy of IMN. Preliminary reports of uncontrolled studies showing a similar effect of native, intact (porcine) ACTH in a gel formulation have very recently appeared, but no RCTs have yet been conducted with this formulation of ACTH. Until broader and more powerful RCTs are performed, no recommendations can be made for the use of ACTH (synthetic or intact) for initial therapy of IMN.

RESEARCH RECOMMENDATIONS

- Larger RCTs with longer follow-up are needed to test MMF and corticosteroids vs. established regimens as initial therapy.
- An RCT is needed to compare rituximab to cyclical corticosteroid/alkylating-agent therapy or CNIs for initial treatment of IMN with nephrotic syndrome.
- An RCT is needed to compare synthetic or native (intact, porcine) ACTH in gel form with cyclical corticosteroid/alkylating-agent therapy or CNIs for initial treatment of IMN with nephrotic syndrome.

7.6: Treatment of IMN resistant to recommended initial therapy

7.6.1: We suggest that patients with IMN resistant to alkylating agent/steroid-based initial therapy be treated with a CNI. (2C)

7.6.2: We suggest that patients with IMN resistant to CNI-based initial therapy be treated with an alkylating agent/steroid-based therapy. (2C)

BACKGROUND

The results of trials using an initial cyclical treatment alternating steroids and an alkylating agent or an initial CNI have shown excellent kidney survival and a high rate of remission, even in the long term.^{204,233–235,249,254,275} However, 9–28% of patients are treatment-resistant (fail to achieve a remission) to steroids and alkylating-agent therapy, and approximately 25% of patients are treatment-resistant to CNI therapy. Patients who fail to achieve a complete or partial remission of nephrotic syndrome should be considered for additional therapy if no contraindication to such treatment exists. The response to alternative therapeutic strategies in treatment-resistant disease cannot presently be predicted with any degree of accuracy. Failure to respond to one

regimen does not reliably predict a failure to respond to another regimen.

RATIONALE

Unresponsiveness to initial therapy is observed in 10–30% of patients following a complete course of treatment. There is low-quality evidence to suggest that failure to respond to one regimen does not reliably predict failure to respond to another regimen.

If there is no remission following cyclical treatment with an alkylating agent/corticosteroid regimen, an alternative is to use CNIs. Cyclosporine is the best studied, although tacrolimus has also been shown to induce a high initial rate of remission, comparable to the overall response rate observed with combined steroids and alkylating agents, particularly after a prolonged administration and associated with moderate doses of steroids.²⁴⁹

Many treatment-resistant patients also have deteriorating kidney function. There has been only one small RCT using cyclosporine in patients with high-grade proteinuria (>10 g/d) and progressive kidney failure (initial CrCl approximately 55 ml/min). It showed a significant reduction in the rate of loss of kidney function with cyclosporine.²⁵¹ For those patients who receive a CNI for initial therapy and show no response after a period of at least 6 months, we suggest treatment with an alkylating agent-based regimen, using the same regimen as for initial therapy. However, adverse effects of treatment may be more frequent in patients with established or progressing kidney impairment. A randomized trial examining the relative safety and efficacy of conservative, alkylating agent or CNI therapy in this group of subjects with IMN is in progress in the UK (ISRCTN 99959692), the results of which could alter recommendations in this area.

In patients with kidney impairment,^{243,251} bone marrow is more susceptible to the toxic effect of alkylating agents, and there may also be heightened susceptibility to infections. Therefore, it is recommended not to exceed daily doses for chlorambucil of 0.1 mg/kg and cyclophosphamide of 1.5 mg/kg in patients with SCr > 2.0 mg/dl [$> 177 \mu\text{mol/l}$]²⁷⁶ and to limit the total duration of therapy to <6 months. A higher incidence of side-effects with this regimen is to be expected. The use of CNIs in this group of subjects may also be associated with worsening renal function due to nephrotoxicity.

The roles of MMF, rituximab, or ACTH in patients resistant to both alkylating agent-based and CNI-based regimens remain undefined; there have been no RCTs.^{111,205,263,265,272,274,277}

Additional causative factors should be considered when there is deteriorating renal function in IMN. Rapidly progressive renal failure may occur from an acute hypersensitivity interstitial nephritis in IMN patients receiving diuretics, antibiotics, or nonsteroidal anti-inflammatory drugs. A superimposed crescentic GN associated with anti-GBM antibodies or ANCA can also rarely develop in those

patients with high-grade proteinuria.^{278,279} Kidney biopsy is often necessary to confirm the diagnosis, and complete recovery of kidney function may follow a course of high-dose oral prednisone in those with acute hypersensitivity interstitial nephritis or intensive immunosuppression in those with crescentic disease (see Chapters 13 and 14).

Finally, pulses of i.v. methylprednisolone as monotherapy should not be used for treatment of resistant disease, unless the steady evolution of IMN is interrupted by a rapidly progressive course, and an extracapillary (crescentic) GN superimposed on IMN is shown by kidney biopsy.

RESEARCH RECOMMENDATIONS

- RCTs are needed to assess risks and benefits of rituximab, MMF, and ACTH in the treatment of IMN patients resistant to first-line therapy.
- RCTs are needed to assess risks and benefits of the cyclical alkylating agent/corticosteroid regimen or with a CNI regimen in IMN patients with impaired or deteriorating kidney function.

7.7: Treatment for relapses of nephrotic syndrome in adults with IMN

7.7.1: We suggest that relapses of nephrotic syndrome in IMN be treated by reinstatement of the same therapy that resulted in the initial remission. (2D)

7.7.2: We suggest that, if a 6-month cyclical corticosteroid/alkylating-agent regimen was used for initial therapy (see Recommendation 7.3.1), the regimen be repeated only once for treatment of a relapse. (2B)

BACKGROUND

Clinical trials using cyclical treatment of alternating steroids and alkylating agents or CNIs in IMN have shown excellent kidney survival in those subjects with complete or partial remission, even in the long term. However, relapses of nephrotic syndrome occur in 25–30% of patients within 5 years of discontinuation of therapy with alkylating agents, and 40–50% of patients within 1 year of discontinuation of CNIs. For those patients who show a complete or partial remission and then a relapse of nephrotic syndrome, a second course of treatment can be given.²⁸⁰

RATIONALE

There is very low-quality evidence to suggest that responses to re-treatment of a relapse are similar to those observed after the first treatment.

There is moderate-quality evidence to suggest that there are significant risks of neoplasia induction, opportunistic infections, and gonadal damage when alkylating agents are used for an extended period.

If there is a relapse of nephrotic syndrome in IMN following remission, reintroduction of a corticosteroid/alkylating-agent regimen or CNIs will often, but not uniformly, induce another remission.

Most data on repeated courses of immunosuppressive therapy relate to patients in whom relapses occurred after a partial remission, and with normal kidney function.^{281,282} There are no RCTs to guide therapy for patients with IMN who relapse after a first course of therapy and have kidney impairment.²⁸³

Cancer induction is a major concern when alkylating agents are used for an extended period. Cumulative doses of more than 36 g of cyclophosphamide (equivalent to 100 mg daily for 1 year) were associated with a 9.5-fold increased risk of bladder cancer, in patients with Wegener granulomatosis. Extended courses have also been associated with an increased risk of lymphoproliferative, myelodysplastic, and leukemic disorders.²⁸⁴ Because of this, repeated courses (more than two) of cyclical alkylating-agent therapy are not advised.

Mild relapses (redevelopment of subnephrotic proteinuria after a complete remission) do not require any specific treatment, and should be managed conservatively. Blood pressure should be kept <125/75 mm Hg and an ACE-I or ARB should be used as the first line of treatment (see Chapter 1).

Other agents such as MMF, rituximab, or ACTH might be considered for treatment of relapses in IMN. There is some observational evidence that rituximab may be beneficial in patients relapsing whenever the dose of CNI is reduced (CNI dependency),²⁸⁵ but the evidence is currently insufficient to make any specific recommendations.

RESEARCH RECOMMENDATION

- RCTs are needed to examine the efficacy and safety of MMF, rituximab, or ACTH in relapsing patients with IMN.

7.8: Treatment of IMN in children

7.8.1: We suggest that treatment of IMN in children follows the recommendations for treatment of IMN in adults. (2C) (See Recommendations 7.2.1 and 7.3.1.)

7.8.2: We suggest that no more than one course of the cyclical corticosteroid/alkylating-agent regimen be given in children. (2D)

BACKGROUND

IMN in children is uncommon, and usually presents as nephrotic syndrome or asymptomatic proteinuria. IMN contributes less than 5% of cases of nephrotic syndrome in children.^{286,287} Most cases (>75%) of MN in children are secondary to chronic viral infections (e.g., hepatitis B), autoimmune diseases (SLE, thyroiditis), or drugs.

RATIONALE

There is low-quality evidence to suggest children with IMN should be treated with the same regimens as adults, with appropriate dosage modification.

Most knowledge of the natural history of IMN in children, treatment options, and long-term outcome is derived from small, uncontrolled observational studies²⁸⁸ that suggest a relatively high spontaneous remission rate, and a low incidence of ESRD. Children with IMN will not usually require more than conservative therapy, unless they are severely symptomatic, as they seem to have a higher spontaneous remission rate than adults. For children with severe symptomatic disease, the same drug combinations used in adults are suggested, with appropriate dosage adjustments.²⁸⁹ Most of these protocols use chlorambucil 0.15–0.2 mg/kg/d or cyclophosphamide 2 mg/kg/d for 8–12 weeks, with alternate-day prednisone. The risk for gonadal toxicity with chlorambucil and cyclophosphamide is greater in boys than in girls, and is related to both the duration and total dose of treatment.²⁹⁰ The cumulative dose of cyclophosphamide should not exceed 200 mg/kg in order to avoid gonadal toxicity.

There are no data on the use of CNIs in children with IMN; the use of CNIs is based only on the evidence from adults RCTs. MMF, rituximab, or ACTH has not been studied in children (see also Table 19).

RESEARCH RECOMMENDATION

- The absence of RCTs of treatment of IMN in children makes treatment recommendations and suggestions moot. RCTs are needed to compare the use of alkylating agents and CNIs for initial therapy of IMN children with nephrotic syndrome.

7.9: Prophylactic anticoagulants in IMN

7.9.1: We suggest that patients with IMN and nephrotic syndrome, with marked reduction in serum albumin (<2.5 g/dl [<25 g/l]) and additional risks for thrombosis, be considered for prophylactic anticoagulant therapy, using oral warfarin. (2C)

BACKGROUND

IMN seems to constitute a special hazard for venous thromboembolism and spontaneous vascular thrombosis (such as deep venous thrombosis or pulmonary artery embolism/thrombosis), even more so than other causes of nephrotic syndrome (see also Chapter 1).^{301–303} This may also apply to other types of primary GN associated with severe nephrotic syndrome; the evidence base, however, is lacking. There have been no RCTs of prophylactic anticoagulation in IMN with nephrotic syndrome.^{301–303}

RATIONALE

There is very low-quality evidence to suggest the use of prophylactic anticoagulation with warfarin in patients with

Table 19 | Pediatric MN studies

Author	N	NS	Steroids	Other immunosuppression	Remission	Persistent disease	CRI	ESRD
Habib <i>et al.</i> ²⁹¹	50	72%	54%	44% (methylprednisolone and chlorambucil)	52%	38%	?	10%
Olbing <i>et al.</i> ²⁹²	9	78%	89%	22% cyclophosphamide, 11% azathioprine	33%	33%	33%	0%
Chan and Tsao ²⁹³	10	80%	100%	None	50%	40%	0%	10%
Trainin <i>et al.</i> ²⁹⁴	14	79%	79%	57% "cytotoxics"	43%	29%	7%	21%
Latham <i>et al.</i> ²⁹⁵	14	100%	≤93%	≤93%: cyclophosphamide	29%	50%	7%	14%
Ramirez <i>et al.</i> ²⁹⁶	22	82%	50%	5% azathioprine + cyclophosphamide, 5% chlorambucil	27%	45%	23%	5%
Tsukahara <i>et al.</i> ²⁹⁷	12	25%	42%	17% cyclophosphamide	67%	33%	0%	0%
Lee <i>et al.</i> ²⁹⁸	19	58%	84%	16% cyclosporine	68%	16%	5%	11%
Chen <i>et al.</i> ²⁹⁹	13	38%	77%	38% CNI, 23% azathioprine, or MMF	?	61%	23%	0%
Valentini <i>et al.</i> ³⁰⁰	12	75%	83%	58% cyclophosphamide	75%	17%	8%	0%

CRI, chronic renal insufficiency; ESRD, end-stage renal disease; MN, membranous nephropathy; MMF, mycophenolate mofetil.

With kind permission from Springer Science+Business Media: *Pediatr Nephrol. Membranous nephropathy in children: clinical presentation and therapeutic approach.* 2010; 25:1419–1428. Menon S, Valentini RP²⁸⁸; accessed <http://www.springerlink.com/content/2222k3x102551528/fulltext.pdf>.

IMN and severe nephrotic syndrome. However, based on Markov modeling of anticipated benefits and risks derived from observational studies, prophylactic anticoagulation might be considered when the serum albumin concentration is <2.0–2.5 g/dl (<20–25 g/l) with one or more of the following: proteinuria >10 g/d; BMI >35 kg/m²; prior history of thromboembolism; family history of thromboembolism with documented genetic predisposition; NYHA class III or IV congestive heart failure; recent abdominal or orthopedic surgery; prolonged immobilization.^{301–303} Treatment with warfarin should always be preceded by a short period of treatment with heparin (fractionated or unfractionated) in sufficient dosage to obtain prolongation of the clotting time. Dosage adjustments for fractionated heparin may be required if kidney function is impaired. Due to insufficient experience with the use of newer oral or parenteral anticoagulants in nephrotic syndrome, no recommendations can be made regarding their use for prophylaxis of thrombosis. The duration of prophylactic anticoagulation needed for optimal benefit compared to risk is not known, but it seems reasonable to continue therapy for as long as the patient remains nephrotic with a serum albumin <3.0 g/dl (<30 g/l).

RESEARCH RECOMMENDATION

- An RCT is needed of prophylactic warfarin in patients with nephrotic syndrome with/without additional risk for thromboembolism in IMN patients.

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every effort is made to ensure that drug doses and other quantities are presented accurately, readers are advised that new methods and techniques involving drug usage, and described within this Journal, should only be followed in conjunction with the drug manufacturer's own published literature.

SUPPLEMENTARY MATERIAL

Supplementary Table 22: Evidence profile of RCTs examining alkylating agents plus steroid treatment vs. control in patients with membranous nephropathy.

Supplementary Table 23: Existing systematic review on alkylating agents vs. control for idiopathic membranous nephropathy in adults with nephrotic syndrome.

Supplementary Table 24: Summary table of RCTs examining alkylating agents plus steroid treatment vs. control in patients with membranous nephropathy (categorical outcomes).

Supplementary Table 25: Summary table of RCTs examining alkylating agents plus steroid treatment vs. control in patients with membranous nephropathy (continuous outcomes).

Supplementary Table 26: Summary table of RCTs examining alkylating agents plus steroid treatment vs. ACTH in patients with membranous nephropathy (categorical outcomes).

Supplementary Table 27: Summary table of RCTs examining alkylating agents plus steroid treatment vs. ACTH in patients with membranous nephropathy (continuous outcomes).

Supplementary Table 28: Evidence profile of RCTs examining CsA/TAC treatment vs. control for idiopathic membranous nephropathy.

Supplementary Table 29: Existing systematic reviews on CsA/TAC treatment vs. placebo for idiopathic membranous nephropathy in adults with nephrotic syndrome.

Supplementary Table 30: Summary table of RCT examining CsA/TAC treatment vs. control for idiopathic membranous nephropathy (categorical outcomes).

Supplementary Table 31: Summary table of RCT examining CsA/TAC treatment vs. control for idiopathic membranous nephropathy (continuous outcomes).

Supplementary Table 32: Evidence profile of RCTs examining MMF treatment vs. control for idiopathic membranous nephropathy in adults with nephrotic syndrome.

Supplementary Table 33: Summary table of RCTs examining MMF treatment for idiopathic membranous nephropathy in adults with nephrotic syndrome (categorical outcomes).

Supplementary Table 34: Summary table of RCTs examining MMF treatment for idiopathic membranous nephropathy in adults with nephrotic syndrome (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 8: Idiopathic membranoproliferative glomerulonephritis

Kidney International Supplements (2012) **2**, 198–199; doi:10.1038/kisup.2012.21

INTRODUCTION

This chapter makes treatment recommendations for MPGN believed to be of unknown cause (idiopathic MPGN) in adults and children. The cost implications for global application of this guideline are addressed in Chapter 2.

8.1: Evaluation of MPGN

8.1.1: Evaluate patients with the histological (light-microscopic) pattern of MPGN for underlying diseases before considering a specific treatment regimen (see Table 20). (Not Graded)

BACKGROUND

MPGN is a light-microscopic “pattern of injury” caused by many disorders (see Table 20).^{304,305} Patients commonly present with nephrotic syndrome, hypertension, glomerular hematuria, and progressive kidney dysfunction.^{304,305} Reduction in the serum concentration of complement components (C3 and/or C4) is commonly, but not uniformly, observed.^{305,306}

MPGN can be further classified based on the extent and location of deposits of immunoglobulin and/or complement. The classification of MPGN according to ultrastructural appearances into MPGN type I, II, or III is commonly employed, but newer classification schema based on immunopathology are replacing this approach.^{307,308} Type I MPGN is associated with subendothelial and mesangial electron-dense deposits containing immunoglobulin and/or C3,^{305,309,310} and is often due to an underlying chronic hepatitis B or C infection (see Chapter 9); type II MPGN with electron dense intramembranous deposits containing numerous complement components, but not immunoglobulin^{305,309} and is now known as “dense-deposit disease”. It has a distinctive etiology based on inherited or acquired abnormalities of complement regulatory proteins.^{305,311} Other rarer variants (type III MPGN) are also recognized based on abnormalities of the glomerular basement membrane and the location of electron-dense deposits. Immunopathological variants are recognized based on deposition of IgG and/or C3 component of complement in glomeruli. Those in which C3 is exclusively deposited are known as C3 GN.^{305,307,308,311}

Treatment of MPGN is highly dependent on proper identification of underlying causes (see Table 20). In some patients C3 nephritic factor, an autoantibody to C3bBb,

can be involved in the pathogenesis of type I, II, III, or C3 GN.^{312,313}

Idiopathic MPGN is defined by exclusion of any other identifiable cause, most typically when the ultrastructural pattern is type I MPGN. Idiopathic type I MPGN is very uncommon in developed countries, but remains a relatively common, although diminishing, cause of nephrotic syndrome in developing countries, especially those with a high burden of endemic infectious diseases.³¹⁴

RATIONALE

- Based on the heterogeneity of cause and pattern of histologic injury of MPGN, all patients with MPGN must be thoroughly evaluated for underlying diseases before being classified as idiopathic MPGN, and before any specific treatment decisions can be made.

8.2: Treatment of idiopathic MPGN

8.2.1: We suggest that adults or children with presumed idiopathic MPGN accompanied by nephrotic syndrome AND progressive decline of kidney function receive oral cyclophosphamide or MMF plus low-dose alternate-day or daily corticosteroids with initial therapy limited to less than 6 months. (2D)

RATIONALE

- There is very low-quality evidence to suggest the benefit of an immunosuppressive agent plus corticosteroids in the treatment of idiopathic (type I) MPGN with nephrotic syndrome and/or deteriorating kidney function.

MPGN is identified by exclusion of all other known causes of the MPGN pattern on kidney biopsy. When there is a secondary MPGN, i.e., a defined cause for the MPGN pattern (see Table 20), treatment should be directed against that cause. A review of the evidence for the management of each of those conditions enumerated in Table 20 is outside the scope of this guideline. This section will consider only those patients who *do not* have any recognized underlying cause or pathobiological mechanism for the MPGN lesion. Most of these patients will have the type I pattern by electron microscopy.

Many of the early reports of treatment of “idiopathic” MPGN likely inadvertently included cases of secondary MPGN. Therefore, the results of these studies must now be

Table 20 | Underlying conditions associated with a membranoproliferative pattern of GN

Chronic infections (especially hepatitis C)
Autoimmune diseases (especially LN)
Monoclonal gammopathies (especially light-chain deposition disease and monoclonal IgG disease)
Complement dysregulation (especially complement factor H deficiency)
Chronic and healed thrombotic microangiopathies

GN, glomerulonephritis; LN, lupus nephritis.

interpreted with great caution given today's knowledge regarding immunopathogenesis.^{304,305,307,308} Truly "idiopathic" MPGN is now a very uncommon condition, except in certain developing countries with a high endemic burden of infections. The few RCTs of treatment of idiopathic MPGN in children and adults have given inconsistent and largely inconclusive results.^{304,305} Many of the reported trials have weak experimental design or are underpowered, and thus the evidence base underlying the recommendations for treatment of "idiopathic" MPGN is very weak. Early claims of benefit for a combination of aspirin and dipyridamole for adults with idiopathic MPGN were later rejected^{315,316} and benefits of "antiplatelet" therapy in "idiopathic" MPGN remain in doubt.^{317,318}

The benefit of long-term alternate-day corticosteroid therapy for "idiopathic" MPGN in children was suggested by observational studies and a single RCT, but the results were equivocal; there have been no subsequent confirmatory RCTs.^{319–322}

The benefits of immunosuppressive therapy (cyclophosphamide or MMF) often combined with high-dose i.v. or oral steroids have never been demonstrated in RCTs. However, small, observational studies with short-term follow-up have suggested a benefit, mostly in subjects with a rapidly progressive course, often associated with extensive crescents, or in those with progressive kidney disease with persistence of severe nephrotic syndrome.^{145,317,323–329} Publication bias might be operative in these reports. Progressive renal failure remains the only indication for immunosuppressive treatment, but the overall evidence for efficacy and safety is weak. See Chapters 13 and 14 for discussion of treatment of those cases of MPGN with superimposed extensive crescentic lesions and rapidly progressive renal failure.

RESEARCH RECOMMENDATION

- An RCT is needed to test corticosteroids in combination with an immunosuppressive agent such as cyclophosphamide, MMF, or rituximab in "idiopathic" MPGN with nephrotic syndrome in adults and children.

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SUPPLEMENTARY MATERIAL

Supplementary Table 35: Evidence profile of RCTs examining alternate-day prednisone treatment vs. control in adults and children with MPGN.

Supplementary Table 36: Summary table of studies examining alternate-day prednisone treatment vs. control in patients with MPGN (categorical outcomes).

Supplementary Table 37: Summary table of studies examining alternate-day prednisone treatment vs. control in patients with MPGN (continuous outcomes).

Supplementary Table 38: Summary table of studies examining dipyridamole plus aspirin treatment vs. placebo in patients with MPGN (categorical outcomes).

Supplementary Table 39: Summary table of studies examining dipyridamole plus aspirin treatment vs. placebo in patients with MPGN (continuous outcomes).

Supplementary Table 40: Summary table of study examining warfarin plus dipyridamole treatment vs. control in patients with MPGN (categorical outcomes).

Supplementary Table 41: Summary table of study examining warfarin plus dipyridamole treatment vs. control in patients with MPGN (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 9: Infection-related glomerulonephritis

Kidney International Supplements (2012) **2**, 200–208; doi:10.1038/kisup.2012.22

9.1: For the following infection-related GN, we suggest appropriate treatment of the infectious disease and standard approaches to management of the kidney manifestations: (2D)

- poststreptococcal GN;
- infective endocarditis-related GN;
- shunt nephritis.

INTRODUCTION

This chapter provides recommendations for the treatment of infection-associated GN, which may occur in association with bacterial, viral, fungal, protozoal, and helminthic infection (Table 21). The cost implications for global application of this guideline are addressed in Chapter 2.

BACTERIAL INFECTION-RELATED GN

BACKGROUND AND RATIONALE

The prototype for bacterial infection-related GN (also called postinfectious GN) is poststreptococcal GN, which most often occurs in children following a pharyngeal or cutaneous infection (impetigo) caused by a particular nephritogenic strain of *Streptococci*, and usually has a favorable outcome.

However, in the last decades the spectrum of postinfectious GN has changed. The incidence of poststreptococcal GN, particularly in its epidemic form, has progressively declined in industrialized countries. Recent series reported that streptococcal infections accounted for only 28–47% of acute GN, *Staphylococcus aureus* or *Staphylococcus epidermidis* being isolated in 12–24% of cases and Gram-negative bacteria in up to 22% of cases.^{330–332} Bacterial endocarditis and shunt infections are also frequently associated with postinfectious GN. Moreover, the atypical postinfectious GN tends to affect mainly adults who are immunocompromised, e.g., in association with alcoholism, diabetes, and drug addiction. While spontaneous recovery within a few weeks is still the rule in children affected by the typical poststreptococcal GN, the prognosis in immunocompromised adults with postinfectious GN is significantly worse, with less than 50% in complete remission after a long follow-up.³³³

POSTSTREPTOCOCCAL GN

BACKGROUND AND RATIONALE

The diagnosis of poststreptococcal GN requires the demonstration of antecedent streptococcal infection in a patient who presents with acute GN. Nephritis may follow 7–15 days after streptococcal tonsillitis and 4–6 weeks after impetigo.³³⁴

The nature of the nephritogenic streptococcal antigen is still controversial.^{334–336} Kidney biopsy is not indicated unless there are characteristics that make the diagnosis doubtful, or to assess prognosis and/or for potential therapeutic reasons. The kidney histology shows acute endocapillary GN with mesangial and capillary granular immune deposition.

The clinical manifestations of acute nephritic syndrome usually last less than 2 weeks. Less than 4% of children with poststreptococcal GN have massive proteinuria, and occasionally a patient develops crescentic GN with rapidly progressive kidney dysfunction. Serum C3 values usually return to normal by 8–10 weeks after recognition of the infection. Persistent hypocomplementemia beyond 3 months may be an indication for a renal biopsy, if one has not already been performed. A lesion of MPGN is commonly found in persistently hypocomplementemic GN.

The short-term prognosis of the acute phase of poststreptococcal GN is excellent in children; however, in elderly patients, mortality in some series is as high as 20%. Although the long-term prognosis of poststreptococcal GN is debated, the incidence of ESRD in studies with 15 years of follow-up is less than 1%, with the exception being that long-term prognosis is poor in elderly patients who develop persistent proteinuria.^{333,334}

Well-documented streptococcal infection should be treated with penicillin, or erythromycin if the patient is allergic to penicillin, to resolve streptococcal infection and prevent the spread of the nephritogenic streptococcus among relatives or contacts. However, antibiotics are of little help for reversing GN, as the glomerular lesions induced by immune complexes are already established.

The management of acute nephritic syndrome, mainly in adults, requires hospital admission if features of severe hypertension or congestive heart failure are present. Hypertension and edema usually subside after diuresis is established. Adult patients persisting with urinary abnormalities beyond 6 months, especially if proteinuria >1 g/d, should receive ACE-I or ARBs, as in other proteinuric glomerular diseases (see Chapter 2). The long-term prognosis is worse in patients, mainly adults, who have persistent proteinuria after 6 months.³³⁷

Pulses of i.v. methylprednisolone can be considered in patients with extensive glomerular crescents and rapidly progressive GN, based on extrapolation from other rapidly progressive and crescentic GNs, although there is no evidence from RCTs.

RESEARCH RECOMMENDATIONS

- An RCT is needed to evaluate the treatment of crescentic poststreptococcal GN with corticosteroids.

Table 21 | Infections associated with glomerulonephritis

<p>Bacterial</p> <p><i>Mycobacterium leprae</i>, <i>M. tuberculosis</i> <i>Treponema pallidum</i> <i>Salmonella typhi</i>, <i>S. paratyphi</i>, <i>S. typhimurium</i> <i>Streptococcus pneumoniae</i>, <i>S. viridans</i>, <i>S. pyogenes</i> <i>Staphylococcus aureus</i>, <i>S. epidermidis</i>, <i>S. albus</i> <i>Leptospira</i> species^a <i>Yersinia enterocolitica</i>^a <i>Neisseria meningitidis</i>, <i>Neisseria gonorrhoeae</i>^a <i>Corynebacterium diphtheriae</i>^a <i>Coxiella burnetii</i>^a <i>Brucella abortus</i>^a <i>Listeria monocytogenes</i>^a</p> <p>Fungal</p> <p><i>Histoplasma capsulatum</i>^a <i>Candida</i>^a <i>Coccidioides immitis</i>^a</p> <p>Protozoal</p> <p><i>Plasmodium malariae</i>, <i>P. falciparum</i> <i>Leishmania donovani</i> <i>Toxoplasma gondii</i> <i>Trypanosoma cruzi</i>, <i>T. brucei</i> <i>Toxocara canis</i>^a <i>Strongyloides stercoralis</i>^a</p>	<p>Viral</p> <p>Hepatitis B and C Human immunodeficiency virus Epstein-Barr virus Coxsackie B ECHO virus Cytomegalovirus Varicella zoster Mumps Rubella Influenza</p> <p>Helminthic</p> <p><i>Schistosoma mansoni</i>, <i>S. japonicum</i>, <i>S. haematobium</i> <i>Wuchereria bancrofti</i> <i>Brugia malayi</i> <i>Loa loa</i> <i>Onchocerca volvulus</i> <i>Trichinella spiralis</i>^a</p>
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ECHO, enteric cytopathic human orphan; GN, glomerulonephritis.

^aOnly case reports documented.

- Research is needed to determine the nature of the streptococcal antigen, as a basis for developing immunoprophylactic therapy.

GN ASSOCIATED WITH INFECTIVE ENDOCARDITIS

BACKGROUND AND RATIONALE

The natural history of GN associated with infective endocarditis has been significantly altered with the changing epidemiology of the disorder, and with the use of antibiotics.³³⁷⁻³⁴⁰

In USA, infective endocarditis is diagnosed in approximately 40 cases per million every year, and the disease is increasingly frequent in elderly individuals and in patients with no underlying heart disease. i.v. drug usage, prosthetic heart valves, and structural heart disease are risk factors. *Staphylococcus aureus* has replaced *Streptococcus viridans* as the leading cause of infective endocarditis. The incidence of GN associated with *Staphylococcus aureus* endocarditis ranges from 22% to 78%, the highest risk being among i.v. drug users. Focal and segmental proliferative GN, often with focal crescents, is the most typical finding. Some patients may exhibit a more diffuse proliferative endocapillary lesion with or without crescents.³³⁷⁻³⁴⁰

The immediate prognosis of the GN is good, and is related to the prompt eradication of the infection, using appropriate antibiotics for 4–6 weeks.

RESEARCH RECOMMENDATION

- Multicenter studies are needed to determine the incidence, prevalence, and long-term prognosis of infective endocarditis-related GN.

SHUNT NEPHRITIS

BACKGROUND AND RATIONALE

Shunt nephritis is an immune complex-mediated GN that develops as a complication of chronic infection on ventriculoatrial or ventriculojugular shunts inserted for the treatment of hydrocephalus.³⁴¹

The diagnosis is based on clinical evidence of kidney disease (most commonly, microscopic hematuria and proteinuria, frequently in the nephrotic range, occasionally elevated SCR and hypertension) with prolonged fever or signs of chronic infection, in a patient with a ventriculovascular shunt implanted for treatment of hydrocephalus. The histologic findings are typically type 1 MPGN, with granular deposits of IgG, IgM, and C3, and electron-dense mesangial and subendothelial deposits.

The renal outcome of shunt nephritis is good if there is early diagnosis and treatment of the infection. Ventriculovascular shunts may become infected in about 30% of cases. GN may develop in 0.7–2% of the infected ventriculovascular shunts in an interval of time ranging from 2 months to many years after insertion. The infecting organisms are usually *Staphylococcus epidermidis* or *Staphylococcus aureus*. In contrast to ventriculovascular shunts, ventriculoperitoneal shunts are rarely complicated with GN.

A late diagnosis, resulting in delays in initiating antibiotic therapy and in removing the shunt, results in a worse renal prognosis.

RESEARCH RECOMMENDATION

- Multicenter observational studies are needed to determine the incidence, prevalence, and long-term prognosis of shunt nephritis.

9.2: Hepatitis C virus (HCV) infection–related GN

(Please also refer to the published KDIGO Clinical Practice Guidelines for the Prevention, Diagnosis, Evaluation, and Treatment of Hepatitis C in Chronic Kidney Disease.³⁴²)

- 9.2.1: For HCV-infected patients with CKD Stages 1 or 2 and GN, we suggest combined antiviral treatment using pegylated interferon and ribavirin as in the general population. (2C) [based on KDIGO HCV Recommendation 2.2.1]**
- 9.2.1.1: Titrate ribavirin dose according to patient tolerance and level of renal function. (Not Graded)**
- 9.2.2: For HCV-infected patients with CKD Stages 3, 4, or 5 and GN not yet on dialysis, we suggest monotherapy with pegylated interferon, with doses adjusted to the level of kidney function. (2D) [based on KDIGO HCV Recommendation 2.2.2]**
- 9.2.3: For patients with HCV and mixed cryoglobulinemia (IgG/IgM) with nephrotic proteinuria or evidence of progressive kidney disease or an acute flare of cryoglobulinemia, we suggest either plasmapheresis, rituximab, or cyclophosphamide, in conjunction with i.v. methylprednisolone, and concomitant antiviral therapy. (2D)**

BACKGROUND

HCV infection is a major public health problem, with an estimated 130–170 million people infected worldwide.^{343–345} HCV frequently causes extrahepatic manifestations, including mixed cryoglobulinemia, lymphoproliferative disorders, Sjögren's syndrome, and kidney disease. A major concern is the lack of safe and effective drugs to treat HCV-infected patients with CKD.³⁴⁶ Unfortunately, there are no large-scale clinical trials in patients with HCV-associated kidney disease; thus, evidence-based treatment recommendations cannot be made in this patient population. However, we have extrapolated HCV treatment from the non-CKD population, with the appropriate and necessary dose adjustments.

Kidney involvement due to HCV is most commonly associated with type II cryoglobulinemia, and is clinically manifested by proteinuria, microscopic hematuria, hypertension, and mild to moderate kidney impairment.^{347,348}

On kidney biopsy, a type I MPGN pattern of injury is the most common pathological finding.³⁴⁹ Vasculitis of the small- and medium-sized renal arteries can also be present. Immunofluorescence usually demonstrates deposition of IgM, IgG, and C3 in the mesangium and capillary walls. On electron microscopy, subendothelial immune complexes are usually seen and may have an organized substructure suggestive of cryoglobulin deposits.^{348,350} Besides MPGN, other forms of glomerular disease have been described in patients with HCV, including IgAN, MN, postinfectious GN, thrombotic microangiopathies, FSGS, and fibrillary and immunotactoid GN.^{348–354}

Patients with type II cryoglobulinemia (mixed polyclonal IgG and monoclonal IgM [Rheumatoid-factor positive] cryoglobulins) should be tested for HCV. Patients with proteinuria and cryoglobulinemia should be tested for HCV RNA even in the absence of clinical and/or biochemical evidence of liver disease. Similarly, HCV-infected patients should be tested at least annually for proteinuria, hematuria, and eGFR to detect possible HCV-associated kidney disease. Practice guidelines for treatment of HCV infection in general have been recently published.³⁵⁵ For detailed information regarding treatment of HCV-mediated kidney disease the reader is also referred to the recently published KDIGO Clinical Practice Guidelines for the Prevention, Diagnosis, Evaluation, and Treatment of Hepatitis C in Chronic Kidney Disease.³⁴²

RATIONALE

- There is low-quality evidence to recommend treatment of HCV-associated GN. Treatment should be focused on reducing or eliminating HCV replication, and reducing the formation and glomerular deposition of HCV-containing immune complexes (including cryoglobulins).
- There is low-quality evidence to recommend dose adjustments for interferon and ribavirin based on level of kidney function.
- There is very low-quality evidence to suggest that patients with HCV-associated GN and severe kidney manifestations require additional treatment with immunosuppression and/or corticosteroids and/ or plasma exchange.

The best long-term prognostic indicator of HCV-associated GN is sustained virologic response (defined as HCV RNA clearance from serum) for at least 6 months after cessation of therapy. In patients with normal kidney function, this aim can be best achieved by the use of pegylated interferon- α -2a/2b in combination with ribavirin, which results in sustained virological response rates of 45–50% in genotypes 1 and 4, and 70–80% in genotypes 2 and 3 in HCV-monoinfected patients. This represents the current standard of care for HCV infection.^{342,355}

Treatment regimens for HCV-associated GN and the doses of individual agents will vary with the severity of the kidney disease. No dose adjustment is needed for patients with eGFR > 60 ml/min.^{356–358}

There is a paucity of information regarding treatment of HCV-infected patients with GFR < 60 ml/min but not yet on dialysis (CKD stages 3–5). The suggested doses (based on expert opinion, not evidence) are pegylated interferon- α -2b, 1 μ g/kg subcutaneously once weekly or pegylated interferon- α -2a, 135 μ g subcutaneously once weekly, together with ribavirin 200–800 mg/d in two divided doses, starting with the low dose and increasing gradually, as long as side-effects are minimal and manageable (see Table 22). Hemolysis secondary to ribavirin very commonly limits its dosage or prevents its use in patients with CKD.

Monotherapy with interferon- α has been used in cryoglobulinemic GN with complete clearance of HCV RNA and improved kidney function; however, recurrence of viremia

Table 22 | Treatment of HCV infection according to stages of CKD

Stages of CKD	IFN ^a	Ribavirin ^b
1 and 2	Pegylated IFN α -2a: 180 μ g SQ q wk Pegylated IFN α -2b: 1.5 μ g/kg SQ q wk	800–1200 mg/d in two divided doses
3 and 4	Pegylated IFN α -2a: 135 μ g SQ q wk Pegylated IFN α -2b: 1 μ g/kg SQ q wk	*
5	Pegylated IFN α -2a: 135 μ g SQ q wk Pegylated IFN α -2b: 1 μ g/kg SQ q wk	*

eGFR, estimated glomerular filtration rate; IFN, interferon; SQ, subcutaneous; q wk, every week.

^aPatients with genotypes 1 and 4 should receive 48 weeks of IFN therapy if an early viral response is obtained at 12 weeks (> 2 log fall in viral titer). Genotypes 2 and 3 should be treated for 24 weeks.

^bPatients with genotypes 2 and 3 infection should receive 800 mg/d with Stages 1 and 2 CKD. Patients infected with genotypes 1 and 4 should receive 1000–1200 mg/d with Stages 1 and 2 CKD.

*Since the publication of KDIGO Hepatitis C in CKD guideline,³⁴² product label changes now permit concurrent use of ribavirin in patients with CKD Stages 3–5 as long as side-effects are minimal and manageable. Caution is advised for patients with clearance <50 ml/min, which may require substantially reduced dosage. Consult local package inserts for information on dosing modifications.

and relapses of kidney disease were universally observed after interferon was discontinued.^{359,360} Subsequent studies with interferon- α monotherapy^{360–363} have yielded mixed results.³⁶⁰ Treatment with interferon- α may exacerbate cryoglobulinemic vasculitis.^{364,365} Thus, it is recommended that interferon - α should be started after the acute flare has been controlled with immunosuppressive agents.³⁶⁶

Better outcomes have been achieved by combined use of interferon- α with ribavirin^{367–370} and pegylated interferon with ribavirin.^{366,370–374} In a recent meta-analysis of controlled clinical trials comparing the efficacy and safety of antiviral vs. immunosuppressive therapy (corticosteroids alone or in combination with cyclophosphamide) in patients with HCV-associated GN, proteinuria decreased more (odds ratio 3.86) after interferon therapy (3 MU thrice weekly for at least 6 months).³⁷⁵ However, both treatments failed to significantly improve kidney function. Recently published KDIGO guidelines for treatment of viral hepatitis in patients with kidney disease suggest that patients with moderate proteinuria and slowly progressive kidney disease can be treated with a 12-month course of standard interferon- α or pegylated interferon- α -2a with dose adjusted as described below plus ribavirin, with or without erythropoietin support, depending on the level of hemoglobin.³⁴² Ribavirin dose needs to be titrated according to patient tolerance; caution is advised for patients with clearance <50 ml/min which may require substantially reduced dosage.

There is very low-quality evidence that patients with nephrotic-range proteinuria and/or rapidly progressive kidney failure or an acute flare of cryoglobulinemia, should receive additional therapy with either plasmapheresis (3 L of plasma thrice weekly for 2–3 weeks), rituximab (375 mg/m² once a week for 4 weeks), or cyclophosphamide (2 mg/kg/d for 2–4 months) plus i.v. methylprednisolone 0.5–1 g/d for 3 days.³⁴² There are no comparative data to favour any one of these three additional therapies. Corticosteroids may lead to increases in HCV viral load.^{376,377}

Case reports have suggested remarkable reduction in proteinuria and stabilization of kidney function in response to rituximab in patients with cryoglobulinemic vasculitis.^{378,379} Although HCV viremia increased modestly in some patients, it remained unchanged or decreased in others and the overall treatment was considered safe.³⁸⁰ Observations in 16 patients with severe refractory HCV-related cryoglobulinemia vasculitis treated with rituximab in combination with pegylated interferon- α -2b and ribavirin also showed good response.³⁸¹ Symptoms usually reappear with reconstitution of peripheral B cells. The long-term safety of multiple courses of rituximab in patients with HCV is unknown. It remains debatable whether antiviral therapy should be commenced as soon as immunosuppression is begun or delayed until a clinical remission (complete or partial) is evident.^{382–384}

There is a paucity of controlled studies available in HCV-associated GN; most studies are retrospective analyses with small sample sizes. Most of the available evidence comes from studies of patients with significant proteinuria, hematuria, or reduced kidney function.

RESEARCH RECOMMENDATIONS

- Epidemiologic studies are needed to determine:
 - the prevalence and types of glomerular lesions in HCV-infected patients;
 - whether there are true associations between HCV infection and GN other than MPGN (e.g., IgAN).
- An RCT is needed to evaluate corticosteroids plus cyclophosphamide in addition to antiviral therapy in HCV-associated GN.
- An RCT is needed to evaluate rituximab in addition to antiviral therapy in HCV-associated GN.

9.3: Hepatitis B virus (HBV) infection-related GN

9.3.1: We recommend that patients with HBV infection and GN receive treatment with interferon- α or with nucleoside analogues as recommended for the general population by standard clinical practice guidelines for HBV infection (see Table 23). (1C)

9.3.2: We recommend that the dosing of these antiviral agents be adjusted to the degree of kidney function. (1C)

BACKGROUND

Approximately one-third of the world's population has serological evidence of past or present infection with HBV, and 350 million people are chronically infected, making it one of the most common human pathogens.^{385,386} The spectrum of disease and natural history of chronic HBV infection is diverse and variable, ranging from a low viremic inactive carrier state to progressive chronic hepatitis, which may evolve to cirrhosis and hepatocellular carcinoma. It is not possible to predict which patients with HBV infection are more likely to develop kidney disease.³⁸⁷

HBV-associated patterns of GN include MN, MPGN, FSGS and IgAN. MN is the most common form of HBV-mediated GN, especially in children. The diagnosis of HBV-mediated GN requires detection of the virus in the blood and the exclusion of other causes of glomerular disease. In children, HBV-mediated GN has a favorable prognosis, with high spontaneous remission rate. In adults, HBV-mediated GN is usually progressive. Patients with nephrotic syndrome and abnormal liver function tests have an even worse prognosis, with >50% progressing to ESRD in the short term.³⁸⁸ There are no RCT studies on the treatment of HBV-mediated GN, so evidence-based treatment recommendations cannot be made. Clinical practice guidelines on the management of chronic hepatitis B have been recently published in Europe and in the USA, but do not include specific recommendations on HBV-mediated kidney disease.^{385,386}

RATIONALE

- Treatment of HBV-associated GN with interferon or nucleoside analogues is indicated.

Several drugs are now available for the treatment of chronic HBV infection (see Table 23). The efficacy of these drugs has been assessed in an RCT at 1 year (2 years with telbivudine). Longer follow-up (up to 5 years) is available for lamivudine, adefovir, entecavir, telbivudine, and tenofovir in patient subgroups.³⁸⁵ However, there are no data to indicate the effect of these treatments for HBV infection on the natural history of HBV-related GN. Treatment of patients with HBV infection and GN should be conducted according to standard clinical practice guidelines for HBV infection. Nephrotoxicity of some of the nucleoside analogues (adefovir and tenofovir) can be of concern.

The heterogeneity of patients with HBV infection (e.g., degree of liver function impairment, extent of extrahepatic involvement) creates substantial complexity in establishing treatment guidelines in patients with HBV-mediated kidney disease.

RESEARCH RECOMMENDATIONS

- RCTs are needed to establish the most effective antiviral treatment regimen in modifying the progression of

HBV-associated GN. Studies will need to account for the extrarenal disease involvement, as well as evaluate varying drug combinations, including timing and duration of therapy.

- RCTs in children should be evaluated separately in view of the higher rate of spontaneous remission in HBV-associated GN.

9.4: Human Immunodeficiency virus (HIV) infection-related glomerular disorders

9.4.1: We recommend that antiretroviral therapy be initiated in all patients with biopsy-proven HIV-associated nephropathy, regardless of CD4 count. (1B)

BACKGROUND

Approximately 5 million people a year are infected with HIV worldwide.³⁹⁰ Kidney disease is a relatively frequent complication in patients infected with HIV.

Human immunodeficiency virus-associated nephropathy (HIVAN) is the most common cause of CKD in patients with HIV-1, and is mostly observed in patients of African descent,^{391,392} perhaps related to susceptibility associated with genetic variation at the *APOL1* gene locus on chromosome 22, closely associated with the *MYH9* locus.^{164,393} Untreated, HIVAN rapidly progresses to ESRD. Typical HIVAN pathology includes FSGS, often with a collapsing pattern, accompanied by microcystic change in tubules. There are usually many tubuloreticular structures seen on electron microscopy. In addition to HIVAN, a number of other HIV-associated kidney diseases have been described.^{391,394,395} In patients with HIV, proteinuria and/or decreased kidney function is associated with increased mortality and worse outcomes.³⁹⁶ Data from a number of RCTs suggest that highly active antiretroviral therapy (HAART) is beneficial in both preservation and improvement of kidney function in patients with HIV.^{397–399} Patients with kidney dysfunction at start of HAART have the most dramatic improvements in kidney function.^{400,401} A decrease in HIV viral load during HAART is associated with kidney function improvement, while an increase in viral load is associated with worsening kidney function.^{402–404}

Table 23 | Dosage adjustment of drugs for HBV infection according to kidney function (endogenous CrCl)

Drug	CrCl > 50 (ml/min)	30 < CrCl < 50 (ml/min)	10 < CrCl < 30 (ml/min)	CrCl < 10 (ml/min)
Lamivudine	300 mg p.o. q.d. or 150 mg p.o. b.i.d.	150 mg p.o. q.d.	150 mg first dose then 100 mg p.o. q.d. ^a	150 mg first dose then 50 mg p.o. q.d. ^b
Adefovir	10 mg p.o. q.d.	10 mg p.o. every 48 hours	10 mg po every 72 hours	No dosing recommended
Entecavir	0.5 mg p.o. q.d.	0.25 mg p.o. q.d.	0.15 mg p.o. q.d.	0.05 mg p.o. q.d.
Entecavir in lamivudine-refractory patients	1 mg p.o. q.d.	0.5 mg p.o. q.d.	0.3 mg p.o. q.d.	0.1 mg p.o. q.d.
Telbivudine	600 mg p.o. q.d.	600 mg p.o. every 48 hours	600 mg p.o. every 72 hours	600 mg p.o. every 96 hours
Tenofovir	300 mg p.o. q.d.	300 mg p.o. q.d every 48 hours	300 mg p.o. q.d every 72–96 hours	300 mg p.o. q.w.

b.i.d., twice daily; CrCl, creatinine clearance; HBV, hepatitis B virus; p.o., orally; q.d., every day; q.w., once a week.

^aFor CrCl < 15 ml/min, 150 mg first dose, then 50 mg p.o. q.d.

^bFor CrCl < 5 ml/min, 50 mg first dose, then 25 mg p.o. q.d.

Adapted by permission from Macmillan Publishers Ltd: Kidney International. Olsen SK, Brown RS, Jr. Hepatitis B treatment: Lessons for the nephrologist. *Kidney Int* 2006; 70: 1897–1904;³⁸⁷ accessed <http://www.nature.com/ki/journal/v70/n11/pdf/5001908a.pdf>. Supplemented with data from ref 389.

RATIONALE

- There is low-quality evidence to suggest a kidney biopsy is necessary to define the specific type of kidney diseases present in patients with HIV infection.
- HAART may be effective in HIVAN, but it is not effective in other GN associated with HIV infection.

Causes of kidney disease, other than HIVAN, that occur in patients with HIV infection include diabetic nephropathy, thrombotic microangiopathies, cryoglobulinemia, immune complex GN, an SLE-like GN, or amyloidosis (see Table 24).^{394,395,405,406} More than a third of the patients with HIV who underwent a kidney biopsy had diabetic nephropathy; or MN, MPGN, IgAN, or another pattern of immune-complex GN.^{395,407} In patients with HIV infection, many of these pathologies can mimic HIVAN, but each condition requires a different therapy.^{391,394,395,408} Studies in HIV-infected patients with kidney disease from Africa showed a high prevalence of HIVAN, but other forms of GN and interstitial nephritis were also present (see Table 24).^{409,410} Cohen and Kimmel recently reviewed the rationale for a kidney biopsy in the diagnosis of HIV-associated kidney disease.^{391,411}

Observational studies and data from uncontrolled or retrospective studies^{398,399,412–415} and from an RCT³⁹⁷ suggest that HAART (defined as combination therapy with three or more drugs) is beneficial in both preservation and improvement of kidney function in patients with HIVAN. Since the

Table 24 | The spectrum of kidney disease in HIV-infected patients

- HIVAN-collapsing FSGS
- Arterionephrosclerosis
- Immune-complex GN
 - MPGN pattern of injury
 - Lupus-like GN
- Idiopathic FSGS
- HCV and cryoglobulinemia
- Thrombotic microangiopathies
- Membranous nephropathy
 - HBV-mediated
 - Malignancy
- Minimal-change nephropathy
- IgAN
- Diabetic nephropathy
- Postinfectious GN
 - Infectious endocarditis
 - Other infections: *Candida*, *Cryptococcus*
- Amyloidosis
- Chronic pyelonephritis
- Acute or chronic interstitial nephritis
- Crystal nephropathy
 - Indinavir, atazanavir, i.v. acyclovir, sulfadiazine
- Acute tubular necrosis
- Proximal tubulopathy (Fanconi syndrome)
 - Tenofovir

FSGS, focal segmental glomerulosclerosis; GN, glomerulonephritis; HBV, hepatitis B virus; HCV, hepatitis C virus; HIVAN, human immunodeficiency virus-associated nephropathy; IgAN, immunoglobulin A nephropathy; MPGN, mesangial proliferative glomerulonephritis.

introduction of HAART in the 1990s, there has also been a substantial reduction in the incidence of HIVAN.⁴¹⁶ In multivariate analysis, HIVAN risk was reduced by 60% (95% CI –30% to –80%) by use of HAART, and no patient developed HIVAN when HAART had been initiated prior to the development of acquired immune deficiency syndrome.⁴¹⁶ The use of HAART has also been associated with improved kidney survival in patients with HIVAN.⁴¹⁷ Antiviral therapy has been associated with GFR improvements in HIV patients with both low CD4 lymphocyte counts and impaired baseline kidney function, supporting an independent contribution of HIV-1 replication to chronic kidney dysfunction in advanced HIV disease.³⁹⁸

Early observational studies suggested a benefit for ACE-I.⁴¹⁸ A number of retrospective, observational, or uncontrolled studies conducted before or during the initial phases of HAART reported variable success with the use of corticosteroids in patients with HIV-associated kidney diseases.^{419–421} There is only one study using cyclosporine in 15 children with HIV and nephrotic syndrome.⁴²² These early observational studies suggested a benefit for ACE-I and corticosteroids in HIV-mediated kidney disease, but the studies were prior to introduction of HAART, and in the era of modern HAART therapy, it is unclear what the potential benefits are, if any, of the use of corticosteroids or cyclosporine in the treatment of patients with HIVAN or other HIV-related kidney diseases. It is not known whether this benefit remains in the context of current management.⁴¹⁸

There is no RCT that evaluates the value of HAART therapy in patients with HIVAN.⁴²³ There is very low-quality evidence to suggest that HAART may be of benefit in patients with HIV-associated immune-complex kidney diseases and thrombotic microangiopathies.^{391,394,411} There are recent comprehensive reviews of HIV and kidney disease that describe current knowledge and gaps therein.^{424,425}

RESEARCH RECOMMENDATIONS

- RCTs are needed to evaluate the efficacy of HAART in HIVAN and other HIV-associated glomerular diseases. Long-term follow-up is needed to determine if kidney damage in susceptible individuals is halted or merely slowed by HAART, particularly when control of viremia is incomplete or intermittent.
- An RCT is needed to evaluate the role of corticosteroids in combination with HAART in the treatment of HIV-associated kidney diseases.
- An RCT is needed to determine if benefits of RAS blockade are independent of HAART therapy in patients with HIVAN and other HIV-mediated kidney diseases.

9.5: Schistosomal, filarial, and malarial nephropathies

9.5.1: We suggest that patients with GN and concomitant malarial, schistosomal, or filarial infection be treated with an appropriate anti-parasitic agent in sufficient dosage and duration to eradicate the organism. (Not Graded)

- 9.5.2: We suggest that corticosteroids or immunosuppressive agents not be used for treatment of schistosomal-associated GN, since the GN is believed to be the direct result of infection and the attendant immune response to the organism. (2D)
- 9.5.3: We suggest that blood culture for *Salmonella* be considered in all patients with hepatosplenic schistosomiasis who show urinary abnormalities and/or reduced GFR. (2C)
- 9.5.3.1: We suggest that all patients who show a positive blood culture for *Salmonella* receive anti-*Salmonella* therapy. (2C)

SCHISTOSOMAL NEPHROPATHY

BACKGROUND

Schistosomiasis (syn. Bilharziasis), a chronic infection by trematodes (blood flukes), is encountered in Asia, Africa, and South America.^{426,427} *S. mansoni* and *S. japonicum* cause glomerular lesions in experimental studies, but clinical glomerular disease has been described most frequently in association with hepatosplenic schistosomiasis produced by *S. mansoni*.^{428–436} A classification of schistosomal glomerulopathies is given in Table 25. It should be recognized that, in highly endemic areas, the association of GN with schistosomiasis may be coincidental rather than causal.

RATIONALE

The incidence of GN in schistosomiasis is not well defined. Hospital-based studies have shown overt proteinuria in 1–10% and microalbuminuria in about 22% of patients with hepatosplenic schistosomiasis due to *S. mansoni*.^{437,438} Sobh *et al.*⁴³⁹ documented asymptomatic proteinuria in 20% patients with “active” *S. mansoni* infection. A field study in an endemic area of Brazil showed only a 1% incidence of proteinuria.⁴⁴⁰ However, histological studies have documented glomerular lesions in 12–50% of cases.^{430,435}

GN is most commonly seen in young adults, and males are affected twice as frequently as females. In addition to nephrotic syndrome, eosinophiluria is seen in 65% of cases and hypergammaglobulinemia in 30%.⁴⁴¹ Hypocomplementemia is common. Several studies have shown new-onset or worsening of nephrotic syndrome in the presence of coinfection with *Salmonella*.⁴⁴²

Several patterns of glomerular pathology have been described (see Table 25). Class I is the earliest and most frequent lesion. Class II lesion is more frequent in patients with concomitant *Salmonella* (*S. typhi*, *S. paratyphi* A, or *S. typhimurium*) infection.^{443,444}

Praziquantel, given in a dose of 20 mg/kg three times for 1 day, is effective in curing 60–90% patients with schistosomiasis. Oxamiquine is the only alternative for *S. mansoni* infection.⁴⁴⁵ Successful treatment helps in amelioration of hepatic fibrosis and can prevent development of glomerular disease. Established schistosomal GN, however, does not respond to any of these agents.

Steroids, cytotoxic agents, and cyclosporine are ineffective in inducing remission.⁴⁴⁶ In one RCT, neither prednisolone nor cyclosporine, given in combination with praziquantel and oxamiquine were effective in inducing remissions in patients with established schistosomal GN.⁴⁴⁷

Treatment of coexistent *Salmonella* infection favorably influences the course of GN. In a study of 190 patients with schistosomiasis, 130 were coinfecting with *Salmonella*. All of them showed improvement in serum complement levels, CrCl, and proteinuria following antibilharzial and anti-*Salmonella* treatment, either together or sequentially.⁴⁴⁸ Other studies have shown disappearance of urinary abnormalities following anti-*Salmonella* therapy alone.^{442,444} The prognosis is relatively good with class I and II schistosomal GN, provided sustained eradication of *Schistosoma* and *Salmonella* infection can be achieved, whereas class IV and V lesions usually progress to ESRD despite treatment.^{446,449,450} The association of *Salmonella* infection with schistosomal GN is not observed in all geographical areas.⁴⁵¹

Table 25 | A clinicopathological classification of schistosomal glomerulopathy

Class	Light-microscopic pattern	Immunofluorescence	Asymptomatic proteinuria	Nephrotic syndrome	Hypertension	Progression to ESRD	Response to treatment
I	Mesangio-proliferative Minimal lesion Focal proliferative Diffuse proliferative	Mesangial IgM, C3, schistosomal gut antigens	+++	+	+/-	?	+/-
II	Exudative	Endocapillary C3, schistosomal antigens	–	+++	–	?	+++
III	A. Mesangio-capillary type I	Mesangial IgG, C3, schistosomal gut antigen (early), IgA (late)	+	++	++	++	–
	B. Mesangio-capillary type II	Mesangial and subepithelial IgG, C3, schistosomal gut antigen (early), IgA (late)	+	+++	+	++	–
IV	Focal and segmental glomerulo-sclerosis	Mesangial IgG, IgM, IgA	+	+++	+++	+++	–
V	Amyloidosis	Mesangial IgG	+	+++	+/-	+++	–

ESRD, end-stage renal disease.

Adapted by permission from Macmillan Publishers Ltd: Kidney International. Barsoum RS. Schistosomal glomerulopathies. *Kidney Int* 1993; 44: 1–12;⁴³⁷ accessed <http://www.nature.com/ki/journal/v44/n1/pdf/ki1993205a.pdf>.

RESEARCH RECOMMENDATION

- Studies are required to evaluate the precise contribution of *Salmonella* infection to schistosomal nephropathy, and the value of treating these two infections separately or together on the outcome.

FILARIAL NEPHROPATHY**BACKGROUND AND RATIONALE**

Filarial worms are nematodes that are transmitted to humans through arthropod bites, and dwell in the subcutaneous tissues and lymphatics. Clinical manifestations depend upon the location of microfilariae and adult worms in the tissues. Of the eight filarial species that infect humans, glomerular disease has been reported in association with *Loa loa*, *Onchocerca volvulus*, *Wuchereria bancrofti*, and *Brugia malayi* infections in Africa and some Asian countries.^{452–456}

Glomerular involvement is seen in a small number of cases. Light microscopy reveals a gamut of lesions, including diffuse GN and MPGN, membranoproliferative GN, minimal-change and chronic sclerosing GN, and the collapsing variant of FSGS.⁴⁵⁷ Microfilariae may be found in the arterioles, glomerular and peritubular capillary lumina, tubules, and interstitium.⁴⁵⁷ Immunofluorescence and electron microscopy show immune deposits along with worm antigens and structural components.^{456,458}

Urinary abnormalities have been reported in 11–25% and nephrotic syndrome is seen in 3–5% of patients with loiasis and onchocerciasis, especially those with polyarthritis and chorioretinitis.^{456,459} Proteinuria and/or hematuria was detected in over 50% of cases with lymphatic filariasis; 25% showed glomerular proteinuria.^{460,461} A good response (diminution of proteinuria) is observed following antifilarial therapy in patients with non-nephrotic proteinuria and/or hematuria. The proteinuria can increase and kidney functions worsen following initiation of diethylcarbamazepine or ivermectin,^{461,462} probably because of an exacerbation of the immune process secondary to antigen release into circulation after death of the parasite.⁴⁶³

The response is inconsistent in those with nephrotic syndrome, and deterioration of kidney function may continue, despite clearance of microfilariae with treatment. Therapeutic apheresis has been utilized to reduce the microfilarial load before starting diethylcarbamazepine to prevent antigen release.⁴⁶⁴

The incidence, prevalence, and natural history of glomerular involvement in various forms of filariasis are poorly documented. This condition is usually found in areas with poor vector control and inadequate health-care facilities. Similarly, the treatment strategies have not been evaluated.

RESEARCH RECOMMENDATION

- Epidemiological studies of kidney involvement in regions endemic for these conditions are required. The effect of population-based treatment with filaricidal agents on the course of kidney disease should be studied.

MALARIAL NEPHROPATHY**BACKGROUND AND RATIONALE**

Infection with *Plasmodium falciparum* usually results in AKI or proliferative GN. Chronic infection with the protozoal malarial parasites *Plasmodium malariae* (and, to a lesser extent, *Plasmodium vivax* or *ovale*) has been associated with a variety of kidney lesions, including MN and membranoproliferative GN.⁴⁶⁵ In the past, this has been known as “quartan malarial nephropathy.”^{465,466} Nephrotic syndrome, sometimes with impaired kidney function, is a common clinical manifestation; it is principally encountered in young children. The glomerular lesions are believed to be caused by deposition of immune complexes containing antigens of the parasite, but autoimmunity may participate as well. The clinical and morphological manifestations vary from country to country.⁴⁶⁷ Nowadays, the lesion is much less common, and most children in the tropics with nephrotic syndrome have either MCD or FSGS, rather than malarial nephropathy.^{467,468} HBV and HIV infection and streptococcal-related diseases are also now more common causes of nephrotic syndrome than malarial nephropathy in Africa.^{467–469}

There are limited observational studies and no RCTs for an evidence-based treatment strategy for malarial nephropathy. Patients with GN and concomitant infection with *Plasmodium* species (typically *Plasmodium malariae*) should be treated with an appropriate antimalarial agent (such as chloroquine or hydroxychloroquine) for sufficient duration to eradicate the organism from blood and hepatosplenic sites. Observational studies have suggested improvement in clinical manifestations in some—but not all—patients, following successful eradication of the parasitic infection. There does not appear to be any role for steroids or immunosuppressant therapy in malarial nephropathy,^{465,466} although controlled trials are lacking. Dosage reductions of chloroquine or hydroxychloroquine may be needed in patients with impaired kidney function.

RESEARCH RECOMMENDATIONS

- Studies of the incidence and prevalence of malarial nephropathy, and its response to antimalarial therapy are needed, especially in endemic areas of West Africa.
- RCTs are needed to investigate the role of corticosteroids and immunosuppressive agents when malarial nephropathy progresses, despite eradication of the malarial parasite.

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SUPPLEMENTARY MATERIAL

Supplementary Table 42: Summary table of studies examining prednisone or CsA treatment vs. control in patients with schistosoma and nephropathy (categorical outcomes).

Supplementary Table 43: Summary table of studies examining prednisone or CsA treatment vs. control in patients with schistosoma and nephropathy (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 10: Immunoglobulin A nephropathy

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INTRODUCTION

This chapter makes treatment recommendations for primary IgAN. Secondary IgAN will not be discussed. The cost implications for global application of this guideline are addressed in Chapter 2.

10.1: Initial evaluation including assessment of risk of progressive kidney disease

- 10.1.1: Assess all patients with biopsy-proven IgAN for secondary causes of IgAN. (Not Graded)
- 10.1.2: Assess the risk of progression in all cases by evaluation of proteinuria, blood pressure, and eGFR at the time of diagnosis and during follow-up. (Not Graded)
- 10.1.3: Pathological features may be used to assess prognosis. (Not Graded)

BACKGROUND

IgAN is diagnosed by kidney biopsy and is defined as dominant or codominant staining with IgA in glomeruli by immunohistology.⁴⁷⁰ LN should be excluded. The intensity of IgA staining should be more than trace. The distribution of IgA staining should include presence in the mesangium, with or without capillary loop staining. IgG and IgM may be present, but not in greater intensity than IgA, except that IgM may be prominent in sclerotic areas. C3 may be present. The presence of C1q staining in more than trace intensity should prompt consideration of LN.

IgAN is the most common primary GN in the world. The prevalence rate varies across different geographical regions. Typically, it is 30–35% of all primary glomerular diseases in Asia, but can be up to 45%.⁴⁷¹ In Europe, this is about 30–40%. Recently in the USA, IgAN was also reported to be the most common primary glomerulopathy in young adult Caucasians.⁴⁷²

Secondary IgAN is uncommon. Cirrhosis, celiac disease, and HIV infection are all associated with a high frequency of glomerular IgA deposition. IgAN has been infrequently associated with a variety of other diseases, including dermatitis herpetiformis, seronegative arthritis (particularly ankylosing spondylitis), small-cell carcinoma, lymphoma (Hodgkin lymphoma and T-cell lymphomas, including mycosis fungoides), disseminated tuberculosis, bronchiolitis obliterans, and inflammatory bowel disease (Crohn's disease and ulcerative colitis). These are usually clinically evident at the time of biopsy. Investigations can include viral serologies (HIV, HBV, and HCV), liver function tests, and electrophoreses of serum immunoglobulins.

IgAN has a wide spectrum of clinical presentations, varying from isolated hematuria to rapidly progressive GN. Thorough risk assessment is essential to determine management and ensure that the risks of therapy are balanced by the selection of patients at highest risk of progression. Definitive outcomes in IgAN are kidney survival and the rate of kidney function decline. Determinants of mortality in IgAN have not been addressed in previous studies, although it is reasonable to assume that CKD increases cardiovascular morbidity and mortality in these patients, as in others with CKD.⁴⁷³

RATIONALE

- There is moderate-quality evidence to suggest that accelerated decline in kidney function is associated with proteinuria ≥ 1 g/d in a dose-dependent fashion and independently of other risk factors.^{474–477}
- There is moderate-quality evidence to suggest a favourable outcome when time-averaged proteinuria is reduced to < 1 g/d.⁴⁷⁷ Whether long-term outcome differs in adult patients with a proteinuria between 0.5 and 1.0 g/d compared to < 0.5 g/d remains uncertain. In children, expert opinion suggests a goal of proteinuria < 0.5 g/d per 1.73 m^2 .⁴⁷⁸
- There is moderate-quality evidence to recommend strict blood pressure control, as it is associated with better kidney survival in chronic proteinuric nephropathies, including IgAN.
- There is low-quality evidence to suggest GFR at presentation is associated with the risk of ESRD. However, studies that have assessed the rate of change of kidney function have questioned its association with initial GFR. Proteinuria, blood pressure, and kidney biopsy findings at presentation have been associated with both risk of ESRD and doubling of SCR.
- There is low-quality evidence to suggest kidney biopsy findings associated with a worse prognosis are the presence and severity of mesangial and endocapillary proliferation, extensive crescents, focal and segmental as well as global glomerulosclerosis, tubular atrophy, and interstitial fibrosis.^{470,479} However, no single approach to the objective evaluation of biopsy findings has yet been validated or evaluated prospectively.
- There is moderate-quality evidence to suggest that IgAN that presents with hematuria and minimal proteinuria is a progressive disease, and that life-long follow-up with regular monitoring of blood pressure and proteinuria is recommended.⁴⁸⁰

Proteinuria is the strongest prognostic factor in IgAN and has a “dose-dependent” effect that is independent of other risk factors in multiple large observational studies, as well as prospective trials. The threshold above which the risk develops in adults is uncertain; some studies indicate 0.5 g/d⁴⁸¹ while others could only demonstrate a higher risk of ESRD and a more rapid rate of decline in kidney function when time-averaged proteinuria was above 1 g/d.^{474,477} A large observational study demonstrated that a reduction of proteinuria to <1 g/d carried the same favorable impact on long-term outcome, whether the initial value was 1–2 g/d, 2–3 g/d, or >3 g/d.⁴⁷⁷ Other surrogates of long-term outcome, such as a 50% decline in proteinuria, have been used.⁴⁸² In children, observational studies have also consistently shown a relationship between the level of proteinuria and outcome, but did not assess a threshold value. Expert opinions in children advocate a cut-off of 0.5 g/d per 1.73 m² for partial remission, and 0.16 g/d per 1.73 m² for complete remission; these thresholds have been used in RCTs.^{478,483}

Uncontrolled hypertension during follow-up is associated with greater proteinuria and predicts a faster GFR decline.^{484,485} As in other proteinuric chronic glomerulopathies, a blood pressure goal <130/80 mm Hg in patients with proteinuria >0.3 g/d, and <125/75 mm Hg when proteinuria is >1 g/d, is recommended.^{486,487}

The GFR at presentation has consistently been related to the risk of ESRD. Whether a lower GFR is also accompanied by a faster rate of kidney function decline is questionable; two observational studies have failed to show this relationship.^{475,488} Proteinuria, blood pressure, and pathological features should take precedence over initial GFR in the estimation of the future rate of kidney function decline.

Numerous studies have addressed the predictive value of pathology findings. Mesangial^{489,490} and endocapillary proliferation,^{479,491} extensive crescents,^{492–495} FSGS,^{496,497} global glomerulosclerosis, tubular atrophy, and interstitial fibrosis^{479,491,493,496} are associated with a more rapid rate of deterioration and lower kidney survival using univariate and, at times, multivariate analysis adjusting for clinical assessment. The recent Oxford Classification of IgAN has demonstrated the importance of (i) mesangial hypercellularity; (ii) segmental glomerulosclerosis; (iii) endocapillary hypercellularity; and (iv) tubular atrophy/interstitial fibrosis, as independent pathological variables predicting kidney outcome.⁴⁷⁹ This may become the standard, but requires validation before it can be recommended in routine clinical practice. Whether classification of the disease in this manner should impact treatment choice has also not been determined.

Obesity has been identified as an independent risk factor for the appearance of ESRD,⁴⁹⁸ and weight loss induces a significant decrease in proteinuria.⁴⁹⁹ Some observational studies^{500,501} have reported an increased risk of greater proteinuria, more severe pathological lesions, and ESRD among IgAN patients who are overweight (BMI > 25 kg/m²).

Other risk factors have also been studied. Outcomes do not differ between sexes.²¹⁷ Children are less likely to reach ESRD compared to adults, but this may be because GFR is higher at presentation in children, even though there is a similar rate of kidney function decline. Different biopsy and treatment practices in the pediatric population limit comparisons to adults. Since the risk factors presented above have been validated in both children and adults, clinicians should consider these before the age of the patient. Similarly, it is uncertain whether geographical or ethnic variations in outcomes are secondary to different biopsy and treatment practices or variations in disease severity.⁴⁷⁵ Macroscopic hematuria is more frequent in children, and some studies have associated its presence with a favorable outcome, while others have shown this benefit to be confounded by a higher initial GFR and earlier detection with no independent value.^{502,503}

10.2: Antiproteinuric and antihypertensive therapy

10.2.1: We recommend long-term ACE-I or ARB treatment when proteinuria is >1 g/d, with up-titration of the drug depending on blood pressure. (1B)

10.2.2: We suggest ACE-I or ARB treatment if proteinuria is between 0.5 to 1 g/d (in children, between 0.5 to 1 g/d per 1.73 m²). (2D)

10.2.3: We suggest the ACE-I or ARB be titrated upwards as far as tolerated to achieve proteinuria <1 g/d. (2C)

10.2.4: In IgAN, use blood pressure treatment goals of <130/80 mm Hg in patients with proteinuria <1 g/d, and <125/75 mm Hg when initial proteinuria is >1 g/d (see Chapter 2). (Not Graded)

RATIONALE

Many of the trials using ACE-I/ARBs in IgAN recruited patients with proteinuria \geq 1 g/d^{1478,504} while some recruited patients with proteinuria \geq 0.5 g/d.⁵⁰⁵

In registry data,⁴⁷⁷ the rate of decline of function increased with the amount of proteinuria; those with sustained proteinuria \geq 3 g/d lost kidney function 25-fold faster than those with proteinuria <1 g/d. Patients who presented with \geq 3 g/d who achieved proteinuria <1 g/d had a similar course to patients who had <1 g/d throughout, and fared far better than patients who never achieved this level. There is, as yet, no evidence in IgAN that reducing proteinuria below 1 g/d in adults gives additional benefit.

Several RCTs^{478,504–506} have shown that ACE-I and ARBs can reduce proteinuria and improve kidney function (assessed by reduction of the slope of GFR deterioration; Online Suppl Table 44). However, there is, as yet, no definitive study of sufficient duration to show the benefit of either ACE-I or ARBs in reducing the incidence of ESRD.

There are no data to suggest preference of ACE-I over ARBs, or vice versa, except in terms of a lesser side-effect profile with ARBs compared to ACE-I.

One study⁵⁰⁷ suggested the combination of ACE-I and ARBs induced a 73% greater reduction of proteinuria than monotherapy (ACE-I 38% and ARB 30%, respectively). A small study of seven pediatric IgAN patients also showed some benefits⁵⁰⁸ with a combination of ACE-I and ARB. However, more studies are needed to determine whether the definite benefit of combination therapy is effective, leading to a better kidney outcome.

RESEARCH RECOMMENDATION

- RCTs are needed to compare the efficacy in proteinuric IgAN of combination therapy using ACE-I and ARBs to monotherapy using either alone.

10.3: Corticosteroids

10.3.1: We suggest that patients with persistent proteinuria ≥ 1 g/d, despite 3–6 months of optimized supportive care (including ACE-I or ARBs and blood pressure control), and GFR > 50 ml/min per 1.73 m², receive a 6-month course of corticosteroid therapy. (2C)

RATIONALE

- There is low-quality evidence that corticosteroids provide an additional benefit to optimized supportive care (Online Suppl Table 47).
- A 6-month corticosteroid regimen can follow either of two regimens, which have been used in published trials (see Table 26).
- There is no evidence to suggest the use of corticosteroids in patients with GFR < 50 ml/min.
- The available studies do not allow recommendations for preferred dosage regimens. The studies did not report serious side-effects. However, there are other studies with similar regimens in non-IgAN patients that suggest more side-effects with high-dose pulse corticosteroids, including hypothalamic-pituitary-adrenal axis suppression and acute myopathies.

Few RCTs so far have tested the efficacy of a corticosteroid regimen vs. no immunosuppressive therapy. In an Italian trial,⁵⁰⁹ a 6-month course of corticosteroids led to better clinical disease remission and long-term outcome⁵¹² than no steroids. However, only about 15% of the patients had received an ACE-I at randomization,⁵⁰⁹ and blood pressure control was not optimal by contemporary standards.⁵¹³

Two more recent RCTs^{510,511,514} used oral prednisone added to an ACE-I and compared this to an ACE-I alone. In the Italian study,⁵¹⁰ the mean annual GFR loss was reduced from about -6 ml/min to -0.6 ml/min, and in the Chinese study⁵¹¹ the proportion of patients with a 50% increase in SCr decreased from 24% to 3% with corticosteroid therapy. A major limitation of both studies is that all ACE-I and ARBs had to be halted for 1 month prior to study inclusion, and then an ACE-I was started together with corticosteroids in the combination group. Therefore, a number of low-risk patients may have been included, who would have achieved proteinuria < 1 g/d with ACE-I therapy alone. A further potential confounder is that both studies included patients who had received prior immunosuppression. An American trial in adults and children, all of whom received an ACE-I, also noted reduced proteinuria with corticosteroids (60 mg/m² prednisone every other day tapered to 30 mg/m² at 12 months) but no difference in kidney function was observed at 2 years.⁵¹⁵

A Japanese RCT that used low-dose corticosteroids (20 mg/d prednisolone, tapered to 5 mg/d by 2 years) observed no benefit on kidney function, despite reduced proteinuria with the corticosteroid regimen.⁵¹⁶

Subjects with IgAN and GFR < 50 ml/min were either excluded from these trials^{509,514} or were few in number,⁵¹¹ so that currently, there are no data to assess the value of corticosteroids in this population.

A recent meta-analysis⁵¹⁷ concluded that corticosteroids reduce doubling of SCr. However, in that analysis, 85% of the weight was contributed by two studies,^{509,518} both of which lacked optimal antiproteinuric and antihypertensive therapy based on contemporary standards. Of note, an American RCT in children and adults with IgAN⁵¹⁵ noted no difference in reaching the endpoint ($> 40\%$ decrease in GFR) between a group receiving ACE-I only vs. ACE-I plus prednisone (60 mg/m² per 48 hours for 3 months, reduced to 30 mg/m² per 48 hours at month 12). However, few end-points were reached in this trial; thus, it was underpowered to detect small differences.

RESEARCH RECOMMENDATION

- Studies using immunosuppressive agents should always include rigorous blood pressure control and antiproteinuric therapy. This is currently being tested in the STOP-IgAN trial.⁵¹⁹ Newer immunosuppressives (alone or in combination) should be compared in RCTs to a “control” group receiving corticosteroids alone.

Table 26 | Corticosteroid regimens in patients with IgAN

References	Pozzi C <i>et al.</i> ⁵⁰⁹	Manno C <i>et al.</i> ⁵¹⁰ ; Lv J <i>et al.</i> ⁵¹¹
Regimen	i.v. bolus injections of 1 g methylprednisolone for 3 days each at months 1, 3, and 5, followed by oral steroid 0.5 mg/kg prednisone on alternate days for 6 months	6-month regime of oral prednisone ^a starting with 0.8–1 mg/kg/d for 2 months and then reduced by 0.2 mg/kg/d per month for the next 4 months

IgAN, immunoglobulin A nephropathy.

^aPrednisone and prednisolone are equivalent and can be used interchangeably with the same dosing regimen.

10.4: Immunosuppressive agents (cyclophosphamide, azathioprine, MMF, cyclosporine)

10.4.1: We suggest not treating with corticosteroids combined with cyclophosphamide or azathioprine in IgAN patients (unless there is crescentic IgAN with rapidly deteriorating kidney function; see Recommendation 10.6.3). (2D)

10.4.2: We suggest not using immunosuppressive therapy in patients with GFR < 30 ml/min per 1.73 m² unless there is crescentic IgAN with rapidly deteriorating kidney function (see Section 10.6). (2C)

10.4.3: We suggest not using MMF in IgAN. (2C)

RATIONALE

Please consult Online Suppl Tables 51–60

- There is very low-quality evidence from a single RCT in high-risk adults to use a combination of prednisolone (40 mg/d reduced to 10 mg/d by 2 years) and cyclophosphamide (1.5 mg/kg/d) for 3 months, followed by azathioprine (1.5 mg/kg/d) for a minimum of 2 years. This study showed a better kidney survival over controls in a highly selected group of patients.
- There is insufficient evidence that immunosuppressive agents other than steroids used as first-line therapy offer an advantage or equivalence compared to steroids.
- The risk-benefit assessment is strongly impacted by the potential for severe adverse effects of these drugs.

Despite retrospective studies in IgAN supporting the use of immunosuppressive therapy other than corticosteroids, few RCTs have demonstrated a benefit. An RCT using corticosteroids combined with cyclophosphamide, followed by azathioprine, included a highly selected group of patients with SCr > 1.47–2.83 mg/dl (> 130–250 μmol/l) with a 15% increase within the last year, and initial proteinuria 3.9 ± 0.8 and 4.6 ± 0.4 g/d in the treatment and control groups, respectively. The active treatment group achieved lower proteinuria, a 4-fold lower rate of kidney function decline, and a much greater kidney survival (72% 5-year survival compared to 6% in controls, *P* = 0.006). There are limitations in the applicability of the findings: (i) there was no steroid monotherapy arm; (ii) the use of RAS blockade was not detailed but these agents could not be initiated after the start of the trial; (iii) the follow-up blood pressure was higher than recommended by current guidelines.

Two RCTs compared cyclophosphamide, dipyridamole, and warfarin to controls and found no benefit.^{520,521} Given these results and the potential side-effects, we do not suggest the use of cyclophosphamide monotherapy.

Azathioprine

Two RCTs, one in children and another in children and adults, tested azathioprine and corticosteroids in patients with preserved kidney function. They demonstrated a reduction in chronic lesions compared to controls on repeat

biopsy.^{483,522} Monotherapy with steroids has been shown to preserve kidney function (a plausible surrogate for reduced chronic lesions). In a recent trial in patients with IgAN,⁵²³ adding low-dose azathioprine for 6 months did not increase the benefit of corticosteroids alone, but did increase the occurrence of adverse events.

A study in 80 children with newly diagnosed IgAN⁵²⁴ compared the effects of the combination of prednisolone, azathioprine, warfarin, and dipyridamole with those of prednisolone alone. There was complete remission of proteinuria (< 0.1 g/m²/d) in 36 (92.3%) of the 39 patients who received the combination and 29 (74.4%) of the 39 who received prednisolone alone (*P* = 0.007). Some side-effects were observed including leucopenia, glaucoma, and aseptic necrosis. The percentage of sclerosed glomeruli was unchanged in the patients who received the combination, but increased in the prednisolone group. In summary of these studies, we do not suggest the addition of azathioprine to corticosteroids for the treatment of IgAN.

An RCT compared 6 months of treatment with corticosteroids plus azathioprine or corticosteroids alone in 207 IgAN patients with plasma creatinine ≤ 2.0 mg/dl (≤ 177 μmol/l) and proteinuria ≥ 1 g/d. After a median follow-up of 4.9 years, a 50% increase in plasma creatinine from baseline occurred in 13% of the combination group and 11% of the monotherapy group (*P* = 0.83); effects on proteinuria and 5-year cumulative kidney survival were also similar in both groups (88% vs. 89%; *P* = 0.83). Treatment-related adverse events were more frequent in the combination group (17%) as compared to the monotherapy group (6%; *P* = 0.01). Thus, in this study, 6 months of treatment with azathioprine did not increase the benefit obtained from steroids alone, but increased the occurrence of adverse events.⁵²³

MMF

The findings from RCTs studying MMF in IgAN are variable. A Belgian study⁵²⁵ assessed MMF 2 g/d for 3 years vs. placebo in 34 patients with an average initial inulin clearance of 70 ml/min per 1.73 m² and proteinuria of 1.8 g/d. No difference in proteinuria reduction or preservation of GFR was observed. Similarly, a North American study⁴⁸² found no benefits over 24 months using a 1-year regimen of MMF 2 g/d vs. placebo in 32 patients with an initial GFR of 40 ml/min per 1.73 m² and a proteinuria of 2.7 g/d. In contrast, a Chinese study in 40 patients with a mean initial GFR of 72 ml/min per 1.73 m² and mean proteinuria 1.8 g/d found a significant reduction in proteinuria at 18 months with MMF given for 6 months over controls.⁵²⁶ A 6-year follow-up of the same cohort demonstrated a kidney survival benefit.⁵²⁷ No steroid was given in these trials, and all patients received ACE-I. The results of these studies are too heterogeneous to suggest the use of MMF at the present time. The reasons for heterogeneity of outcome require further investigation, but different ethnicity or differences in drug levels achieved may be contributory factors. Of note is a retrospective cohort

study that suggested delayed severe pneumonia could occur in MMF-treated patients with IgAN.⁵²⁸ The potential side-effects of using MMF and the heterogeneity of outcomes from these data require better-performed studies before this drug can be recommended as first-line therapy.

Steroid Resistance

The approach to patients, who have no benefit in response to corticosteroids added to optimal antihypertensive and antiproteinuric therapy is unknown; no relevant RCTs have been conducted.

RESEARCH RECOMMENDATIONS

- An RCT is needed comparing MMF and corticosteroids vs. corticosteroids alone in patients receiving optimal antihypertensive and antiproteinuric therapy.
- An RCT is needed to investigate the different efficacy of MMF in Asians vs. Caucasians, including evaluation of drug and metabolite levels.

10.5: Other treatments

10.5.1: Fish oil treatment

10.5.1.1: We suggest using fish oil in the treatment of IgAN with persistent proteinuria ≥ 1 g/d, despite 3–6 months of optimized supportive care (including ACE-I or ARBs and blood pressure control). (2D)

BACKGROUND

Fish oil supplements have shown a number of beneficial cardiovascular effects, including systolic blood pressure and triglyceride lowering, reduced resting heart rate, improvement in several markers of endothelial damage, and reduction in the risk of sudden cardiac death in patients with established coronary heart disease. Several RCTs have evaluated the effect of fish oil in IgAN.

RATIONALE

Please consult Online Suppl Tables 61–64.

- There is mostly low-quality evidence that suggests using fish oil supplements in patients with IgAN, but the RCTs evaluating this therapy have reported conflicting results. However, given the very low risk profile and the potentially beneficial cardiovascular effects, fish oil can be considered a very safe treatment.

In a trial that included 106 patients, fish oil treatment (12 g/d) improved kidney survival and retarded the rate of kidney function loss, without significant reduction of proteinuria.⁵²⁹ Of note, the outcome of the control group, treated with 12 g/d of olive oil was poor (cumulative incidence of death or ESRD after 4 years was 10% in fish oil-treated patients, 40% in the control group). Longer follow-up confirmed the beneficial influence of fish oil treatment in this study.⁵³⁰ Another RCT including 34 patients

reported a beneficial influence of fish oil (3 g/d) on two end-points: the risk of ESRD, and $\geq 50\%$ increase in SCr.⁵³¹ In this study, fish oil reduced proteinuria significantly. In a short-term (6-month) RCT, a significant proteinuria reduction was observed in patients treated with a combination of ACE-I and ARB plus fish oil (3 g/d) in comparison to a control group that received only ACE-I and ARB (percentage of patients with $\geq 50\%$ proteinuria reduction, 80% and 20%, respectively).⁵³²

In contradiction to these studies, other RCTs failed to detect a significant benefit of fish oil treatment.^{533,534} A meta-analysis⁵³⁵ concluded that fish oils are not beneficial in IgAN, although another meta-analysis that combined clinical trials focused on IgAN, diabetes, lupus nephritis, and other glomerular diseases showed a greater proteinuria decrease in patients treated with fish oil, without changes in renal function.⁵³⁶ A more recent RCT compared steroids (33 patients), fish oil (4 g/d, 32 patients), and placebo (31 patients) for 2 years.⁵¹⁵ Neither treatment group showed benefit over the placebo group. However, patients in the placebo group had a statistically significant lower degree of proteinuria at baseline.

In trying to explain these discordant results, some authors have proposed that the effects of fish oil in IgAN patients could be dosage-dependent.⁵³⁷ However, another prospective trial reported that high (6.7 g/d) and low (3.3 g/d) doses of fish oil were similar in slowing the rate of kidney function loss in high-risk IgAN patients.⁵³⁸ At present, there is no evidence to support the use of high-dose fish oil in IgAN.

We suggest fish oil (3.3 g/d) can be considered in the treatment of IgAN with persistent proteinuria ≥ 1 g/d, despite 3–6 months of optimized supportive care (including ACE-I or ARBs and blood pressure control).

RESEARCH RECOMMENDATION

- An RCT is needed of fish oil in IgAN to examine preserved kidney function with persistent significant proteinuria, despite optimal antihypertensive and antiproteinuric therapy.

10.5.2: Antiplatelet agents

10.5.2.1: We suggest not using antiplatelet agents to treat IgAN. (2C)

RATIONALE

Please consult Online Suppl Table 65.

- There is low-quality evidence to recommend not using antiplatelet therapy in IgAN.

A meta-analysis⁵³⁹ based on seven studies, most of them performed in Japan, concluded that antiplatelet therapy resulted in reduced proteinuria and protected kidney function in patients with moderate to severe IgAN. However, there were significant limitations of the evidence in this meta-analysis, due to suboptimal quality of individual controlled trials. Importantly, the effect of antiplatelet agents alone

could not be discerned because patients received other concomitant therapies. Thus, in three studies, both treatment and control groups received other agents, including cytotoxics, steroids, antihypertensive agents, and anticoagulants. In three other studies, the intervention group received warfarin (two studies) and aspirin (one study) in addition to the antiplatelet agent (dipyridamole). Dipyridamole was the most commonly used antiplatelet agent (five studies) followed by trimetazidine and Dilazep (one study each).

RESEARCH RECOMMENDATION

- A multicenter RCT is needed to address the role of antiplatelet therapy in IgAN.

10.5.3: Tonsillectomy

10.5.3.1: We suggest that tonsillectomy not be performed for IgAN. (2C)

RATIONALE

- There is low-quality evidence to suggest not using tonsillectomy as treatment for IgAN. No RCT has been performed of tonsillectomy for IgAN.

Tonsillectomy may be indicated in those with IgAN for conventional reasons, e.g., recurrent bacterial tonsillitis. Clinical judgment needs to be exercised to decide whether to perform tonsillectomy in a very selected group of patients with a close relationship between paroxysm of gross hematuria and tonsillitis. However, only retrospective analyses^{540,541} as well as one nonrandomized trial⁵⁴² have reported a better outcome for IgAN after tonsillectomy. In these studies, tonsillectomy was often combined with other—in particular, immunosuppressive—treatment;^{540–542} thus, the specific value of tonsillectomy is not always apparent. Furthermore, in other retrospective series, investigators failed to note a benefit from tonsillectomy.⁵⁴³

RESEARCH RECOMMENDATION

- A multicenter RCT is needed to address the role of tonsillectomy in IgAN.

10.6: Atypical forms of IgAN

10.6.1: MCD with mesangial IgA deposits

10.6.1.1: We recommend treatment as for MCD (see Chapter 5) in nephrotic patients showing pathological findings of MCD with mesangial IgA deposits on kidney biopsy. (2B)

BACKGROUND

Patients with IgAN can present with proteinuria within the nephrotic range (>3.5 g/d), and it portends a poor prognosis if this high-grade proteinuria persists during follow-up. However, the typical accompanying findings of complete nephrotic syndrome (edema, hypoalbuminemia,

hyperlipidemia) are uncommon. Rarely, some patients with nephrotic syndrome have been identified in whom kidney biopsy shows minimal glomerular changes by light microscopy, diffuse podocyte foot process effacement on electron microscopy, and predominant mesangial deposits of IgA on immunofluorescence. A coincidence of two different glomerular diseases (minimal-change nephrotic syndrome and IgAN) has been proposed as the most likely explanation for such cases.

RATIONALE

- There is low-quality evidence to recommend that patients with nephrotic syndrome and coincidental histological findings of MCD and IgAN should be treated like patients with MCD.

Several series^{544,545} have described prompt, complete remissions after corticosteroid therapy in a majority of patients with nephrotic syndrome and a pathological diagnosis of coincidental MCD and IgAN. This initial treatment response and the following clinical course, with a frequent appearance of nephrotic syndrome relapses, are very reminiscent of that of patients with pure MCD. An RCT in IgAN patients with nephrotic proteinuria⁵⁴⁶ also showed a high percentage of complete remission in patients with such characteristics.

10.6.2: AKI associated with macroscopic hematuria

10.6.2.1: Perform a repeat kidney biopsy in IgAN patients with AKI associated with macroscopic hematuria if, after 5 days from the onset of kidney function worsening, there is no improvement. (Not Graded)

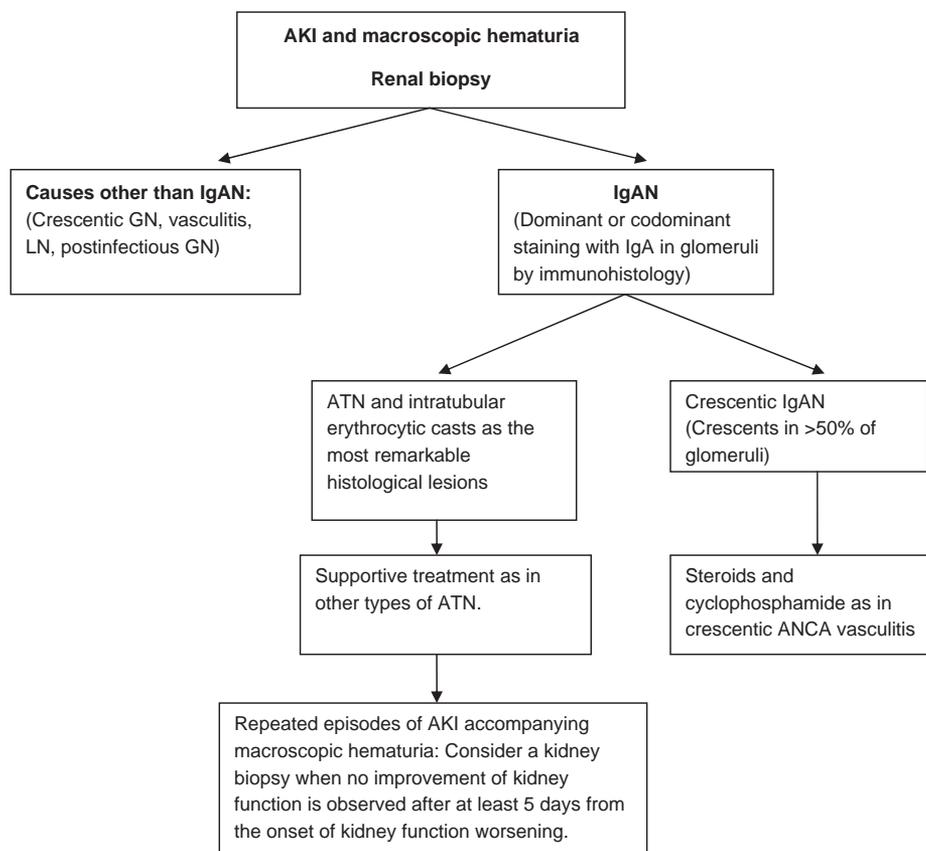
10.6.2.2: We suggest general supportive care for AKI in IgAN, with a kidney biopsy performed during an episode of macroscopic hematuria showing only ATN and intratubular erythrocyte casts. (2C)

BACKGROUND

Episodic macroscopic hematuria coinciding with mucosal (usually upper respiratory) infections are typical of IgAN. The macroscopic hematuria usually resolves spontaneously in a few days, but in some cases it can persist for several weeks.⁵⁴⁷ The development of AKI during macroscopic hematuria episodes is uncommon^{547,548} but represents the first manifestation of IgAN in some patients.

RATIONALE

- ATN and intratubular erythrocyte casts are the most common pathological findings in kidney biopsies during AKI accompanying macroscopic hematuria episodes in IgAN.
- Kidney function usually, but not always, recovers completely after the disappearance of macroscopic hematuria.



Algorithm 1 | Management algorithm of patients with AKI associated with macroscopic hematuria.

- Kidney biopsy allows differentiation of tubular damage and tubular occlusion by erythrocyte casts from crescentic IgAN or other coincidental causes of AKI.

Kidney biopsies performed during an episode of macroscopic hematuria typically show mesangial proliferation and occasional segmental crescents.⁵⁴⁹ In those cases with AKI coincidental with gross hematuria, the glomerular changes are usually insufficient to account for the AKI. Hematuria by itself may be responsible for the AKI, through tubular injury that is induced by intratubular erythrocytic casts and a possible nephrotoxic effect of the hemoglobin that is released from these casts. Features of ATN and tubules filled by red blood cells are the most relevant histological findings. In a majority of patients, kidney function returns to baseline after the disappearance of macroscopic hematuria,^{547–549} but incomplete recovery of kidney function has been described in up to 25% of affected patients.⁵⁴⁷ Duration of macroscopic hematuria longer than 10 days is the most significant risk factor for persistent kidney impairment.⁵⁴⁷ Continuous supportive care, as in other types of ATN, is the recommended therapeutic approach to these patients. There is no information about the usefulness of corticosteroids in patients with more severe forms of AKI or longer duration of macroscopic hematuria.

However, some patients with AKI and macroscopic hematuria exhibit a crescentic form of IgAN (crescents affecting >50% of glomeruli), whose prognosis is considerably worse.^{492–495} A repeat kidney biopsy is suggested in patients with known IgAN who present a protracted AKI accompanying a new episode of gross hematuria, in order to differentiate ATN from crescentic IgAN or other types of AKI (Algorithm 1).

10.6.3: Crescentic IgAN

10.6.3.1: Define crescentic IgAN as IgAN with crescents in more than 50% of glomeruli in the renal biopsy with rapidly progressive renal deterioration. (Not Graded)

10.6.3.2: We suggest the use of steroids and cyclophosphamide in patients with IgAN and rapidly progressive crescentic IgAN, analogous to the treatment of ANCA vasculitis (see Chapter 13). (2D)

BACKGROUND

Crescentic IgAN has a poor prognosis. In a historical group of 12 untreated crescentic IgAN patients, about 42% reached ESRD in 36 months.⁴⁹⁵ Another Japanese study showed that patients with >50% crescents developed ESRD in 75% of

patients by 10 years follow-up.⁵⁵⁰ In this study, the patients were divided into four groups: group 1, absence of crescents and fibrous adhesion of glomerular tufts to Bowman's capsule; group 2, less than 25%; group 3, 25-50%; group 4, more than 50%. Ten-year renal survival rates were 100% in group 1, 94.3% in group 2, 81.8% in group 3, and 25.5% in group 4, respectively, indicating that patients with >50% crescents in glomeruli had a much worse survival than those with ≤50% glomerular crescents.

The outcome of IgAN with diffuse crescent formation has also been studied in 25 Chinese IgAN patients.⁵⁵¹ Most of them showed rapidly progressive GN associated with more severe pathological changes, including glomerular, tubular interstitial, and vascular lesions, than in patients with general IgAN. The infiltrates in glomeruli may contribute to the crescentic formation. Diffuse crescent formation was defined by 50% or more of the glomeruli affected.⁵⁵¹ The pathological diagnosis of crescentic IgAN has not been unified among these studies. While some use crescents involving over 50% of glomeruli as the definition,⁵⁵¹ others use the presence of incipient to fulminant cellular crescents, with or without segmental endocapillary proliferation in >10% of glomeruli.⁴⁹⁵ Although there is insufficient evidence for a unifying definition, we suggest a definition of crescentic IgAN as both a pathological finding of over 50% glomeruli having crescents and the clinical feature of rapidly progressive deterioration of renal function.

A recent study of 67 patients⁵⁵² with vasculitic IgAN (33 HSP, 34 IgAN) showed that three factors significantly affected kidney outcome: kidney function, blood pressure at presentation, and the amount of chronic damage in the biopsy.

RATIONALE

- There is no RCT of treatment in crescentic IgAN.

The three largest observational studies^{495,551,552} all concluded that immunosuppression is potentially useful. In a study of 25 patients with diffuse crescentic IgAN treated with immunosuppression, 67% of patients maintained sufficient kidney function to avoid renal replacement therapy, four had SCr <1.4 mg/dl (<124 μmol/l), and only five were dialysis-dependent. In another study, although an improved outcome was seen in those receiving immunosuppression, the conclusions were cautious, as the treated and untreated groups were not comparable. The third study also suggested positive effects of immunosuppression.⁴⁹⁵ This study used i.v. methylprednisolone 15 mg/kg/d for 3 days and monthly i.v. cyclophosphamide 0.5 g/m² for 6 months. Twelve treated patients were compared to 12 historical controls. After 36 months, the rate of ESRD in the treated group was lower (one out of 12) than in the historical controls (five out of 12).

Recommended therapeutic regimens in these reports are varied, but initial therapy has usually included high-dose oral or i.v. corticosteroids plus oral or i.v. cyclophosphamide. In one study, some patients were changed from

cyclophosphamide to azathioprine at 3 months. Durations of treatment in these three series varied from 3 to 24 months.

There is only poor-quality evidence to support the use of plasma exchange. One anecdotal report indicated benefit in five patients using plasma exchange in a combination of immunosuppressive therapies.⁵⁵³

RESEARCH RECOMMENDATION

- RCTs are needed to investigate the benefits of cyclophosphamide, MME, and azathioprine in crescentic IgAN.

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SUPPLEMENTARY MATERIAL

Supplementary Table 44: Evidence profile of RCTs examining ACE-I or ARB in biopsy-proven IgA nephropathy.

Supplementary Table 45: Summary table of RCTs examining ACE-I or ARB in biopsy-proven IgA nephropathy (categorical outcomes).

Supplementary Table 46: Summary table of RCTs examining ACE-I or ARB in biopsy-proven IgA nephropathy (continuous outcomes).

Supplementary Table 47: Evidence profile of RCTs examining steroid regimens in biopsy-proven IgA nephropathy.

Supplementary Table 48: Meta-analyses and systematic reviews on immunosuppression for IgA nephropathy.

Supplementary Table 49: Summary table of RCTs examining steroid regimens in biopsy-proven IgA nephropathy (categorical outcomes).

Supplementary Table 50: Summary table of RCTs examining steroid regimens in biopsy-proven IgA nephropathy (continuous outcomes).

Supplementary Table 51: Meta-analyses and systematic reviews on immunosuppression for IgA nephropathy.

Supplementary Table 52: Summary table of RCTs examining steroid and immunosuppressive regimens in biopsy-proven IgA nephropathy (categorical outcomes).

Supplementary Table 53: Summary table of RCTs examining steroid and immunosuppressive regimens in biopsy-proven IgA nephropathy (continuous outcomes).

Supplementary Table 54: Evidence profile of RCTs examining AZA in combination vs: AZA alone in biopsy-proven IgA nephropathy.

Supplementary Table 55: Summary table of RCT examining AZA in biopsy-proven IgA nephropathy (categorical outcomes).

Supplementary Table 56: Summary table of RCT examining AZA in biopsy-proven IgA nephropathy (continuous outcomes).

Supplementary Table 57: Evidence profile of RCTs examining MMF in biopsy-proven IgA nephropathy.

Supplementary Table 58: Meta-analyses and systematic reviews on MMF therapy for IgA nephropathy.

Supplementary Table 59: Summary Table of RCTs examining MMF in biopsy-proven IgA nephropathy (categorical outcomes).

Supplementary Table 60: Summary Table of RCTs examining MMF in biopsy-proven IgA nephropathy (continuous outcomes).

Supplementary Table 61: Evidence profile of studies examining omega-3 fatty acid treatment in IgA nephropathy.

Supplementary Table 62: Meta-analyses and systematic reviews on fish oil treatment in IgA nephropathy.

Supplementary Table 63: Summary table of RCTs examining omega-3 fatty acids in biopsy-proven IgA nephropathy (categorical outcomes).

Supplementary Table 64: Summary table of RCTs examining omega-3 fatty acids in biopsy-proven IgA nephropathy (continuous outcomes).

Supplementary Table 65: Meta-analyses and systematic reviews on antiplatelet therapy for IgA nephropathy.

Supplementary Table 66: Summary table of RCT examining immunosuppression and anti-platelets in biopsy-proven IgA nephropathy (categorical outcomes).

Supplementary Table 67: Summary table of RCT examining immunosuppression and anti-platelets in biopsy-proven IgA nephropathy (continuous outcomes).

Supplementary Table 68: Summary table of RCT examining antiplatelet treatments in biopsy-proven IgA nephropathy (continuous outcomes)*.

Supplementary Table 69: Summary table of RCTs examining miscellaneous treatments in biopsy-proven IgA nephropathy (categorical outcomes).

Supplementary Table 70: Summary table of RCTs examining miscellaneous treatments in biopsy-proven IgA nephropathy (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 11: Henoch-Schönlein purpura nephritis

Kidney International Supplements (2012) **2**, 218–220; doi:10.1038/kisup.2012.24

INTRODUCTION

This chapter will focus on the treatment of HSP nephritis in adults and children. The cost implications for global application of this guideline are addressed in Chapter 2.

11.1: Treatment of HSP nephritis in children

11.1.1: We suggest that children with HSP nephritis and persistent proteinuria, >0.5-1 g/d per 1.73 m², are treated with ACE-I or ARBs. (2D)

11.1.2: We suggest that children with persistent proteinuria, >1 g/d per 1.73 m², after a trial of ACE-I or ARBs, and GFR >50 ml/min per 1.73 m², be treated the same as for IgAN with a 6-month course of corticosteroid therapy (see Chapter 10). (2D)

11.2: Treatment of crescentic HSP nephritis in children

11.2.1: We suggest that children with crescentic HSP with nephrotic syndrome and/or deteriorating kidney function are treated the same as for crescentic IgAN (see Recommendation 10.6.3). (2D)

BACKGROUND

HSP is an acute small-vessel vasculitis, characterized clinically by a nonthrombocytopenic purpuric rash, nondeforming arthritis, gastrointestinal involvement, and nephritis.⁵⁵⁴ The incidence of HSP is about 10 cases per 100,000 per year. It affects all ages, but 90% of cases are found in those less than 10 years of age, with the median age at presentation being 6 years.⁵⁵⁴ Kidney involvement occurs in 30–50% patients.^{554–556} Microscopic hematuria is the most common finding. In a systematic review of 12 studies of 1133 unselected children with HSP, abnormal urinalysis occurred in 34% with the majority (79%) having isolated hematuria with or without proteinuria.⁵⁵⁵ Only 21% of those with kidney involvement (or 7.2% of all cases) developed a nephritic and/or nephrotic syndrome. Ninety percent of children had developed kidney involvement by 8 weeks after acute presentation, while 97% developed kidney involvement by 6 months. Recurrence of rash and other symptoms occur in one-third of patients.⁵⁵⁶ Nephritis is associated with older age at presentation, persistent rash, and recurrence of HSP, while proteinuria >20 mg/m²/h was associated with recurrence and severe abdominal pain.⁵⁵⁷ Only 1–3% of patients progress to ESRD.⁵⁵⁴ Long-term prognosis correlates with kidney presentation at onset. Compared to 1.6% of children with isolated hematuria with/without proteinuria, 19.5% of

children with nephritic or nephrotic syndromes at initial presentation have nephrotic-range proteinuria, hypertension, and/or reduced GFR at long-term follow up.⁵⁵⁵ Among 78 patients managed in specialized pediatric kidney units, 44% of those with a nephritic or nephrotic presentation had hypertension and/or impaired kidney function at a mean follow-up of 23.4 years, while 82% of those presenting with hematuria with or without proteinuria had normal urinalysis, kidney function, and blood pressure.⁵⁵⁸ A recent study of 103 children found that, at final follow up, GFR correlated with GFR and proteinuria at onset and 1 year, with ISKDC pathology grade and interstitial fibrosis. Multivariate analysis identified that proteinuria at 1 year and ISKDC grade were most useful in identifying patients with a poor prognosis.⁵⁵⁹ However, one long-term study found that severity of findings on first kidney biopsy did not correlate with the risk of a poor outcome (hypertension, persistent proteinuria, ESRD).⁵⁶⁰

RATIONALE

- There is no evidence for the use of RAS blockade in HSP nephritis in children, but an RCT in children and young adults with IgAN demonstrated the benefit of this therapy in reducing proteinuria and maintaining GFR.
- There is no evidence for the use of oral corticosteroids in HSP nephritis, but data from RCTs in adults with IgAN have demonstrated a benefit in reducing proteinuria and maintaining GFR.
- There is very low-quality evidence for the benefit of high-dose corticosteroids and immunosuppressive agents in HSP nephritis with deteriorating kidney function.

There is no evidence available for the use of RAS blockade in HSP nephritis. However, an RCT in 66 children and young adults with IgAN with moderate proteinuria (>1 to <3.5 g/d per 1.73 m²) and GFR >50 ml/min per 1.73 m² demonstrated the benefit of ACE-I in reducing proteinuria and maintaining GFR.⁴⁷⁸ There are very limited data to support the use of corticosteroids in children with established nephritis of any severity,⁵⁶¹ though corticosteroids are widely used in children presenting with nephrotic-range proteinuria or acute nephritis. In a post-hoc analysis of one placebo-controlled RCT,⁵⁶² nephritis resolved more rapidly in children treated with prednisone compared to placebo. Seven of 36 children (19%) in the prednisone group still had kidney involvement at 6 months compared to 15 of 35 (43%) in the placebo group. The trial only provided outcome data to 6 months after randomization, so it is unclear whether prednisone treatment reduced the number of patients with

persistent HSP nephritis overall, or promoted more rapid resolution of kidney disease compared to placebo.

A prospective but uncontrolled study of 38 consecutive children with mean follow-up period of 5 years and 7 months showed resolution of severe nephritis (nephrotic syndrome and/or >50% crescents on biopsy) in 27 of 38 children treated with three pulses of methylprednisolone followed by oral prednisone for 4 months.⁵⁶³ Seven children had residual abnormalities and four progressed to ESRD. Two recent RCTs in adults with IgAN, proteinuria ≥ 1 g/d, and GFR ≥ 30 -50 ml/min per 1.73 m² have demonstrated the benefit of 6-8 months of prednisone and ACE-I, compared to ACE-I alone, on reducing the rate of kidney functional deterioration and reducing proteinuria during follow-up periods of up to 48 months⁵¹¹ or 96 months.⁵¹⁰

In the absence of sufficient long-term data in HSP nephritis, we suggest that persistent HSP nephritis can be treated as isolated IgAN (see Recommendation 10.3.1). However, there are no data to determine when prednisone should be commenced in children with HSP nephritis, and for how long ACE-I or ARB therapy should be administered before commencing prednisone. Foster *et al.*⁵⁶⁴ noted that the chronicity score (interstitial fibrosis, tubular atrophy, fibrosed crescents) on initial kidney biopsy increased with increasing delay between onset of kidney involvement and time of biopsy. Most children in their series of 20 patients were biopsied within 3 months, with a median of 30 days. Treatment with prednisone and azathioprine resulted in improvement in acuity score but not chronicity score. Therefore, in HSP nephritis, it may be appropriate to commence prednisone therapy earlier than in IgAN.

There are limited data on immunosuppressive agents, so it remains unclear whether these have any role in HSP nephritis. In a single RCT of 56 children with significant HSP nephritis (nephrotic range proteinuria, reduced kidney function, ISKDC* grades III-V on kidney biopsy [crescents <50% to >75%]) treated within 3 months of onset of HSP and followed for 5-6 years, there was no significant difference in the risk for persistent kidney involvement of any severity between cyclophosphamide and supportive treatment (RR 1.07; 95% CI 0.65-1.78).⁵⁶⁵ Corticosteroids were not administered to these children. A nonrandomized comparative study of 37 children with HSP nephritis and >50% crescents (ISKDC grades IV-V) on kidney biopsy found that none of 17 treated with cyclophosphamide plus corticosteroids, compared to four of 20 treated with corticosteroids alone, had persistent nephropathy (proteinuria >20 mg/m²/h with/without GFR <40 ml/min per 1.73 m²) at 6-8 years of follow-up.⁵⁶⁶ A small RCT, in children with nephrotic-range proteinuria and/or ISKDC grades III-V on kidney biopsy, found that all of 10 children treated with cyclosporin achieved remission compared to five of nine children treated with methylprednisolone.⁵⁶⁷ However, at the 2-year follow-up of

23 children, seven of 11 children treated with cyclosporin and seven of 12 treated with methylprednisolone had persistent proteinuria with/without decreased GFR.⁵⁶⁸

One nonrandomized comparative study involving 20 children with nephrotic-range proteinuria and ISKDC grades II-III on kidney biopsy reported that none of 10 children treated with azathioprine and prednisone, compared to four of 10 treated with prednisone alone, had nephrotic-range proteinuria and/or GFR <60 ml/min per 1.73 m² after 4-5 years of follow-up.⁵⁶⁹ Observational studies have reported good outcomes with corticosteroids combined with azathioprine,⁵⁶⁴ cyclophosphamide,⁵⁷⁰ cyclosporine,^{571,572} and plasma exchange.^{573,574} There are no data, other than small observational studies, examining the treatment of crescentic HSP nephritis with rapidly progressive kidney failure. In the absence of data, we suggest treating such patients similarly to patients with ANCA vasculitis.

A single small RCT⁵⁷⁵ comparing 1 year of treatment with MMF to azathioprine has enrolled 17 children (ISKDC grade II and III) to date. Proteinuria resolved in all of 10 children treated with MMF, and six of eight treated with azathioprine. Seven patients treated with MMF and five treated with azathioprine showed regression of histological changes at 1 year. Children received prednisone for 6 months, but were not treated with ACE-I. These data are insufficient to draw any conclusions on the value of MMF in HSP nephritis in children.

11.3: Prevention of HSP nephritis in children

11.3.1: We recommend not using corticosteroids to prevent HSP nephritis. (1B)

BACKGROUND

At first presentation with HSP, nephritis may be clinically mild or even absent. Therefore, treatment strategies at the time of presentation have been developed with the goal of preventing nephritis, or reducing the risk of severe persistent nephritis.

RATIONALE

- There is moderate-quality evidence to recommend that corticosteroids not be given at presentation of HSP, since they do not appear to influence the development of persistent kidney involvement.

A meta-analysis^{576,577} of five RCTs (789 children) found no significant difference in the number of children with evidence of persistent kidney disease (microscopic hematuria, proteinuria, hypertension, reduced kidney function) during follow-up between those treated with prednisone for 2-4 weeks and those not treated (RR 0.73; 95% CI 0.43-1.24). There were no significant differences in the risk of persistent kidney disease at 6 months (379 children; RR 0.54; 95% CI 0.25-1.18) and 12 months (498 children; RR 1.02; 95% CI 0.40-2.62). Three of the five trials (568 patients) were well designed, placebo-controlled trials; exclusion of poor-quality studies from the

*The histological classification of HSP nephritis proposed by the International Study of Kidney Disease in Children is still widely used.

meta-analysis removed heterogeneity without altering the findings. Two RCTs^{562,578} found no significant difference in the risk of severe nephritis (nephrotic-range proteinuria, hypertension with/without reduced kidney function) between children treated with prednisone or placebo at presentation, though the number of events was small, resulting in imprecision (261 children; RR 1.92; 95% CI 0.57-6.50). There are no data on prevention strategies for HSP nephritis in adults.

11.4: HSP nephritis in adults

11.4.1: We suggest that HSP nephritis in adults be treated the same as in children. (2D)

RATIONALE

Outcome data from HSP nephritis in adults are from retrospective series. A Spanish retrospective study of HSP in adults suggested a higher frequency of kidney involvement than children, but the final outcome of HSP is equally good in patients of both age groups.⁵⁷⁹ In an Italian cohort, the risk for progression of HSP nephritis was found greater in adults and was associated with increasing proteinuria during follow-up.⁵⁸⁰ In a UK series, the risk factors for ESRD were: proteinuria ≥ 1 g/d during follow-up, hypertension at presentation and during follow-up, kidney impairment at presentation—very similar to the prognostic indicators in IgAN in adults.⁵⁸¹

In a Finnish series, kidney survival 10 years after biopsy was 91%.⁵⁸² A recent cohort of HSP nephritis in Chinese adults showed a higher risk of progression to kidney impairment compared to children.⁵⁸³ The biggest retrospective cohort of 250 adults with HSP was from France.⁵⁸⁴ After a median follow-up of 14.8 y, 32% of the patients showed kidney impairment (CrCl < 50 ml/min), usually associated with proteinuria and/or hematuria.

There are very few RCTs investigating the treatment of HSP nephritis in adults. A recent 12-month, multicenter, prospective, open-label trial (CESAR study) was performed using steroid therapy without or with cyclophosphamide in 54 adults with severe HSP including proliferative GN and severe visceral manifestations.⁵⁸⁵ The study did not include patients with rapidly progressive GN. All patients received

steroids while 25 were randomized to also receive cyclophosphamide. There was no additional benefit of cyclophosphamide compared to steroids alone. The investigators commented that the small population size did not permit definitive conclusions.

We suggest that treatment for HSP nephritis in adults should use the approach proposed for HSP in children (see Sections 11.1 and 11.2). Current evidence does not suggest using additional immunosuppressive agents other than steroids in HSP nephritis in adults.

RESEARCH RECOMMENDATIONS

- An RCT comparing a 6- to 12-month course of corticosteroids to shorter-duration corticosteroids (28 days) should be performed in children with moderately severe HSP nephritis (acute nephritic syndrome or nephrotic syndrome with normal kidney function and $< 50\%$ crescents or sclerosing lesions on biopsy).
- RCTs are required to determine whether immunosuppressive agents (cyclosporine, azathioprine, MMF) and corticosteroids are effective in treating children with severe HSP nephritis (acute nephritic syndrome, nephrotic syndrome with or without reduced kidney function with $> 50\%$ crescents or sclerosing lesions on biopsy).

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Chapter 12: Lupus nephritis

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INTRODUCTION

This chapter makes treatment recommendations for LN in adults and children. The cost implications for global application of this guideline are addressed in Chapter 2.

BACKGROUND

Kidney involvement in systemic lupus, known as LN, is most often due to glomerular immune complex accumulation, which leads to glomerular inflammation and, if unchecked, also involves the renal interstitium. The kidney may also sustain damage by other mechanisms, such as thrombotic microangiopathy. Lupus patients with LN have worse outcomes than those with no kidney involvement.^{586–588} This poor prognosis is explained only in part by the risk of CKD and ESRD, suggesting that LN is a manifestation of a more severe form of systemic lupus.

The reported incidence of clinically important kidney disease in systemic lupus is about 38%. Of those who develop clinical LN, 40–60% have overt kidney disease at the time lupus is diagnosed.^{589–591} The incidence of kidney involvement differs with ethnicity. Caucasians (European, European Americans; 12–33%) are less likely to have LN than black (African American, Afro-Caribbean; 40–69%), Hispanic (36–61%), or Asian (Indian, Chinese; 47–53%) patients.

Based on the United States Renal Data Service database, between 1996 and 2004 the incidence of ESRD attributed to LN in adults was 4.5 cases per million in the general population,⁵⁹² but was greater in blacks (17–20/million) and Hispanics (6/million) than Caucasians (2.5/million). Similarly, a retrospective cohort from the UK found that 19% of Caucasians and 62% of blacks with LN progressed to ESRD.⁵⁹³ In a Saudi Arabian population, 12% of patients with LN developed ESRD.^{589,594} The prevalence of CKD in patients with systemic lupus is difficult to estimate, but because current therapies induce complete remission in only about 50% of those with LN, CKD is likely to be common.

The presence of LN should be considered in any lupus patient with impaired kidney function, proteinuria, hypertension, or an active urine sediment. An active sediment includes hematuria, especially acanthocytes suggestive of glomerular bleeding, leukocyturia in the absence of infection, and red and white blood cell casts. LN must be confirmed by kidney biopsy. The histologic findings provide the basis for treatment recommendations for LN.

12.1: Class I LN (minimal-mesangial LN)

12.1.1: We suggest that patients with class I LN be treated as dictated by the extrarenal clinical manifestations of lupus. (2D)

BACKGROUND

In class I LN, glomeruli are normal by light microscopy. Class I LN is defined by the presence of immune deposits restricted to the mesangium, and seen only by immunofluorescence or electron microscopy.

RATIONALE

- Class I LN has no clinical kidney manifestations.
- Class I LN is not associated with long-term impairment of kidney function.

Kidney tissue obtained for research purposes in patients with systemic lupus but without clinical signs of kidney disease showed LN was present in about 90% of patients,^{595,596} far more than the 40% or so who manifest clinical kidney disease. In some patients with clinically silent class I LN, there is transformation to more aggressive and clinically relevant forms of LN.⁵⁹⁷ However, at present, there are no data to suggest that every patient with lupus requires a kidney biopsy, or that treatment of class I LN is clinically necessary.

12.2: Class II LN (mesangial-proliferative LN)

12.2.1: Treat patients with class II LN and proteinuria < 1 g/d as dictated by the extrarenal clinical manifestations of lupus. (2D)

12.2.2: We suggest that class II LN with proteinuria > 3 g/d be treated with corticosteroids or CNIs as described for MCD (see Chapter 5). (2D)

BACKGROUND

The kidney biopsy of class II LN shows mesangial hypercellularity and matrix expansion on light microscopy, and mesangial immune deposits by immunofluorescence and electron microscopy. Clinically, proteinuria and/or hematuria may be seen in class II LN, but usually not nephrotic syndrome, or kidney impairment. If nephrotic-range proteinuria is found with class II LN, this may be due to a concomitant podocytopathy.

RATIONALE

- There are no evidence-based data on the treatment of class II LN.
- Podocytopathies, characterized histologically by diffuse foot process effacement in the absence of glomerular capillary wall immune complex deposition or endocapillary proliferation, have been observed in patients with class II LN.

Podocyte injury in class II LN does not appear related to the extent of mesangial immune complex deposition.⁵⁹⁸ While there have been no prospective studies of the treatment of nephrotic-range proteinuria in class II LN, it is reasonable to treat such patients as for MCD/FSGS in case of nephrotic syndrome, or if proteinuria cannot be controlled using RAS blockade.

12.3: Class III LN (focal LN) and class IV LN (diffuse LN)—initial therapy

12.3.1: We recommend initial therapy with corticosteroids (1A), combined with either cyclophosphamide (1B) or MMF (1B).

12.3.2: We suggest that, if patients have worsening LN (rising SCr, worsening proteinuria) during the first 3 months of treatment, a change be made to an alternative recommended initial therapy, or a repeat kidney biopsy be performed to guide further treatment. (2D)

BACKGROUND

Class III and IV LN are differentiated by the percentage of affected glomeruli (class III, <50%; class IV, ≥50%). Glomerular lesions are classified as active (A) or chronic (C). The active lesions of class III and IV are endocapillary and (usually) mesangial hypercellularity, crescents, necrosis, wire loops, and hyaline thrombi. Chronic lesions include segmental and global glomerulosclerosis. Immunofluorescence and electron microscopy show significant subendothelial and mesangial immune deposits. If there are extensive subepithelial immune deposits, there is coincidental class V LN (see Rationale).

Almost all patients will have microscopic hematuria and proteinuria; nephrotic syndrome and kidney impairment are common. However, if the histologic lesions are mainly chronic (see Rationale) there may be less overt clinical activity, other than progressive kidney failure. Therapy should be adjusted according to the extent of activity or chronicity.

There is no standard definition of treatment response for class III and IV LN, which makes direct comparison of clinical trials difficult. Nonetheless, the overall goals of treatment are similar between trials, and definitions of response based on published trials are provided as a guide to the success of therapy (Table 27).

Table 27 | Definitions of response to therapy in LN

Complete response: Return of SCr to previous baseline, plus a decline in the uPCR to <500 mg/g (<50 mg/mmol).

Partial response: Stabilization ($\pm 25\%$), or improvement of SCr, but not to normal, plus a $\geq 50\%$ decrease in uPCR. If there was nephrotic-range proteinuria (uPCR ≥ 3000 mg/g [≥ 300 mg/mmol]), improvement requires a $\geq 50\%$ reduction in uPCR, and a uPCR <3000 mg/g [<300 mg/mmol].

Deterioration: There is no definition of deterioration in LN to define treatment failure that has been tested prospectively as an indication to change in initial therapy. A sustained 25% increase in SCr is widely used but has not been validated.

RATIONALE

- Proliferative LN (class III or IV) is an aggressive disease.
- Before 1970, kidney survival and overall patient survival in diffuse proliferative LN were very poor, in the range of 20–25%.
- Patient and kidney survival in class III and IV LN have dramatically improved through the use of intensive immunosuppression.
- The International Society of Nephrology/Renal Pathology Society classification of LN assigns activity (A) or chronicity (C) in class III and IV LN. Our treatment recommendations are for active or active plus chronic lesions. Thorough review with the nephropathologist is required to ensure accurate classification prior to starting therapy.
- Therapy for class III and IV LN has initial and maintenance phases. The objective is to rapidly decrease kidney inflammation by initial intensive treatment, and then consolidate treatment over a longer time. The initial phase is often called induction, which implies remission is achieved at its completion. This, however, is often not the case, and remissions continue to occur well into the maintenance phase. The term “initial” treatment is therefore preferred.
- The benefit of the addition of cyclophosphamide to corticosteroids for initial treatment was shown in controlled trials demonstrating that, during long term follow-up, this combination decreased the frequency of kidney relapse, CKD, and ESRD compared to corticosteroids alone.
- The evolution of initial therapy in proliferative LN has been to reduce toxicity while maintaining efficacy. This has resulted in several modifications of cyclophosphamide dosing, and the introduction of MMF as an alternative to cyclophosphamide.
- The efficacy of newer initial treatment regimens should be assessed not only by initial responses, but also by long-term effects on kidney relapse, and development of CKD.

Widely used treatment regimens are shown in Table 28.

Increases in disease activity in systemic lupus in general, and in LN in particular, may be described as “flares” or “relapses”. In this guideline, we use the term “relapse”.

Corticosteroids

All regimens use similar corticosteroid dosing: an initial dose of oral prednisone up to 1 mg/kg, tapering according to clinical response over 6–12 months. Additional i.v. methylprednisolone is widely used at the beginning of treatment for more severe disease. However, the dosing and duration of corticosteroids has never been subject to evaluation by RCTs.

Cyclophosphamide

i.v. cyclophosphamide (0.5–1 g/m²) given monthly for 6 months (Regimen A, sometimes called the “NIH regimen”) was the first immunosuppressive treatment shown in RCT to be superior to corticosteroids alone.^{599–602}

Table 28 | Regimens for initial therapy in class III/class IV LN

Regimen	A. NIH	B. Euro-Lupus	C. Oral cyclophosphamide	D. MMF
Cyclophosphamide	i.v. cyclophosphamide 0.5–1 g/m ² ; monthly for 6 months	i.v. cyclophosphamide 500 mg; every 2 weeks for 3 months	Oral cyclophosphamide 1.0–1.5 mg/kg/d (maximum dose 150 mg/d) for 2–4 months	—
MMF	—	—	—	MMF up to 3 g/d for 6 months
Benefit shown by RCT in proliferative LN	Yes	Yes	Yes	Yes
Benefit shown by RCT in severe proliferative LN	Yes	Untested	Untested	Untested
Comments	Effective in whites, blacks, Hispanics, Chinese	Effective in whites. Untested in blacks, Hispanics, Chinese	Effective in whites, blacks, Chinese; easy to administer and lower cost than i.v. cyclophosphamide	Effective in whites, blacks, Hispanics, Chinese; high cost

LN, lupus nephritis; MMF, mycophenolate mofetil; RCT, randomized controlled trial.

All regimens include corticosteroids:

- Oral prednisone, initial dose up to 0.5–1 mg/kg/d, tapering over 6–12 months according to clinical response.
- i.v. methylprednisolone is sometimes added initially for severe disease.

A lower-dose regimen using i.v. cyclophosphamide 500 mg every 2 weeks for 3 months (Regimen B, sometimes called the “Euro-Lupus regimen”) had equivalent efficacy to Regimen A in an RCT in Caucasians.^{603,604} However, few patients in the Euro-Lupus trial had severe kidney disease, defined as rapidly progressive kidney failure and typically with widespread (>50%) segmental glomerular necrosis or crescents. It remains uncertain whether Regimen B has equivalent efficacy to Regimen A in severe class III/IV LN, and in patients of other ethnicities.

Oral cyclophosphamide 1.0–1.5 mg/kg/d (maximum dose 150 mg/d) for 2–4 months (Regimen C) has been used as an alternative to i.v. cyclophosphamide.^{605,606} It has equivalent efficacy to i.v. cyclophosphamide in prospective observational studies,^{599,607–610} and has also been shown equivalent to mycophenolate in Chinese patients,^{611,612} although this has not yet been verified in other ethnicities. More adverse effects have been reported with oral compared to i.v. cyclophosphamide, but this is not a consistent finding.

Mycophenolate

MMF (maximum 3 g/d) for 6 months (Regimen D) has been tested in an RCT in a Chinese population, and was equivalent in achieving remission to Regimen C; patients with severe LN were excluded from this study.⁶¹²

An RCT known as the Aspreva Lupus Management Study (ALMS)⁶¹³ recruited 370 patients with class III, IV, and V LN, and comparing MMF to Regimen A, showed that MMF had an equivalent response rate to i.v. cyclophosphamide at 6 months, and had a similar incidence of adverse events including serious infections and deaths.⁶¹³

Enteric-coated mycophenolate sodium may also be effective in LN, as suggested by a small trial in cyclophosphamide resistant patients.⁶¹⁴

Other regimens

There is more limited RCT evidence for the use of three other regimens as initial treatment: corticosteroids combined with

(i) azathioprine; or (ii) cyclosporine; or (iii) the combination of tacrolimus and MMF (sometimes called “multitarget” therapy).

Azathioprine

An RCT in Europeans compared initial therapy with azathioprine combined with i.v. methylprednisone, followed by oral prednisone, to i.v. cyclophosphamide with oral prednisone.⁶¹⁵ At 2 years, there was no difference in response rate, and fewer adverse effects in those receiving azathioprine. However, supplementary studies in these cohorts showed a higher late relapse rate and higher risk of doubling of SCr after azathioprine. Furthermore, there was more chronicity on later biopsies after azathioprine.⁶¹⁶

Cyclosporine

A small ($n=40$), open-label RCT compared cyclosporine to cyclophosphamide as initial therapy combined with corticosteroids for proliferative LN.⁶¹⁷ Cyclosporine (4–5 mg/kg/d) was used for 9 months, and then tapered over the next 9 months. Cyclophosphamide was used in a different regimen than in most published trials: eight i.v. pulses (10 mg/kg) were given in the first 9 months, and then four to five oral pulses (10 mg/kg) over the next 9 months. There were no differences in responses or remissions at 9 or 18 months, or relapse rate after 40 months of follow-up. Infections and leukopenia did not differ between the groups.

Tacrolimus with Mycophenolate

In a small RCT from China in patients with combined class IV and V LN, the combination of tacrolimus (4 mg/d), MMF (1 g/d), and oral corticosteroids (sometimes known as “multitarget” therapy) was compared to pulse monthly i.v. cyclophosphamide (0.75 g/m² for 6 months) plus oral corticosteroids. At 6 months, 90% of patients treated with this multitarget therapy and 45% of patients treated with cyclophosphamide achieved either complete or partial remission ($P=0.002$).⁶¹⁸ This regimen has not yet been evaluated in other ethnic groups.

The use of cyclophosphamide in the treatment of class III/IV LN became routine after a prospective RCT demonstrated that cyclophosphamide added to corticosteroids reduced development of ESRD.⁵⁹⁹ Other studies showed that adding cyclophosphamide to corticosteroids decreased LN relapses, improved remission rate, and decreased development of CKD.^{600–602} Retrospective analysis of repeat kidney biopsies from selected patients who had participated in the NIH trials showed that those receiving only corticosteroids had a linear increase in the chronicity index over time (median 44 months after treatment), whereas patients receiving corticosteroids and cyclophosphamide (or other immunosuppressive drugs) had no change in the chronicity index,⁶¹⁹ suggesting the immunosuppressive drugs prevented progressive kidney scarring. A criticism of these studies is the small number of patients, especially during long-term follow-up.

There were no significant differences in outcome between i.v. and oral cyclophosphamide in the original RCT that led to the widespread use of Regimen A,⁵⁹⁹ but because bladder toxicity (chemical cystitis) developed only in patients receiving oral cyclophosphamide, i.v. cyclophosphamide became the standard treatment⁵⁹⁹ (Online Suppl Tables 78–79). In this initial trial, patients were exposed to large cumulative amounts of cyclophosphamide; oral cyclophosphamide was used at doses up to 4 mg/kg/d for a median of 4 years, far greater than now recommended, and i.v. cyclophosphamide was continued for a median of 4 years. Given the potential for developing hematologic malignancies later in life, these large cumulative doses of cyclophosphamide should be avoided. We suggest a lifetime maximum of 36 g cyclophosphamide in patients with systemic lupus.^{13,284} This is reflected in Regimens A–C.

There are other important considerations, when using cyclophosphamide, to reduce its toxicity. The dose of cyclophosphamide should be decreased by 20% or 30% in patients with CrCl 25–50 and 10–25 ml/min, respectively.⁶²⁰ The dose of i.v. cyclophosphamide should be adjusted to keep the day 10–14 leucocyte count nadir $\geq 3000/\mu\text{l}$. When using oral cyclophosphamide, white blood cell counts should be monitored weekly and cyclophosphamide dose should be adjusted to keep leucocytes $\geq 3000/\mu\text{l}$. Leukopenia requires careful evaluation, since systemic lupus, as well as cyclophosphamide, can cause suppression of bone marrow.

To minimize bladder toxicity with oral cyclophosphamide, we suggest instructing patients to take cyclophosphamide in the morning, and to drink extra fluid at each meal and at bed time. The use of sodium-2-mercaptoethane (mesna) will also minimize the risk of hemorrhagic cystitis when cyclophosphamide is given as i.v. pulses.

To protect fertility, women should be offered prophylaxis with leuprolide and men testosterone while cyclophosphamide is being given.^{621,622} Administration of leuprolide must be timed carefully in relation to cyclophosphamide to maximize benefit. Ovarian tissue cryopreservation is an additional, but expensive, option. The efficacy of testosterone

in preserving fertility in males is poorly established, so sperm banking should be offered.

Given the toxicity of cyclophosphamide, studies were undertaken to determine if the dosing regimen could be modified. An RCT has tested the efficacy of low-dose, short-duration cyclophosphamide (Regimen B) in Caucasians.^{603,604} This regimen resulted in a higher percentage of remissions and a lower incidence of severe infections than Regimen A, although the differences were not statistically significant.⁶⁰⁴ Importantly, this low-dose cyclophosphamide regimen had similar long-term outcomes (mean follow-up of 10 years) to Regimen A⁶⁰³ (Online Suppl Table 77). In this trial, the majority of patients were white, and most patients did not have clinically severe disease. Therefore, it is not certain whether this protocol will be effective in patients of other ancestry, or in patients with more severe class III/IV LN.

A cyclophosphamide-free regimen has been proposed (Regimen D). MMF is used for the first 6 months of LN treatment, instead of sequential cyclophosphamide followed by MMF. The basis for this approach was three small studies of MMF in Asia, and one larger study (140 patients) from the USA.^{611,623–625} The Asian studies concluded MMF was equivalent to cyclophosphamide, but the USA trial demonstrated MMF was superior to i.v. cyclophosphamide, although many patients did not achieve the target dose of cyclophosphamide, and a significant percentage of patients showed no response or withdrew from the study. An RCT (ALMS)⁶¹³ recruited 370 patients with class III, IV, and V LN, giving oral corticosteroids and either daily oral MMF or 6-monthly i.v. pulses of cyclophosphamide (0.5–1 g/m²). The ALMS trial showed that MMF was equivalent to i.v. cyclophosphamide in inducing a response at 6 months.⁶¹³ ALMS showed a similar incidence of adverse events, serious infections, and deaths for MMF and cyclophosphamide (Online Suppl Tables 71–73). Similar results were found in an Egyptian cohort.⁶²⁶

A posthoc analysis of the ALMS trial indicated that black, Hispanic, and mixed-race patients, (generally considered to have more resistant LN⁶²⁷) had inferior outcomes with cyclophosphamide compared to MMF. Further information is required from RCTs before recommendations can be made about the efficacy of MMF in patients of specific ethnicity.

Because the kidney response rate for class III and IV LN with any of the initial therapies so far discussed is only about 60% at 6–12 months, an RCT adding rituximab or placebo to MMF plus corticosteroids for initial LN therapy was undertaken to determine if remission rates could be improved.⁶²⁸ This RCT was based on several small, open-label, uncontrolled trials that suggested rituximab may be effective in proliferative LN, either for refractory disease or as initial therapy.^{629–635} At 12 months, however, there were no differences between the rituximab and placebo groups in terms of complete or partial remissions. Thus, rituximab cannot be recommended as adjunctive initial therapy.

Choice of Initial Therapy

The patients in the two largest studies of MMF vs. cyclophosphamide generally had less severe LN, assessed by level of proteinuria and kidney function,^{613,623} than the patients in some of the RCTs of cyclophosphamide.^{601,636} Thus, in severe class III/IV LN, a cyclophosphamide-containing protocol for initial therapy may be preferred. However, a subset of patients in the ALMS trial did have severe LN and responded to MMF, so more data are required. In patients with less severe proliferative LN, an initial regimen not containing cyclophosphamide should be considered.

Additionally, the beneficial effect of cyclophosphamide in preservation of kidney function was only apparent after 3–5 years of follow-up.^{599–601} This length of time, which was needed to show a difference between initial therapies in long-term kidney survival, must therefore be kept in mind when evaluating new, non-cyclophosphamide-containing regimens as initial therapy for class III/IV LN. For example, the Dutch Working Party on systemic lupus found that azathioprine, an antimetabolite like MMF, was equivalent to cyclophosphamide as initial therapy of class III and IV LN; however, in the long term, repeat biopsies showed more chronic damage with azathioprine, as well as a higher incidence of kidney relapse and doubling of SCr (Online Suppl Tables 74–76).^{615,616} In some regions where cost and drug availability are an issue, it may be necessary to use azathioprine for initial treatment of class III and IV LN.

In a long-term study of continuous MMF therapy compared to initial cyclophosphamide followed by azathioprine, there were no significant differences in kidney function between the groups after a median of 64 months.⁶¹² However, in the MMF group, more patients had relapses, prolonged proteinuria >1 g/d, and persistent SCr >2 mg/dl (>177 μmol/l). These combined clinical findings have been associated, in other studies, with deterioration of kidney function over time.

After the initial 6-month treatment period, the ALMS trial was extended for 3 years to evaluate maintenance therapy with either MMF or azathioprine.⁶³⁷ Although not designed to compare the long-term efficacy of initial therapy on kidney function, there was a (nonsignificant) trend toward fewer treatment failures in those who received cyclophosphamide as initial therapy as opposed to MMF. This result was independent of whether maintenance therapy was azathioprine or MMF.

Thus, it cannot yet be stated that initial therapy with MMF is equal to cyclophosphamide for proliferative LN with respect to long-term kidney function.

12.4: Class III LN (focal LN) and class IV LN (diffuse LN)—maintenance therapy

12.4.1: We recommend that, after initial therapy is complete, patients with class III and IV LN receive maintenance therapy with azathioprine (1.5–2.5 mg/kg/d) or MMF (1–2 g/d in divided

doses), and low-dose oral corticosteroids (≤10 mg/d prednisone equivalent). (1B)

12.4.2: We suggest that CNIs with low-dose corticosteroids be used for maintenance therapy in patients who are intolerant of MMF and azathioprine. (2C)

12.4.3: We suggest that, after complete remission is achieved, maintenance therapy be continued for at least 1 year before consideration is given to tapering the immunosuppression. (2D)

12.4.4: If complete remission has not been achieved after 12 months of maintenance therapy, consider performing a repeat kidney biopsy before determining if a change in therapy is indicated. (Not Graded)

12.4.5: While maintenance therapy is being tapered, if kidney function deteriorates and/or proteinuria worsens, we suggest that treatment be increased to the previous level of immunosuppression that controlled the LN. (2D)

RATIONALE

- There is moderate-quality evidence from RCTs in patients with class III/IV LN that prolonged maintenance therapy after initial treatment is required.
- There is moderate-quality evidence that maintenance therapy with azathioprine or MMF is superior to maintenance with cyclophosphamide as judged by risk of death, and risk of development of CKD.
- There is moderate-quality evidence that azathioprine and cyclosporine A have comparable efficacy as maintenance therapies for class III/IV LN.
- There is very low-quality evidence to guide the duration of maintenance therapy after complete remission, but most randomized studies of class III/IV LN have given therapy for several years.

The need for maintenance therapy was suggested when patients treated only with short-term (6 months) i.v. cyclophosphamide therapy were shown to have an increased frequency of kidney relapses.⁶⁰⁰

Choice of Maintenance Therapy

Presently, there are several options for maintenance therapy after the initial treatment of proliferative LN. The data currently available do not allow a definitive recommendation as to the choice of agent for maintenance therapy, although in a multiethnic cohort MMF was superior to azathioprine. Patient-specific factors, such as desire for pregnancy or occurrence of side-effects, should however be considered when making this choice.

A cohort of mainly black and Hispanic patients with class III/IV LN was treated with monthly i.v. cyclophosphamide for up to seven cycles, followed by azathioprine or MMF, and compared to patients treated with 6-monthly cyclophosphamide pulses followed by quarterly cyclophosphamide

pulses for 1 year beyond remission.⁶³⁸ This study showed that, over 72 months, the patients treated with maintenance azathioprine or MMF were significantly less likely to reach the composite end-point of death or CKD than the cyclophosphamide maintenance group, and to experience fewer adverse effects.

The MAINTAIN Nephritis Trial compared MMF with AZA as maintenance therapy in a predominantly Caucasian population after initial treatment with low-dose (Regimen B) cyclophosphamide.⁶³⁹ They had not necessarily achieved remission after initial therapy. The primary end-point was time to kidney relapse. After at least 3 years of follow-up, this trial found MMF and azathioprine to be equivalent.

The ALMS trial extension phase⁶³⁷ compared MMF and AZA as maintenance therapies after the 6-month initial treatment period (Regimen D). Patients entered this extension phase only if they achieved a complete or partial remission after initial therapy. Over 3 years, the composite treatment failure end-point (death, ESRD, kidney flare, sustained doubling of SCr, or requirement for rescue therapy) was reached in 16% of MMF-treated patients compared to 32% of azathioprine-treated patients ($P=0.003$). The superiority of MMF over azathioprine was not dependent on initial therapy or race of the patient.

A pilot RCT in 69 patients with class III/IV LN suggested that 2 years of cyclosporine may be as effective as 2 years of azathioprine for maintenance, after initial treatment with prednisone and oral cyclophosphamide, in terms of relapse prevention and reduction of proteinuria.⁶⁰⁶ Another RCT showed cyclosporine was as effective as azathioprine in terms of tapering maintenance corticosteroids in severe systemic lupus, but only 29% of the patients had LN.⁶⁴⁰

Duration of Therapy

Few patients reach complete remission by 6 months, and kidney biopsies after 6 months of initial therapy have shown that, while active inflammation tends to improve, complete resolution of pathologic changes is unusual.^{614,625,641,642} Consistent with this finding, clinical improvement in class III/IV LN continues well beyond 6 months and into the maintenance phase of therapy.^{603,605,607,610,615,643} Decisions to alter therapy should not be based on urine sediment alone. A repeat kidney biopsy may be considered if kidney function is deteriorating.

There is no evidence to help determine the duration of maintenance therapy. The average duration of immunosuppression was 3.5 years in seven RCTs.^{599,600,603,604,609,612,615,638} We suggest that immunosuppressive therapy should usually be slowly tapered after patients have been in complete remission for a year. If a patient has a history of kidney relapses it may be prudent to extend maintenance therapy.

Immunosuppression should be continued for patients who achieve only a partial remission. However, the strategy of trying to convert a partial remission to a complete remission by increasing corticosteroids or using alternative immunosuppressive agents is not supported by evidence.

There are few data on repeat biopsies after therapy. Biopsies taken two or more years after initial therapy often continue to show activity, especially when there is still significant proteinuria or an abnormal SCr.⁶⁴⁴ Of more concern, one study found that, in patients with initial class III and IV LN, only 40% had reverted to class II LN on repeat biopsy after 2 years of immunosuppressive therapy.⁶¹⁶ The SCr and extent of proteinuria at the time of the second biopsy did not differentiate between the group that reverted to class II and the group that remained with class III or IV LN.

Predictors of Response to Treatment of Class III/IV LN

Reported response rates are affected by variability in the definition of remission and variability of initial treatment regimens. Although complete remission should be the goal for LN, attaining at least a partial remission significantly improves kidney prognosis and patient mortality compared to no remission.⁶⁴⁵

The 6- to 12-month response rates (both complete and partial) from several trials involving black, white, Hispanic, Mexican, and mixed-race patients are between 20% and 85%.^{604,605,613,615,623,638} Complete remission rates at 6–12 months were between 8% and 30% in these studies. In contrast, Chinese patients in clinical trials had a consistently better response rate of about 90% and a complete remission rate of 60–80%.^{607–609,611}

Multivariate analyses of retrospective studies suggest that the most important predictors for not achieving remission are SCr at the start of treatment (RR 0.21 per 1 mg/dl [88 μ mol/l]), the magnitude of increase in SCr during relapse, a delay in starting therapy for more than 3 months after a clinical diagnosis of LN, and severity of proteinuria (HR 0.86 per 1 g/d proteinuria [uPCR 1000 mg/g or 100 mg/mmol]).^{627,643}

In one prospective study there were no clinical variables predictive of achieving remission on multivariate analysis,⁶⁰⁹ while another prospective study showed initial SCr was a predictor of complete remission (RR = 0.96 per μ mol/l [0.0113 mg/dl] increase in SCr).⁶⁰⁸

Multivariate analysis from a prospective study showed that failure to achieve complete remission was a major risk factor for kidney relapse,⁶⁰⁷ while other studies found that no variables were independently predictive of relapse.⁶¹⁶ A survey of several retrospective studies shows that the one common predictor for risk of CKD, ESRD, or death is SCr at presentation.^{627,646–648} In children with LN, failure to respond to therapy and kidney relapse were risk factors for ESRD, HR 5.5 and 11.8 respectively.⁶⁴⁹

Monitoring Therapy of Class III/IV LN

The progress of LN therapy is monitored with serial measurements of proteinuria and SCr. There are not yet any more sensitive biomarkers of kidney response in lupus of proven clinical value.⁶⁵⁰ In LN, as in other proteinuric GN, resolution of proteinuria is the strongest predictor of kidney survival;^{477,651,652} thus, effective treatment is expected to decrease proteinuria over time.

Effective therapy is also expected to result in reduction of an elevated SCr. A caveat is that there may be an acceptable increment in SCr in association with concomitant RAS blockade. Urine sediment should be monitored serially during LN therapy, specifically looking for resolution of cellular casts over time. However, hematuria may persist for months even if therapy is otherwise successful in improving proteinuria and kidney dysfunction. It is desirable to see serologic markers of lupus activity, such as complement and double-stranded DNA antibody levels, normalize with treatment. However, C3 and C4, and anti-double-stranded DNA antibodies have low sensitivity (49–79%) and specificity (51–74%) in relationship to LN activity.^{653–659}

RESEARCH RECOMMENDATIONS

- RCTs are needed to compare the efficacy of MMF and cyclophosphamide as initial therapy in non-Caucasian patients.
- RCTs are needed to examine steroid-free and steroid-limited regimens.
- An RCT is needed to determine the duration of maintenance therapy in proliferative LN after complete remission.
- Studies are needed to determine if repeat biopsy of patients who achieve only partial remission can guide therapy to achieve complete remission.
- Biomarkers need to be identified that reflect response to therapy and kidney pathology. These would then need to be tested to determine whether they could be used to guide treatment withdrawal, re-treatment, and change in treatment.

12.5: Class V LN (*membranous LN*)

12.5.1: We recommend that patients with class V LN, normal kidney function, and non-nephrotic-range proteinuria be treated with antiproteinuric and antihypertensive medications, and only receive corticosteroids and immunosuppressives as dictated by the extrarenal manifestations of systemic lupus. (2D)

12.5.2: We suggest that patients with pure class V LN and persistent nephrotic proteinuria be treated with corticosteroids plus an additional immunosuppressive agent: cyclophosphamide (2C), or CNI (2C), or MMF (2D), or azathioprine (2D).

BACKGROUND

In class V LN, light microscopy typically shows thickened glomerular basement membranes; immunofluorescence and electron microscopy show only subepithelial immune complexes. If class V LN is accompanied by endocapillary hypercellularity and/or subendothelial immune deposits, this adds class III or IV to the histologic diagnosis. In class V LN, the main clinical finding is proteinuria, often nephrotic-range, with or without hematuria; kidney function is usually

normal. If class III or IV LN is also present, urine sediment may be more active, and kidney impairment is more likely.

RATIONALE

- Pure class V LN, although regarded as indolent compared to class III and IV LN, is still associated with the development of CKD and ESRD, especially if there is heavy proteinuria.
- Nephrotic-range proteinuria in class V LN generally does not spontaneously remit.
- There has only been one small RCT in class V LN, which compared corticosteroids plus immunosuppression to corticosteroids alone.
- There have been a few small, retrospective trials of MMF and azathioprine in class V LN.
- There have been no studies of the effect of treatment of class V LN on long-term kidney outcomes.
- The prognosis for patients with mixed membranous and proliferative lesions [i.e., class V plus class III or IV LN] is less favorable than pure class V LN, and similar to that of patients with class III or IV LN. Patients with mixed membranous and proliferative lesions should be treated similarly to those with class III and IV LN.

There are no convincing data to treat class V LN and subnephrotic proteinuria with immunosuppression; however, given the adverse effects of proteinuria on the kidney, it is reasonable to treat these patients with antiproteinuric and antihypertensive medications (see Chapter 2). These therapies may reduce proteinuria by as much as 30–50% in class V LN.^{486,652,660} They should also be used as an adjunct to immunosuppression for patients with nephrotic-range proteinuria.

The justifications to treat class V LN and nephrotic proteinuria with immunosuppression are as follows. Decreased GFR occurs in about 20% of cases of class V LN, and ESRD in about 8–12% after 7–12 years,^{661–664} with one study reporting death or ESRD in 28% of patients at 10 years.⁶⁶⁵ Spontaneous remission of heavy proteinuria occurs in only a minority of class V LN.^{666,667} The adverse effects of sustained, heavy proteinuria include hyperlipidemia and atherosclerosis, contributing to cardiovascular morbidity and mortality,^{652,668} and hypercoagulability with arterial and venous thromboses.^{588,652} Thrombotic events occur in 13–23% of class V LN, and have been associated with antiphospholipid antibodies, and/or the nephrotic syndrome.^{661,664,669}

There is only one small RCT ($n = 15$ in each treatment arm) examining the treatment of class V LN.⁶⁷⁰ This study compared the addition of cyclophosphamide or cyclosporine to prednisone in a USA cohort that included blacks, Hispanics, and whites. Both cyclophosphamide and cyclosporine significantly increased response (complete remission 40–50% vs. 14% at 12 months). However, relapse after stopping therapy was much more likely in those treated with cyclosporine (40% within 1 year) compared to cyclophosphamide (no relapse in 48 months). In the same study, the only independent predictor of failure to achieve remission

(by multivariate analysis) was initial proteinuria over 5 g/d. Failure to achieve sustained remission was a risk factor for decline in kidney function (Online Suppl Tables 82–84).

There have been small uncontrolled retrospective, or open-label, studies of MMF and azathioprine with or without corticosteroids in class V LN.^{663,669,671,672} In general, these studies have shown complete remission rates of 40–60% at 6–12 months. A small open-label trial of tacrolimus in class V LN showed a complete remission rate of 39% at 6 months.⁶⁷³ Before these regimens can be recommended, they will need to be tested in RCTs.

Patients with mixed class V and class III or IV LN may have a less favorable prognosis, and should be treated as for the proliferative component.⁶⁶⁴

RESEARCH RECOMMENDATION

- An RCT is needed to compare MMF to cyclophosphamide or a CNI, for induction of remission of pure class V LN.

12.6: General treatment of LN

12.6.1: We suggest that all patients with LN of any class are treated with hydroxychloroquine (maximum daily dose of 6–6.5 mg/kg ideal body weight), unless they have a specific contraindication to this drug. (2C)

RATIONALE

- There is low-quality evidence that hydroxychloroquine may protect against the onset of LN, against relapses of LN, ESRD, vascular thrombosis, and that it has a favorable impact on lipid profiles.⁶⁷⁴

In a prospective study, hydroxychloroquine was maintained or withdrawn in a cohort of patients who had been receiving it before the diagnosis of LN.⁶⁷⁵ Those who had been on hydroxychloroquine before developing LN had a lower frequency of ESRD, cardiovascular events, and thrombotic events than patients who had never received hydroxychloroquine; HR for ESRD 0.29 (95% CI 0.026–1.009).⁶⁷⁶ A large ($n = 1930$), retrospective study found that treatment with hydroxychloroquine protected against vascular thrombosis (OR 0.62; $P < 0.0005$).⁶⁷⁷ Finally, in a prospective observational cohort, hydroxychloroquine was shown to retard kidney damage in LN; the cumulative probability of a 50% reduction in GFR or ESRD after 10 years was 38% for patients on hydroxychloroquine and 70% for those who were not ($P < 0.0001$).⁶⁷⁸ Patients on hydroxychloroquine should have yearly eye examinations for retinal toxicity, especially after 5 years of continuous use.

12.7: Class VI LN (advanced sclerosis LN)

12.7.1: We recommend that patients with class VI LN be treated with corticosteroids and immunosuppressives only as dictated by the extrarenal manifestations of systemic lupus. (2D)

BACKGROUND

In class VI LN, at least 90% of the glomeruli are sclerotic, usually globally, along with interstitial fibrosis and tubular atrophy, with no signs of immunologic activity; the biopsy specimen should be sufficient to be representative of the whole kidney. The dominant clinical picture in class VI LN is severe kidney impairment, usually accompanied by proteinuria and sometimes hematuria.

RATIONALE

- Class VI LN reflects chronic injury, and the consequences of the loss of functional kidney mass, without active immune-mediated injury. Therefore, immunosuppression is not indicated.
- Despite the absence of active LN, patients may still have extrarenal manifestations of systemic lupus requiring immunosuppression.
- As with CKD from any etiology, antiproteinuric and antihypertensive therapies are indicated to preserve residual kidney function and delay ESRD as long as possible.

12.8: Relapse of LN

12.8.1: We suggest that a relapse of LN after complete or partial remission be treated with the initial therapy followed by the maintenance therapy that was effective in inducing the original remission. (2B)

12.8.1.1: If resuming the original therapy would put the patient at risk for excessive lifetime cyclophosphamide exposure, then we suggest a non-cyclophosphamide-based initial regimen be used (Regimen D, Table 28). (2B)

12.8.2: Consider a repeat kidney biopsy during relapse if there is suspicion that the histologic class of LN has changed, or there is uncertainty whether a rising SCr and/or worsening proteinuria represents disease activity or chronicity. (Not Graded)

RATIONALE

- LN is a relapsing condition.
- Relapses are associated with development of CKD.
- The pathologic findings in LN may change with a relapse, and such changes cannot, with certainty, be predicted clinically.

In subjects with LN who had participated in RCTs, 40% of complete responders experienced a kidney relapse within a median of 41 months after remission, and 63% of partial responders had a kidney flare within a median of 11.5 months after response.⁶⁷⁹ The strongest risk factor for relapse is failure to achieve complete remission (HR 6.2).⁶⁰⁷

Relapses are important to recognize and treat, because the kidneys sustain some chronic damage with each relapse that may culminate in CKD, or eventually ESRD. This is

Table 29 | Criteria for the diagnosis and classification of relapses of LN

Mild kidney relapse	Moderate kidney relapse	Severe kidney relapse
Increase in glomerular hematuria from <5 to >15 RBC/hpf, with ≥2 acanthocytes/hpf <i>and/or</i> recurrence of ≥1 RBC cast, WBC cast (no infection), or both	If baseline creatinine is: <2.0 mg/dl [$<177 \mu\text{mol/l}$], an increase of 0.20–1.0 mg/dl [$17.7\text{--}88.4 \mu\text{mol/l}$] ≥2.0 mg/dl [$\geq 177 \mu\text{mol/l}$], an increase of 0.40–1.5 mg/dl [$35.4\text{--}132.6 \mu\text{mol/l}$] <i>and/or</i> If baseline uPCR is: <500 mg/g [$<50 \text{mg/mmol}$], an increase to ≥1000 mg/g [$\geq 100 \text{mg/mmol}$] 500–1000 mg/g [$50\text{--}100 \text{mg/mmol}$], an increase to ≥2000 mg/g [$\geq 200 \text{mg/mmol}$], but less than absolute increase of <5000 mg/g [$<500 \text{mg/mmol}$] >1000 mg/g [$>100 \text{mg/mmol}$], an increase of ≥2-fold with absolute uPCR <5000 mg/g [$<500 \text{mg/mmol}$]	If baseline creatinine is: <2 mg/dl [$<177 \mu\text{mol/l}$], an increase of >1.0 mg/dl [$>88.4 \mu\text{mol/l}$] ≥2 mg/dl [$\geq 177 \mu\text{mol/l}$], an increase of >1.5 mg/dl [$>132.6 \mu\text{mol/l}$] <i>and/or</i> an absolute increase of uPCR >5000 mg/g [$>500 \text{mg/mmol}$]

hpf, high-power field; LN, lupus nephritis; RBC, red blood cell; uPCR, urine protein:creatinine ratio; WBC, white blood cell.

Adapted from Lahita RG, Tsokos GT, Buyon JP, Koike T (eds). Systemic Lupus Erythematosus, 5th edn. Rovin BH, Stillman IE. Chapter 42: Kidney. Elsevier: Waltham, MA, 2011, pp 769–814 with permission from Elsevier.⁶⁸⁷

supported by repeat biopsy studies that showed an increase in the chronicity index at the second biopsy, even after successful treatment.^{614,616,618,625,641,644,680}

LN may spontaneously transform from one class to another. The most common transformation is from class III to IV.⁶⁴⁴ Also, a recent retrospective study found clinically relevant class transformation to be more frequent from a nonproliferative to a proliferative class, rather than proliferative to nonproliferative transformation.⁶⁸¹ Clues to a change in LN class are the development of nephrotic-range proteinuria and changes in the activity of urine sediment, but definitive diagnosis requires a biopsy.

Kidney relapse is diagnosed by clinical criteria based on changes in urine sediment, rate of protein excretion, and SCr change from baseline values in an individual patient. There is no consensus on the definition of a kidney relapse; criteria used in several published studies are shown in Table 29.^{682–686} A fall in levels of serum complement components and a rise in anti-double-stranded DNA antibody titers also support a diagnosis of relapse but will not necessarily be present.

RESEARCH RECOMMENDATION

- A study of repeat kidney biopsies at the time of kidney relapse is needed to determine whether it is beneficial to tailor therapy based on biopsy findings.

12.9: Treatment of resistant disease

12.9.1: In patients with worsening SCr and/or proteinuria after completing one of the initial treatment regimens, consider performing a repeat kidney biopsy to distinguish active LN from scarring. (Not Graded)

12.9.2: Treat patients with worsening SCr and/or proteinuria who continue to have active LN on

biopsy with one of the alternative initial treatment regimens (see Section 12.3). (Not Graded)

12.9.3: We suggest that nonresponders who have failed more than one of the recommended initial regimens (see Section 12.3) may be considered for treatment with rituximab, i.v. immunoglobulin, or CNIs. (2D)

RATIONALE

- Most patients are expected to show some evidence of response to treatment after a year of therapy, although complete remission may occur beyond a year.
- There are no prospective data on patients who fail to achieve at least partial response; it is reasonable, however, to repeat biopsy and determine if there has been a change in kidney pathology that could account for treatment failure.
- There are no prospective data on patients who fail initial therapy; however, it is reasonable to try a second course of initial therapy using an alternative regimen, as dictated by repeat biopsy.
- There have been small studies of “rescue” therapies for patients who have been refractory despite multiple treatment attempts.

In both prospective and retrospective LN cohorts, despite treatment with different protocols and follow-up under different definitions of remission, the majority of patients who remitted did so within 1 year of therapy.^{604,605,615,618,645} Studies generally show that 50% of patients had a remission (complete or partial) by 12 months, with another 5–25% remitting by 24 months. Among complete remissions, about half were achieved by 12 months, and the other half by 20–24 months.

There is no consensus definition of refractory LN. A patient may be considered refractory if conventional cyclophosphamide regimens have been tried without success, and non-cyclophosphamide regimens have not worked. If repeat kidney biopsy confirms active LN is the cause of continuing clinical abnormalities, there is no definitive information to guide therapy. The following “salvage” treatments have only been evaluated in small observational studies.

The evidence that refractory LN can be treated with rituximab comes only from small, open-label studies.^{623,688} Many of these patients had failed multiple attempts at treatment with the conventional therapies described previously. Rituximab may be considered as a “rescue therapy” when usual therapeutic options have been exhausted. This use of rituximab is in contrast to its lack of utility as add-on therapy to an initial standard regimen (Regimen D) for proliferative LN.⁶⁴²

The evidence for using i.v. immunoglobulin in refractory cases is of very low quality. It has been used in a handful of patients with proliferative LN, and in some has shown comparable efficacy to cyclophosphamide (reviewed by Rauova *et al.*⁶⁸⁹ Some formulations of i.v. immunoglobulin (sucrose-containing) have shown nephrotoxicity, and are therefore best avoided in patients with pre-existing kidney impairment.

There is only evidence from small prospective, open-label trials for using low-dose cyclosporine (2.5 mg/kg/d) to treat refractory LN.^{690,691} Although kidney function did not improve, most patients had a reduction in proteinuria, resolution of hematuria, and needed lower doses of corticosteroids. Similarly, a prospective trial used tacrolimus (3 mg/d) in patients with LN in whom corticosteroids could not be reduced, and demonstrated improvement in proteinuria and C3 levels.⁶⁹²

RESEARCH RECOMMENDATIONS

- A globally accepted definition of nonresponse needs to be developed.
- The salvage therapies discussed in the text must be subject to RCTs to determine effect on remission and kidney outcomes.

12.10: Systemic lupus and thrombotic microangiopathy

12.10.1: We suggest that the antiphospholipid antibody syndrome (APS) involving the kidney in systemic lupus patients, with or without LN, be treated by anticoagulation (target international normalized ratio [INR] 2–3). (2D)

12.10.2: We suggest that patients with systemic lupus and thrombotic thrombocytopenic purpura (TTP) receive plasma exchange as for patients with TTP without systemic lupus. (2D)

BACKGROUND

Lupus-associated thrombotic microangiopathies (TMA) may occur alone or in combination with immune-complex LN.

TMA in systemic lupus may occur in association with accelerated hypertension, systemic sclerosis, TTP, or in lupus anticoagulant/APS.

While TMA associated with APS, TTP, and accelerated hypertension is often characterized by AKI, APS can also cause slowly progressive kidney impairment with few specific clinical manifestations. In retrospective studies, kidney APS occurred in about 30% of systemic lupus patients.^{693,694} Lupus anticoagulant was present in 30–52% of those with kidney APS, while 72–95% of patients had anticardiolipin antibodies, but 15% had neither of these serologic markers.^{693,695} Routine testing does not identify all antiphospholipid antibodies; therefore, those with TMA who are antiphospholipid antibody-negative are treated in the same way as antibody-positive patients. A high index of suspicion is needed along with a kidney biopsy to confirm the diagnosis.

RATIONALE

- APS occurs frequently in systemic lupus, and there is moderate-quality evidence that failure to treat it may lead to CKD or ESRD, despite adequate control of LN or other systemic lupus manifestations with immunosuppression.
- Although there are no specific studies of anticoagulation for APS with systemic lupus, there have been two RCTs of the intensity of warfarin therapy in APS.^{696,697} They provided moderate-quality evidence of no difference in thrombotic events if the INR was 2–3 or 3–4, but that bleeding complications were higher when INR was maintained greater than 3.
- TTP in lupus is associated with a high mortality.⁶⁹⁸ There are no RCTs to guide treatment of TTP in the setting of systemic lupus, but it seems appropriate to use regimens beneficial in TTP without lupus.

RESEARCH RECOMMENDATIONS

- A clinical trial is needed to determine the effect of treating APS on long-term kidney function.
- A clinical trial is needed to determine the efficacy of plasma exchange in TTP, in the setting of systemic lupus.

12.11: Systemic lupus and pregnancy

12.11.1: We suggest that women be counseled to delay pregnancy until a complete remission of LN has been achieved. (2D)

12.11.2: We recommend that cyclophosphamide, MMF, ACE-I, and ARBs not be used during pregnancy. (1A)

12.11.3: We suggest that hydroxychloroquine be continued during pregnancy. (2B)

12.11.4: We recommend that LN patients who become pregnant while being treated with MMF be switched to azathioprine. (1B)

12.11.5: We recommend that, if LN patients relapse during pregnancy, they receive treatment

with corticosteroids and, depending on the severity of the relapse, azathioprine. (1B)

12.11.6: If pregnant patients are receiving corticosteroids or azathioprine, we suggest that these drugs not be tapered during pregnancy or for at least 3 months after delivery. (2D)

12.11.7: We suggest administration of low-dose aspirin during pregnancy to decrease the risk of fetal loss. (2C)

RATIONALE

- Data suggest that active LN or LN in partial remission is associated with an increase in fetal loss and an increased rate of kidney relapse during pregnancy.
- Cyclophosphamide, MMF, ACE-I, and ARBs are teratogenic.
- Hydroxychloroquine, azathioprine, and corticosteroids have been used safely during pregnancy in patients with systemic lupus; low-dose aspirin may decrease fetal loss in systemic lupus.

The risk of fetal loss in patients with LN has been examined in several retrospective series. In a nested case-control study of 78 pregnancies, the incidence of fetal loss was not different in patients with a history of LN compared to systemic lupus patients with no history of LN.⁶⁹⁹ In patients with LN in remission, fetal loss of 8–13% has been documented.^{700–702} However, in patients with active LN, fetal loss was significantly higher at 35%.⁷⁰² In addition to the clinical activity of LN, hypocomplementemia appears to be a risk factor for fetal loss, whereas the use of low-dose aspirin may be protective. In a retrospective study of 113 pregnancies in patients with systemic lupus and LN, hypocomplementemia conferred a RR of 19 for fetal loss, and aspirin conferred a RR of 0.11.⁷⁰¹ All the patients in this investigation were Caucasian, so the results may not be applicable to other ethnicities.

Hydroxychloroquine should be continued in pregnancy because its withdrawal may lead to flares of lupus, including LN.⁷⁰³

There may be additional risk to the kidneys of patients with LN who become pregnant. One study noted that kidney relapses and progressive kidney dysfunction were not different between pregnant and nonpregnant patients with LN.⁶⁹⁹ In other studies, kidney relapses were more common in pregnancies occurring when only partial remission of LN had been achieved, or in patients who had more than 1 g/d proteinuria or kidney impairment.^{700–702} Kidney relapse rates of 10–69% have been reported during or following pregnancy.^{699–702}

12.12: LN in children

12.12.1: We suggest that children with LN receive the same therapies as adults with LN, with dosing based on patient size and GFR. (2D)

RATIONALE

- LN in children shows the same range of clinical and pathological phenotypes as is seen in adults.
- There are no RCTs of LN therapy in children.

Therefore, we suggest that children with LN be treated with the regimens recommended earlier in this chapter. The research recommendations made under 12.1–12.10 also apply to children.

DISCLAIMER

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SUPPLEMENTARY MATERIAL

Supplementary Table 71: Evidence profile of RCTs of MMF vs. Cyc for induction therapy in lupus nephritis.

Supplementary Table 72: Summary table of RCTs examining MMF vs. IV Cyc for induction therapy in patients with lupus nephritis (categorical outcomes).

Supplementary Table 73: Summary table of RCTs examining MMF vs. IV Cyc for induction therapy in patients with lupus nephritis (continuous outcomes).

Supplementary Table 74: Existing systematic review on Cyc vs. AZA for induction treatment in patients with lupus nephritis.

Supplementary Table 75: Summary table of RCT examining Cyc vs. AZA for induction treatment in patients with lupus nephritis (categorical outcomes).

Supplementary Table 76: Summary table of RCT examining Cyc vs. AZA for induction treatment in patients with lupus nephritis (continuous outcomes).

Supplementary Table 77: Summary table of RCT examining low vs. high dose IV Cyc in patients with lupus nephritis (categorical outcomes).

Supplementary Table 78: Existing systematic review on IV vs. p.o. Cyc treatment in patients with lupus nephritis.

Supplementary Table 79: Summary table of RCT examining IV Cyc vs. p.o. Cyc in patients with lupus nephritis (categorical outcomes).

Supplementary Table 80: Summary table of RCT examining Cyc vs. AZA for maintenance therapy in patients with lupus nephritis (categorical outcomes).

Supplementary Table 81: Summary table of RCT examining Cyc vs. AZA for maintenance therapy in patients with lupus nephritis (continuous outcomes).

Supplementary Table 82: Summary table of RCT examining IV Cyc vs. prednisone in patients with membranous lupus nephritis (categorical outcomes).

Supplementary Table 83: Summary table of RCT examining IV CsA vs. prednisone in patients with membranous lupus nephritis (categorical outcomes).

Supplementary Table 84: Summary table of RCT CsA vs. IV Cyc in patients with membranous lupus nephritis (categorical outcomes).

Supplementary Table 85: Summary table of RCT examining rituximab + Cyc vs. rituximab in patients with proliferative lupus nephritis (categorical outcomes).

Supplementary Table 86: Summary table of RCT examining rituximab + Cyc vs. rituximab in patients with proliferative lupus nephritis (continuous outcomes).

Supplementary Table 87: Summary table of RCT examining TAC vs. placebo in patients with lupus nephritis (categorical outcomes).

Supplementary Table 88: Summary table of RCT examining TAC vs. placebo in patients with lupus nephritis (continuous outcomes).

Supplementary Table 89: Summary table of a study examining TAC vs. standard protocols of steroid + p.o. Cyc or AZA in patients with class V lupus (categorical outcomes).

Supplementary Table 90: Summary table of a study examining TAC vs. standard protocols of steroid + p.o. Cyc or AZA in patients with class V lupus (continuous outcomes).

Supplementary Table 91: Summary table of a study examining AZA vs. IV Cyc maintenance therapy in patients with lupus nephritis (categorical outcomes).

Supplementary Table 92: Summary table of a study examining MMF vs. IV Cyc maintenance therapy in patients with lupus nephritis (categorical outcomes).

Supplementary Table 93: Evidence profile of studies examining MMF vs. AAZA maintenance therapy in patients with lupus nephritis.

Supplementary Table 94: Summary table of studies examining MMF vs. AZA maintenance therapy in patients with lupus nephritis (categorical outcomes).

Supplementary Table 95: Summary table of studies examining MMF vs. AZA maintenance therapy in patients with lupus nephritis (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 13: Pauci-immune focal and segmental necrotizing glomerulonephritis

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INTRODUCTION

This chapter makes treatment recommendations for adults with pauci-immune focal and segmental necrotizing GN with or without systemic vasculitis, and with or without circulating ANCA. The cost implications for global application of this guideline are addressed in Chapter 2.

13.1: Initial treatment of pauci-immune focal and segmental necrotizing GN

- 13.1.1: We recommend that cyclophosphamide and corticosteroids be used as initial treatment. (1A)
- 13.1.2: We recommend that rituximab and corticosteroids be used as an alternative initial treatment in patients without severe disease or in whom cyclophosphamide is contraindicated. (1B)

13.2: Special patient populations

- 13.2.1: We recommend the addition of plasmapheresis for patients requiring dialysis or with rapidly increasing SCr. (1C)
- 13.2.2: We suggest the addition of plasmapheresis for patients with diffuse pulmonary hemorrhage. (2C)
- 13.2.3: We suggest the addition of plasmapheresis for patients with overlap syndrome of ANCA vasculitis and anti-GBM GN, according to proposed criteria and regimen for anti-GBM GN (see Chapter 14). (2D)
- 13.2.4: We suggest discontinuing cyclophosphamide therapy after 3 months in patients who remain dialysis-dependent and who do not have any extrarenal manifestations of disease. (2C)

BACKGROUND

Small-vessel vasculitis encompasses a group of diseases characterized by necrotizing inflammation of the small vessels: arterioles, capillaries, and venules. They are characterized by little or no deposition of immune complexes in the vessel wall (pauci-immune). Medium or large vessels may occasionally be involved. Pauci-immune small vessel vasculitides include granulomatosis with polyangiitis (Wegener's), microscopic polyangiitis, and Churg-Strauss syndrome. The characteristic kidney lesion in these conditions is pauci-immune focal and segmental necrotizing and crescentic

glomerulonephritis (NCGN). Active pauci-immune small-vessel vasculitis is typically associated with circulating ANCA (ANCA vasculitis). NCGN may also occur without extrarenal manifestations of disease.

The clinical manifestations associated with NCGN include microscopic hematuria with dysmorphic red blood cells and red cell casts, and proteinuria that is usually moderate (1–3 g/d). Pauci-immune NCGN is frequently associated with a rapidly declining GFR over days or weeks. A minority of patients may present with a more indolent course with asymptomatic microscopic hematuria and minimal proteinuria, which may progress over months.

Patients with systemic vasculitis may present with a variety of extrarenal clinical manifestations affecting one or several organ systems, with or without kidney involvement. Commonly involved systems are upper and lower respiratory tract, skin, eyes, and the nervous system. Severe pulmonary hemorrhage affects about 10% of patients with ANCA GN, and is associated with an increased risk of death.⁷⁰⁴ The need to treat extrarenal vasculitis may impinge on treatment choices for renal vasculitis.

About 90% of patients with small-vessel vasculitis or pauci-immune NCGN have ANCA, directed primarily to the neutrophil granule proteins myeloperoxidase (MPO) or proteinase 3 (PR3).

The treatment recommendations in this guideline derive from studies of patients with ANCA vasculitis and/or GN. About 10% of patients presenting with signs and symptoms of microscopic polyangiitis, granulomatosis with polyangiitis (Wegener's), or pauci-immune NCGN are persistently ANCA-negative. These patients are treated similarly to ANCA-positive patients, although no study has focused specifically on the treatment of ANCA-negative patients.

RATIONALE

- Without therapy, ANCA vasculitis with GN is associated with very poor outcomes.
- There is high-quality evidence for treatment with corticosteroids and cyclophosphamide that has dramatically improved the short- and long-term outcomes of ANCA vasculitis associated with systemic disease.
- Immunosuppressive therapy may not be appropriate in patients with severe NCGN already requiring dialysis.
- All patients with extrarenal manifestations of disease should receive immunosuppressive therapy regardless of the degree of kidney dysfunction.

Table 30 | Recommended treatment regimens for ANCA vasculitis with GN

Agent	Route	Initial dose
Cyclophosphamide ^a	i.v.	0.75 g/m ² q 3–4 weeks. Decrease initial dose to 0.5 g/m ² if age > 60 years or GFR < 20 ml/min per 1.73 m ² . Adjust subsequent doses to achieve a 2-week nadir leukocyte count > 3000/mm ³ .
Cyclophosphamide ^b	p.o.	1.5–2 mg/kg/d, reduce if age > 60 years or GFR < 20 ml/min per 1.73 m ² . Adjust the daily dose to keep leucocyte count > 3000/mm ³ .
Corticosteroids	i.v.	Pulse methylprednisolone: 500 mg i.v. daily × 3 days.
Corticosteroids	p.o.	Prednisone 1 mg/kg/d for 4 weeks, not exceeding 60 mg daily. Taper down over 3–4 months.
Rituximab ^c	i.v.	375 mg/m ² weekly × 4.
Plasmapheresis ^d		60 ml/kg volume replacement. <i>Vasculitis</i> : Seven treatments over 14 days. If diffuse pulmonary hemorrhage, daily until the bleeding stops, then every other day, total 7–10 treatments. <i>Vasculitis in association with anti-GBM antibodies</i> : Daily for 14 days or until anti-GBM antibodies are undetectable.

ANCA, antineutrophil cytoplasmic antibody; GBM, glomerular basement membrane; GFR, glomerular filtration rate; GN, glomerulonephritis; i.v., intravenous; p.o., orally.
^aGiven with pulse and oral steroids. An alternative i.v. cyclophosphamide dosing schema is 15 mg/kg given every 2 weeks for three pulses, followed by 15 mg/kg given every 3 weeks for 3 months beyond remission, with reductions for age and estimated GFR.⁷⁰⁵

^bGiven with pulse and oral steroids.

^cGiven with pulse and oral steroids.

^dNot given with pulse methylprednisolone. Replacement fluid is 5% albumin. Add 150–300 ml fresh frozen plasma at the end of each pheresis session if patients have pulmonary hemorrhage, or have had recent surgery, including kidney biopsy.

- There is high-quality evidence that plasmapheresis provides additional benefit in those with severe NCGN.
- There is low-quality evidence that plasmapheresis provides additional benefit for diffuse pulmonary hemorrhage.
- There is evidence that rituximab is not inferior to cyclophosphamide in induction therapy.

Recommended treatment regimens are shown in Table 30.

Without therapy, ANCA vasculitis with GN is associated with very poor outcomes. Treatment with corticosteroids and cyclophosphamide has dramatically improved the short- and long-term outcomes of ANCA vasculitis associated with systemic disease. Treatment with immunosuppressive therapy is therefore considered indicated in all cases of ANCA vasculitis and GN. The rare possible exception relates to patients with severe kidney-limited disease, in the absence of extrarenal manifestations of small-vessel vasculitis. Thus, in patients with severe pauci-immune NCGN requiring dialysis, the question arises as to whether the risks of therapy are greater than the likelihood of recovering kidney function, or whether there is a point beyond which immunosuppressive therapy is futile.

Cohort studies did not detect a level of kidney function below which therapy can be deemed futile, as remission occurred in about 57% of patients with a GFR of 10 ml/min or less at presentation.⁷⁰⁶ Of 69 patients who presented dialysis-dependent at the beginning of the Methylprednisolone or Plasma Exchange (MEPEX) trial,⁷⁰⁷ 44% were dialysis-independent at 12 months, and the point at which the chance of dying from therapy with plasmapheresis exceeded that of the chance of recovery was reached only in patients with severe tubular atrophy and injury of nearly all glomeruli.⁷⁰⁸ This study suggests that, in the absence of extrarenal manifestations of disease, treatment is warranted

in all but patients with extreme glomerular obsolescence and severe tubulointerstitial scarring. All patients with extrarenal manifestations of disease should receive immunosuppressive therapy, regardless of the degree of kidney dysfunction.

Disease Activity

Kidney manifestations of active GN are a progressive decline in kidney function, ongoing proteinuria with the continued presence of dysmorphic red cells in the urine, and red cell casts.

Remission is defined by the absence of manifestations of vasculitis and GN disease activity. For GN, it is defined as the absence of microscopic hematuria and a stable or improved proteinuria and GFR. Disease activity of ANCA vasculitis represents signs or symptoms attributable to active disease in any organ system.

Cyclophosphamide

The addition of cyclophosphamide to corticosteroids in induction therapy improved the remission rate from about 55% to about 85%, and decreased the relapse rate three-fold.^{706,709}

Pulse i.v. and daily oral regimens for cyclophosphamide are associated with similar remission and relapse rates (Online Suppl Tables 96–99).⁷⁰⁵ Considerations in choosing one approach over the other are: compliance, cost, cumulative dose of cyclophosphamide, frequency of leucopenia, and infection. For the same duration of therapy, patients in the i.v. pulse arm received about half the cumulative amount of cyclophosphamide as in the daily oral arm.⁷⁰⁵ In a meta-analysis of four RCTs, pulse i.v. cyclophosphamide compared to daily oral cyclophosphamide was associated with less leucopenia (RR 0.53 95%CI 0.36–0.77; P = 0.0009), fewer infections (not significant), increased risk of relapse (RR 1.79, 95%CI 1.11–2.87; P = 0.02), and a trend toward an increased number of patient requiring renal replacement therapy.⁷¹⁰

Based on the RCT of maintenance therapy comparing cyclophosphamide to azathioprine, the majority of patients (77%) achieved remission with oral cyclophosphamide by 3 months, and another 16% between 3 and 6 months.⁷¹¹ Thus, the duration of continuous oral cyclophosphamide should usually be limited to 3 months, with a maximum of 6 months. Whether this duration of treatment applies to pulse i.v. cyclophosphamide is inferred, but not tested. The only study of a short (6-month) vs. long (12-month) course of cyclophosphamide was not powered to detect a difference in outcome.⁷¹² A retrospective cohort analysis did not indicate that longer treatment with cyclophosphamide reduces the rate of relapse.⁷⁰⁶

Among patients who require dialysis, those who recover sufficient kidney function nearly always do so within the first 3 months of treatment.^{708,709} Therefore, in patients who are still dialysis-dependent after 3 months and who have no evidence of ongoing extrarenal manifestations of active vasculitis, we suggest discontinuing cyclophosphamide therapy.

Pulse Methylprednisolone

The value of pulse methylprednisolone induction therapy has not been tested directly. The rationale for pulse methylprednisolone is related to its rapid anti-inflammatory effect. High-dose methylprednisolone may also contribute to a rapid reduction in ANCA-producing plasma cells. The only randomized evaluation of pulse methylprednisolone (3×1000 mg) was in the setting of the MEPEX trial, where it was compared to plasmapheresis as adjunctive therapy to oral corticosteroids and oral cyclophosphamide.⁷⁰⁷ In that trial, pulse methylprednisolone was less efficacious than plasmapheresis in preserving kidney function. There are no data that 1000 mg daily for 3 days is better than 500 mg; this lower dose is widely used in clinical practice, and the higher dose may be associated with increased short- and long-term risks of infection and other complications of steroids.

Rituximab

Two RCTs examined rituximab as first-line induction therapy for ANCA vasculitis (Online Suppl Tables 100-102). In the RITUXVAS trial, 44 patients with newly diagnosed ANCA vasculitis were randomized 3:1 to either rituximab (375 mg/m^2 weekly $\times 4$) in addition to cyclophosphamide (15 mg/kg i.v., 2 weeks apart for a total of two doses); or to cyclophosphamide (15 mg/kg i.v. every 2 weeks $\times 3$, then every 3 weeks for a maximum total of 10 doses).⁷¹³ Both groups received the same regimen of methylprednisolone 1000 mg i.v. followed by oral corticosteroids. Rates of remission were similar (76% with rituximab group vs. 82% with cyclophosphamide), as were rates of serious adverse events.⁷¹³

In Rituximab for the Treatment of Wegener's Granulomatosis and Microscopic Polyangiitis (RAVE), 197 patients were randomized to treatment with either rituximab (375 mg/m^2 infusions once weekly for 4 weeks) or cyclophosphamide (2 mg/kg/d orally) for months 1-3, followed by

azathioprine (2 mg/kg/d orally) for months 4-6.⁷¹⁴ All patients received one to three i.v. pulses of methylprednisolone (1000 mg each) followed by the same oral corticosteroid regimen. There was no significant difference between the two treatment groups in rates of complete remission at 6 months, adverse events, or relapse rates. The RAVE trial excluded patients with severe alveolar hemorrhage or severe kidney dysfunction ($\text{SCr} > 4 \text{ mg/dl}$ [$> 354 \mu\text{mol/l}$]), so the role of rituximab for such patients remains unknown.

Rituximab shows equivalent efficacy to cyclophosphamide in initial therapy and the evidence does not suggest a difference in rates of adverse effects. However, analysis of the long-term outcomes, including safety, is still awaited. In addition, the very high cost of rituximab compared to cyclophosphamide limits its application from a global perspective.

Plasmapheresis

The addition of plasmapheresis to initial therapy with corticosteroids and cyclophosphamide is indicated for patients presenting with either advanced kidney failure ($\text{SCr} > 5.66 \text{ mg/dl}$ [$> 500 \mu\text{mol/l}$]) or with diffuse alveolar hemorrhage.

In a large, multicenter controlled trial,⁷⁰⁷ 137 patients with a new diagnosis of ANCA vasculitis confirmed by kidney biopsy were randomly assigned to either seven treatments of plasmapheresis, or three doses of 1000 mg of i.v. methylprednisolone. Both groups received standard therapy with oral cyclophosphamide and oral prednisone followed by azathioprine for maintenance therapy. Plasmapheresis was associated with a significantly higher rate of kidney recovery at 3 months (69% of patients with plasmapheresis vs. 49% with i.v. methylprednisolone), and with dialysis-free survival at 12 months. Whether duration of plasmapheresis should be tailored to ANCA titers has not been studied.

Studies of plasmapheresis as adjunctive therapy in patients with $\text{SCr} < 5.66 \text{ mg/dl}$ ($< 500 \mu\text{mol/l}$) have not shown benefit, but were underpowered to provide definitive evidence.^{715,716} A large RCT of adjunctive therapy with plasmapheresis is currently underway (clinicaltrials.gov identifier NCT00987389).

Plasmapheresis for Patients with Diffuse Alveolar Hemorrhage

The impact of plasmapheresis in patients with diffuse, severe alveolar hemorrhage is the reduction of mortality, based on retrospective case series.^{716,717} Although the strength of supportive data is low (retrospective case series without controls), the impact of such treatment is high (less mortality).^{709,718} Whether patients with "mild" alveolar hemorrhage (small focal infiltrate without or with mild hypoxemia) require plasmapheresis is unknown.

Patients with ANCA Vasculitis: Anti-GBM GN Overlap Syndrome

The recommendation for plasmapheresis, in addition to corticosteroids and cyclophosphamide for patients with both

circulating ANCA and anti-GBM antibodies, is based on the rationale for the treatment of anti-GBM GN. About one-third of patients with anti-GBM disease also have ANCA antibodies, usually directed against MPO. Patients with ANCA/anti-GBM overlap have a worse outcome than patients with ANCA vasculitis alone, or anti-GBM alone.⁷¹⁹

MMF

There are insufficient data to support the use of MMF for induction therapy in ANCA vasculitis. Although small uncontrolled studies report remission rates similar to those reported with corticosteroids and cyclophosphamide,⁷²⁰ relapses have been reported, despite continued use of MMF.⁷²¹

The only controlled study to date of MMF (1.5-2 g/d) vs. cyclophosphamide (monthly i.v. pulse of 0.75-1 g/m²) includes 35 patients from China,⁷²² four of whom were lost to follow-up (all in the cyclophosphamide group). When patients lost to follow-up were excluded from the analysis, the rates of remission were similar in the two groups. No data on follow-up beyond 6 months is provided in this study. A larger RCT of MMF vs. i.v. cyclophosphamide for induction treatment is currently underway (clinicaltrials.gov identifier NCT00414128).

13.3: Maintenance therapy

- 13.3.1: We recommend maintenance therapy in patients who have achieved remission. (1B)
- 13.3.2: We suggest continuing maintenance therapy for at least 18 months in patients who remain in complete remission. (2D)
- 13.3.3: We recommend no maintenance therapy in patients who are dialysis-dependent and have no extrarenal manifestations of disease. (1C)

13.4: Choice of agent for maintenance therapy

- 13.4.1: We recommend azathioprine 1-2 mg/kg/d orally as maintenance therapy. (1B)
- 13.4.2: We suggest that MMF, up to 1 g twice daily, be used for maintenance therapy in patients who are allergic to, or intolerant of, azathioprine. (2C)
- 13.4.3: We suggest trimethoprim-sulfamethoxazole as an adjunct to maintenance therapy in patients with upper respiratory tract disease. (2B)
- 13.4.4: We suggest methotrexate (initially 0.3 mg/kg/wk, maximum 25 mg/wk) for maintenance therapy in patients intolerant of azathioprine and MMF, but not if GFR is <60 ml/min per 1.73 m². (1C)
- 13.4.5: We recommend not using etanercept as adjunctive therapy. (1A)

BACKGROUND

The indications for maintenance therapy are not well defined. The goal of maintenance therapy is to decrease the incidence and severity of relapsing vasculitis. With the exception of a small trial with trimethoprim-sulfamethoxazole (see

Rationale), no placebo-controlled RCT has studied the benefit of maintenance therapy, although RCTs have compared the efficacy of different maintenance regimens. Therefore, the likely benefit of maintenance therapy depends on the assessment of the risk of relapse, which differs among various subgroups of patients. For example, the risk of low-dose maintenance immunosuppression in a frail, elderly patient has to be weighed against the very high risk for such a patient of severe relapse. Maintenance immunosuppressive therapy is justified in patients at high risk of relapse, but the potential benefit of maintenance therapy may be low in patients who have a low likelihood of relapse.

RATIONALE

- There is moderate-quality evidence that maintenance therapy is required in those at high risk of relapse or who have received less than 6 months induction treatment with cyclophosphamide.
- There is low-quality evidence that the duration of maintenance therapy should be at least 18 months.
- There is moderate-quality evidence that azathioprine is the preferred maintenance immunosuppressive agent, being equivalent in efficacy to cyclophosphamide in an RCT with a more favorable adverse-effect profile.
- There is moderate-quality evidence that trimethoprim-sulfamethoxazole as an adjunct to maintenance therapy reduces the risk of relapse, but only in those with upper respiratory disease due to vasculitis.

Risk of Relapse

Based on cohort studies, risk factors for relapse include persistence of PR3-ANCA (compared to MPO-ANCA), history of upper respiratory tract disease (e.g., sinusitis, subglottic stenosis), or lower respiratory tract disease (e.g. alveolar hemorrhage, cavities, or nodules). Patients with any one of these three risk factors have an approximately 1.7-fold increased risk of relapse, and those with all three risk factors have an approximately 4.7-fold increased risk of relapse.⁷⁰⁶

Patients with persistent PR3-ANCA-positivity at the end of cyclophosphamide therapy have a 2- to 3-fold increased risk of relapse, compared to patients who are ANCA-negative at the end of initial therapy.⁷²³ In addition, patients who are persistently PR3-ANCA-positive are significantly more likely to relapse within 5 years after diagnosis.⁷²³ Among patients who achieved remission and were switched from cyclophosphamide to azathioprine, those who remained PR3-ANCA-positive at the time of the switch had a 2.2-fold increased risk of suffering a relapse when compared to patients who were PR3-ANCA-negative. No similar data are available for patients with MPO-ANCA.

It is unknown whether patients with none of the risk factors for relapse need maintenance immunosuppression. The risk-benefit ratio of maintenance therapy has not been evaluated in such patients. The tailoring of maintenance therapy, based on the risk factors of relapse, has not been tested in clinical trials.

Choice of Immunosuppressive Agent for Maintenance Therapy

The optimal total duration of corticosteroid therapy is unknown. Some studies have maintained patients on a low dose of prednisone (7.5 mg daily) for >12 months.⁷¹¹ In other cohort studies, corticosteroids are tapered completely off by the end of 5 months if the patient is in remission.⁷⁰⁶

The best available data support the use of azathioprine 1-2 mg/kg/d for 6-18 months. This is inferred from an RCT of azathioprine vs. cyclophosphamide for the maintenance of remission.⁷¹¹ Although not specifically designed to demonstrate the ability of azathioprine to prevent relapses (compared to placebo), the study established that introducing azathioprine after 3-6 months of cyclophosphamide, compared to continuing cyclophosphamide for 12 months, resulted in similar rates of relapse up to 18 months.

Maintenance therapy with azathioprine appears superior to MMF. In a large RCT of 155 patients with ANCA vasculitis, who attained remission with cyclophosphamide and corticosteroids, those randomized to MMF (2 g/d) vs. azathioprine (2 mg/kg/d) had a higher cumulative incidence of relapse (HR 1.7; $P = 0.02$).⁷²⁴ We therefore recommend azathioprine as the first choice for maintenance therapy in ANCA vasculitis. However, we suggest using MMF in patients who are allergic to or intolerant of azathioprine.

In a placebo-controlled trial, the use of trimethoprim-sulfamethoxazole was associated with a decreased rate of upper airway-relapse.⁷²⁵ The use of trimethoprim-sulfamethoxazole had no impact on the rate of relapse in other organs.

In a large prospective RCT, 12 months maintenance therapy with methotrexate (0.3 mg/kg/wk initially and progressively increased to 25 mg/wk) was compared to azathioprine (2 mg/kg/d) after induction of remission with cyclophosphamide and corticosteroids.⁷²⁶ The study was not designed to demonstrate the superiority of methotrexate over azathioprine in preventing relapses, but to test the hypothesis that methotrexate would be safer than azathioprine. The rates of relapse were not significantly different between the azathioprine- and methotrexate-treated groups (36% and 33%, respectively; $P = 0.71$) with a mean randomization-to-relapse interval of 20.6 ± 13.9 months. Methotrexate was not associated with a higher rate of adverse events when compared to azathioprine (HR 1.65; 95% CI 0.65-4.18; $P = 0.29$). However, the severity of the adverse effects with the use of methotrexate was greater; therefore, it is not recommended in patients with a reduced GFR <30 ml/min per 1.73 m^2 , and the dose should be adjusted in patients with a GFR <60 ml/min per 1.73 m^2 .

The efficacy and safety of the tumor necrosis factor receptor-Fc fusion protein, etanercept, in the maintenance of remission among patients with granulomatosis with polyangiitis (Wegener's) was evaluated in an RCT in which etanercept or placebo was added to a regimen of daily oral cyclophosphamide or methotrexate and corticosteroids. Etanercept did not reduce the rate or the severity of relapses,

and was associated with a higher rate of solid tumors and is therefore not recommended.^{727,728} Although not tested, we also do not recommend the use of other anti-tumor necrosis factor agents.

Duration of Maintenance Therapy

There are no direct data to support a recommendation for the duration of maintenance therapy. The suggestion of continuing maintenance therapy for 18 months in patients who remain in complete remission is inferred from the duration of maintenance therapy used in the CYCAZAREM trial.⁷¹¹ Some cohort studies, but not others, have suggested a higher incidence of relapse in the first 18 months after induction therapy.

In retrospective analyses of patients with ANCA vasculitis, the relapse rates of vasculitis were about 60% lower in patients with ESRD, and infections almost twice as frequent among patients maintained on immunosuppressive agents with ESRD.^{727,728} In addition, infections were an important cause of death in this population. Given the lower risk of relapse and higher risk of infection and death, the risk-benefit ratio does not support the routine use of maintenance immunosuppression therapy in ANCA vasculitis patients on chronic dialysis, in the absence of active extrarenal disease.

Continued maintenance therapy is associated with the risks of immunosuppression, bone marrow suppression (leucopenia, anemia, thrombocytopenia), and possibly increased risk of cancer, notably skin cancer.²⁸⁴

13.5: Treatment of relapse

13.5.1: We recommend treating patients with severe relapse of ANCA vasculitis (life- or organ-threatening) according to the same guidelines as for the initial therapy (see Section 13.1). (1C)

13.5.2: We suggest treating other relapses of ANCA vasculitis by reinstating immunosuppressive therapy or increasing its intensity with agents other than cyclophosphamide, including instituting or increasing dose of corticosteroids, with or without azathioprine or MMF. (2C)

RATIONALE

- Relapse is associated with increased risk of ESRD.
- Relapse is associated with severe or life-threatening extrarenal damage.
- There is low-quality evidence that relapses are responsive to reintroduction or increased dosing of immunosuppression, but the preferred treatment regimen has not been defined.

Impact of Relapse

Relapse is defined as the occurrence of increased disease activity after a period of partial or complete remission. Thus, a relapse can manifest as a worsening of pre-existing disease

activity or the recurrence or development of active GN, or new signs or symptoms of vasculitis in any organ system.

Severe relapse is defined as life- or organ-threatening relapse. Examples of life-threatening relapse include diffuse alveolar hemorrhage and severe subglottic stenosis. Examples of organ-threatening disease are active GN, or a retro-orbital mass threatening vision.

In a cohort study, patients who had a relapse of GN were 4.7 times more likely to progress to ESRD compared to those who did not relapse. This increased risk of ESRD associated with relapse was independent of age, gender, race, ANCA specificity, and kidney function at the time of initial biopsy.⁷⁰⁶

Relapses respond to immunosuppression with corticosteroids and cyclophosphamide with a similar response rate as the initial disease.⁷⁰⁹ The repeated use of cyclophosphamide should be based on the severity of the relapse, taking into account the cumulative dose previously received by the patient. Severe relapses should be treated with cyclophosphamide, corticosteroids and plasmapheresis (when indicated) as described in Section 13.1 and Table 30.

Although a “safe” dose of cyclophosphamide has not been precisely determined, a recent retrospective study suggests that the risk of malignancy (other than nonmelanoma skin cancer) increases with cumulative doses of cyclophosphamide above 36 g.²⁸⁴ Therefore, for patients who have received, or are approaching a 36 g cumulative dose of cyclophosphamide, we suggest treating subsequent relapses with a rituximab-based regimen.

For patients with a relapse that is not severe (as defined earlier), immunosuppressive therapy should be increased while avoiding, if possible, more cyclophosphamide. If such a relapse occurs when the patient is not receiving maintenance therapy, treatment may include the reinstatement of corticosteroids, azathioprine, or MMF, alone or in combination; however, there is no RCT evidence to support any of these regimens. In patients who suffer a relapse while on maintenance therapy with azathioprine or MMF, one treatment option is i.v. immunoglobulin. In an uncontrolled study, the addition of 6-monthly pulses of i.v. immunoglobulin (0.5 g/kg/d × 4 days) over background maintenance immunosuppression was associated with rates of complete or partial remission of 83% and 63% at 6 and 9 months, respectively.⁷²⁹ In patients with kidney dysfunction, it is preferable to use a sucrose-free formulation of i.v. immunoglobulin in order to minimize the risk of osmotic-induced AKI.⁷³⁰

Rituximab was more effective than cyclophosphamide in treating patients with relapsing ANCA vasculitis (OR 1.40; 95% CI 1.03-1.91; $P=0.03$).⁷¹⁴ Although more experience will be needed with the use of rituximab for treatment of severe relapses, and although the long-term safety of rituximab remains uncertain, its use in relapse may provide an opportunity to minimize cumulative dosage and avoid the potential long-term toxicity of cyclophosphamide.

13.6: Treatment of resistant disease

13.6.1: In ANCA GN resistant to induction therapy with cyclophosphamide and corticosteroids, we recommend the addition of rituximab (1C), and suggest i.v. immunoglobulin (2C) or plasmapheresis (2D) as alternatives.

BACKGROUND

Resistance is defined as the persistence of or appearance of kidney and/or systemic manifestation of vasculitis, while receiving treatment equal in intensity to initial immunosuppressive therapy. Kidney manifestations of resistance include the continued presence of dysmorphic erythrocyturia and red blood cell casts, and are associated with a progressive decline in kidney function. Disease resistance to corticosteroids and cyclophosphamide occurs in approximately 20% of patients.

RATIONALE

Adjunctive therapy with i.v. immunoglobulin (single course of a total of 2 g/kg) was evaluated in an RCT in patients with resistant ANCA vasculitis. Patients treated with i.v. immunoglobulin had a more rapid decline in disease activity (as measured by a 50% reduction in Birmingham vasculitis activity score) and C-reactive protein at 1 and 3 months, but there was no significant difference between the two groups after 3 months, with respect to disease activity or frequency of relapse.⁷³¹

Several small, uncontrolled case series suggest a role for rituximab in resistant ANCA vasculitis.⁷³²⁻⁷³⁴ In these reports, rituximab (375 mg/m² i.v. weekly × 4, or 500 mg i.v. weekly × 4 fixed doses), in conjunction with corticosteroids, resulted in remission in the majority of patients, and was generally well-tolerated.

There has been no trial of plasmapheresis in resistant ANCA vasculitis, but its value in this setting has been inferred from the MEPEX study, which demonstrated improved kidney outcome with plasmapheresis in patients with severe kidney dysfunction, and studies suggesting decreased mortality with plasmapheresis in patients with diffuse alveolar hemorrhage (see Recommendation 13.2.2).

13.7: Monitoring

13.7.1: We suggest not changing immunosuppression based on changes in ANCA titer alone. (2D)

RATIONALE

Available data mostly report the assessment of PR3-ANCA, with limited data for MPO-ANCA. The data do not support the contention that PR3-ANCA is clinically useful in predicting relapse and should not be used (alone) to alter immunosuppression.^{735,736} A persistently positive PR3-ANCA, at the time of switch to maintenance therapy with azathioprine, is associated with a 2- to 3-fold increased risk of relapse, and warrants close follow up.⁷²³ For patients who are in clinical remission but remain PR3-ANCA-positive after 3-4 months of cyclophosphamide and corticosteroids, continuing cyclophosphamide for up to 6 months may be

considered; however, there are no data on the risks or benefits of such an approach. If ANCA titers increase, it may be worth intensifying patient follow-up.

13.8: Transplantation

13.8.1: We recommend delaying transplantation until patients are in complete extrarenal remission for 12 months. (1C)

13.8.2: We recommend not delaying transplantation for patients who are in complete remission but are still ANCA-positive. (1C)

RATIONALE

No prospective data are available to assess the likelihood of recurrent ANCA vasculitis after kidney transplantation, or the impact of disease activity or that of a positive ANCA test at the time of transplantation, on patient outcome. The frequency of recurrent ANCA vasculitis after kidney transplantation has been assessed in several retrospective case series. These have revealed a frequency of relapse around 15-20%, although the frequency of recurrent pauci-immune necrotizing GN is only around 5%.^{737,738} In the largest retrospective study of 107 kidney transplant recipients in the UK, relapses occurred in only 5% of patients.⁷³⁹ By multivariate analysis, kidney transplantation within 12 months of achieving remission was associated with increased mortality; the causes of death were not related to recurrent vasculitis. ANCA positivity at the time of transplantation does not appear to affect graft or patient survival, or the frequency of relapse after transplantation.

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SUPPLEMENTARY MATERIAL

Supplementary Table 96: Evidence profile of IV vs. p.o. Cyc for ANCA vasculitis.

Supplementary Table 97: Existing systematic review of Induction with pulse Cyc vs. daily p.o. Cyc in patients with ANCA vasculitis.

Supplementary Table 98: Summary table of RCT examining induction with pulse Cyc vs. daily p.o. Cyc in patients with ANCA vasculitis (categorical outcomes).

Supplementary Table 99: Summary table of RCT examining induction with pulse Cyc vs. daily p.o. Cyc in patients with ANCA vasculitis (continuous outcomes).

Supplementary Table 100: Evidence profile of RCTs examining induction with rituximab vs. Cyc in patients with ANCA vasculitis.

Supplementary Table 101: Summary table of RCTs examining induction with rituximab vs. Cyc in patients with ANCA vasculitis (categorical outcomes).

Supplementary Table 102: Summary table of RCTs examining induction with rituximab vs. Cyc in patients with ANCA vasculitis (continuous outcomes).

Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Chapter 14: Anti-glomerular basement membrane antibody glomerulonephritis

Kidney International Supplements (2012) **2**, 240–242; doi:10.1038/kisup.2012.27

INTRODUCTION

This chapter makes treatment recommendations for GN mediated by antibodies against the GBM (i.e., anti-GBM GN) whether or not it is associated with pulmonary hemorrhage (Goodpasture's disease). The cost implications for global application of this guideline are addressed in Chapter 2.

14.1: Treatment of anti-GBM GN

- 14.1.1: We recommend initiating immunosuppression with cyclophosphamide and corticosteroids plus plasmapheresis (see Table 31) in all patients with anti-GBM GN except those who are dialysis-dependent at presentation and have 100% crescents in an adequate biopsy sample, and do not have pulmonary hemorrhage. (1B)
- 14.1.2: Start treatment for anti-GBM GN without delay once the diagnosis is confirmed. If the diagnosis is highly suspected, it would be appropriate to begin high-dose corticosteroids and plasmapheresis (Table 31) while waiting for confirmation. (Not Graded)
- 14.1.3: We recommend no maintenance immunosuppressive therapy for anti-GBM GN. (1D)
- 14.1.4: Defer kidney transplantation after anti-GBM GN until anti-GBM antibodies have been undetectable for a minimum of 6 months. (Not Graded)

BACKGROUND

Anti-GBM GN is generally a fulminant and rapidly progressive disease that is caused by autoantibodies to the noncollagenous domain of the $\alpha 3$ chain of type IV collagen. Anti-GBM GN is relatively rare, with an estimated annual incidence of 0.5–1 per million population. It can present as an isolated GN, or as a pulmonary-renal syndrome with severe lung hemorrhage. Prior to the introduction of intense immunosuppression for anti-GBM GN, patient survival was very poor. Although mortality has improved, kidney survival remains poor, possibly because of delays in making the diagnosis and initiating treatment. The strategy for treating anti-GBM GN is to remove the pathogenic autoantibodies from the circulation, and simultaneously prevent further autoantibody production and attenuate existing glomerular inflammation and injury.

RATIONALE

- Patient and kidney survival in untreated anti-GBM GN is poor.

- There is moderate-quality evidence that intense immunosuppression plus plasmapheresis improves patient and kidney survival; this evidence comes from one small RCT, one large, and several smaller retrospective series. All of these studies demonstrate good patient survival and moderate kidney survival, providing a compelling rationale to use immunosuppression and plasmapheresis.
- Many patients at presentation have severe kidney failure, and require dialysis. This is usually correlated with the number of glomeruli that show crescents on kidney biopsy. Despite intense immunosuppression, patients who are dialysis-dependent at the start of treatment and have 85–100% glomerular crescents do not recover kidney function, and generally will require long-term RRT.
- Because the progression of anti-GBM GN can be very rapid, and outcome is related to the severity at presentation, it is appropriate to start treatment immediately with high-dose corticosteroids. After the diagnosis is confirmed, cyclophosphamide and plasmapheresis must be started. Patients should be free of infection or receiving appropriate antimicrobial therapy.
- Patients with pulmonary hemorrhage as well as anti-GBM GN (Goodpasture's disease) should receive treatment with corticosteroids, cyclophosphamide, and plasmapheresis, even in the setting of severe kidney failure and extensive glomerular crescent formation. Without such therapy, Goodpasture's disease has a very high mortality. There is, however, no definite evidence that plasmapheresis is beneficial when there are only minor clinical signs of pulmonary hemorrhage.
- Because anti-GBM antibodies are pathogenic, it is prudent to wait until they are undetectable before considering a kidney transplant for those with ESRD.

As the pathogenesis of anti-GBM GN became clear, treatment regimens were designed to remove the circulating pathogenic antibody that caused the disease, suppress further synthesis of this pathogenic antibody, and attenuate the glomerular inflammatory response initiated by the anti-GBM antibody. The best summary of this approach is a large retrospective study of anti-GBM GN from the Hammersmith Hospital,⁷⁴⁰ including 85 patients seen over 25 years. Seventy-one patients were treated with high-dose prednisone*

*Prednisone and prednisolone are interchangeable according to local practice, with equivalent dosing.

Table 31 | Therapy of anti-GBM GN

Corticosteroids	
Week	Prednisone dose
0–2	Methylprednisolone 500–1000 mg/d i.v. for 3 days, followed by prednisone, 1 mg/kg/d IBW (maximum 80 mg/d)
2–4	0.6 mg/kg/d
4–8	0.4 mg/kg/d
8–10	30 mg/d
10–11	25 mg/d
11–12	20 mg/d
12–13	17.5 mg/d
13–14	15 mg/d
14–15	12.5 mg/d
15–16	10 mg/d
16–	IBW < 70 kg: 7.5 mg/d IBW ≥ 70 kg: 10 mg/d
Discontinue after 6 months	

Cyclophosphamide: 2 mg/kg/d orally for 3 months.

Plasmapheresis: One 4-liter exchange per day with 5% albumin. Add 150–300 ml fresh frozen plasma at the end of each pheresis session if patients have pulmonary hemorrhage, or have had recent surgery, including kidney biopsy. Plasmapheresis should be continued for 14 days or until anti-GBM antibodies are no longer detectable.

GBM, glomerular basement membrane; GN, glomerulonephritis; IBW, ideal body weight.

There is no evidence to support these dosing schedules, which are based on regimens associated with good outcome in observational studies.

(1 mg/kg/d) tapered over 6–9 months, oral cyclophosphamide for 2–3 months, and daily plasmapheresis for 14 days, or until the anti-GBM antibody was no longer detectable. The kidney outcome for this cohort was influenced by kidney function at presentation. Patients who had an initial SCr < 5.7 mg/dl (< 504 μmol/l) had a 1-year overall survival of 100% and a kidney survival of 95%, and at 5 years patient and kidney survival were both 94%. If the initial SCr was > 5.7 mg/dl (> 504 μmol/l) but dialysis was not required immediately, the patient and kidney survivals were 83% and 82% at 1 year, and 80% and 50% at 5 years, respectively. However, among patients who needed dialysis at presentation, patient and kidney survival were reduced to 65% and 8% at 1 year, and 44% and 13% at 5 years, respectively. Compared to nearly 100% mortality from pulmonary hemorrhage and kidney failure in historical series, this treatment strategy represented a significant improvement.

The role of plasmapheresis in addition to immunosuppression has been questioned, and was tested in a small RCT ($n = 17$).⁷⁴¹ Although this study used prednisone and cyclophosphamide for immunosuppression, there were slight differences in dose and duration compared to the Hammersmith study. Most importantly, plasmapheresis was done every 3 days instead of daily and a mean of nine treatments was completed. All patients received prednisone and cyclophosphamide, and half were randomized to additional plasmapheresis. In those receiving plasmapheresis, anti-GBM antibodies disappeared about twice as fast as in the control group (all within 50 days, $P < 0.05$). At the end of therapy, SCr in those receiving plasmapheresis was $4.1 \pm$

0.5 mg/dl ($362 \pm 44 \mu\text{mol/l}$) compared to $9.2 \pm 0.7 \text{ mg/dl}$ ($813 \pm 62 \mu\text{mol/l}$) in the controls ($P < 0.05$); only two patients receiving plasmapheresis needed chronic dialysis vs. six in the controls. Although the two treatment groups were well-matched clinically at the beginning of the study, kidney biopsies showed a higher percentage of glomerular crescents in controls. Because of this difference in histology and the small study size, the evidence for better kidney outcome with plasmapheresis cannot be regarded as definitive.

Anti-GBM antibody titers should be regularly monitored.⁷⁴² Plasmapheresis may be stopped when the circulating antibody is no longer detectable, usually after 10–14 treatments. Corticosteroids have generally been continued for at least 6 months, and cyclophosphamide for 2–3 months. This immunosuppression must be sufficient both to prevent further antibody production, and to treat kidney inflammation.

About 20–30% of patients with anti-GBM disease will also have ANCA, usually with anti-MPO specificity, but the double-antibody-positive patients do not appear to have a different prognosis or disease course, according to most studies.^{743–747}

The outcomes of the Hammersmith cohort⁷⁴⁰ are representative of what can be expected with a uniform, aggressive approach to therapy as outlined. In other series of anti-GBM GN, not all necessarily using the same treatment regimens, and encompassing patients from the USA, Europe, China, and Japan, patient survival at 6–12 months was approximately 67–94%, and kidney survival was about 15–58%.^{619,741,745,748,749}

The predictors of kidney survival in anti-GBM GN are SCr at presentation, the need for dialysis at presentation, and the percentage of glomerular crescents.^{740,741,743} In two studies, patients with an initial SCr > 5.7 mg/dl (> 504 μmol/l) or 9.7 mg/dl (858 μmol/l) all became chronically dialysis-dependent despite aggressive treatment.^{744,747} Two studies found that patients who required dialysis at presentation were never able to come off dialysis, despite aggressive treatment.^{744,745} The most optimistic study observed that all patients with a combination of dialysis at presentation plus 100% crescents on kidney biopsy never recovered kidney function sufficiently to come off dialysis.⁷⁴⁰ A survey of several studies shows dialysis dependence at diagnosis in a median of 55% (range 12–83%) of patients, 100% crescents on kidney biopsy in 20.5% (range 7–50%) of patients, and a median initial SCr of 6.9 mg/dl (610 μmol/l) (range 4.9–7.2 mg/dl [433–637 μmol/l]), underscoring the importance of early diagnosis and intervention.^{740,741,744,745,747–750} These findings, along with the patient's general condition, will help in deciding how aggressive to be in treating the kidney manifestations of anti-GBM GN. However, in the presence of pulmonary hemorrhage, aggressive treatment should be undertaken, regardless of the kidney prognosis.⁷⁵¹

In contrast to most other autoimmune kidney diseases, anti-GBM GN is not characterized by a frequently relapsing course; the autoantibodies seem to disappear spontaneously after 12–18 months.⁷⁵² Nonetheless, relapses of anti-GBM

GN have been reported in the literature, can manifest as recurrent clinical kidney disease or pulmonary hemorrhage, and are often associated with a reappearance of circulating anti-GBM antibodies.^{752–755} It has been estimated that the mean time to recurrence is 4.3 years, with a range of 1–10 years, and that late recurrences may occur with a frequency of 2–14%.^{748,752,754} Retreatment with intense immunosuppression and plasmapheresis is generally successful in re-inducing remission.⁷⁵²

There is very little information on the treatment of refractory anti-GBM GN. Some case reports have used MMF or rituximab, but no firm recommendation can be made.

There is very little evidence as to the timing of transplant after anti-GBM disease has caused ESRD. Most transplant centers require at least 6 months of undetectable anti-GBM antibody levels before kidney transplantation.^{756,757} Recurrent anti-GBM disease in a kidney allograft is very unusual.^{756,757}

RESEARCH RECOMMENDATIONS

- A study is needed to compare rituximab to cyclophosphamide, both combined with prednisone plus plasmapheresis for induction of remission.

- A study is needed to compare MMF plus prednisone plus plasmapheresis to standard treatment—cyclophosphamide plus prednisone plus plasmapheresis—for induction of remission.

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Methods for guideline development

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AIM

The overall aim of the project was to create a clinical practice guideline with recommendations for GN, using an evidence-based approach. After topics and relevant clinical questions were identified, the pertinent scientific literature on those topics was systematically searched and summarized.

OVERVIEW OF PROCESS

The development of the guideline included sequential and concurrent steps:

- Appoint the Work Group and Evidence Review Team (ERT), which were responsible for different aspects of the process.
- Confer to discuss process, methods, and results.
- Develop and refine topics.
- Assign topics to systematic review or narrative review.
- Define specific populations, interventions or predictors, and outcomes of interest for systematic review topics.
- Create and standardize quality assessment methods.
- Create data-extraction forms.
- Develop literature search strategies and run searches.
- Screen abstracts and retrieve full articles based on predetermined eligibility criteria.
- Extract data and perform critical appraisal of the literature.
- Incorporate existing systematic reviews and underlying studies.
- Grade quality of the outcomes of each study.
- Tabulate data from articles into summary tables.
- Update the systematic review search.
- Grade the quality of evidence for each outcome, and assess the overall quality and findings of bodies of evidence with the aid of evidence profiles.
- Write recommendations and supporting rationale statements.
- Grade the strength of the recommendations based on the quality of the evidence and other considerations.

The Work Group, KDIGO Co-Chairs, ERT, and NKF support staff met for three 3-day meetings for training in the guideline development process, topic discussion, and consensus development.

Creation of Groups

The KDIGO Co-Chairs appointed the Co-Chairs of the Work Group, who then assembled the Work Group to be responsible for the development of the guidelines. The Work Group included individuals with expertise in adult and

pediatric nephrology, epidemiology, and kidney pathology. For support in evidence review, expertise in methods, and guideline development, the NKF contracted with the ERT based at the Tufts Center for Kidney Disease Guideline Development and Implementation at Tufts Medical Center in Boston, Massachusetts, USA. The ERT consisted of physician-methodologists with expertise in nephrology and internal medicine, and research associates and assistants. The ERT instructed and advised Work Group members in all steps of literature review, critical literature appraisal, and guideline development. The Work Group and the ERT collaborated closely throughout the project.

Systematic Review: General Process

The first task of the Work Group was to define the overall topics and goals for the guideline. The Work Group Co-Chairs drafted a preliminary list of topics. The Work Group identified the key clinical questions and triaged topics for systematic review and narrative review. The Work Group and ERT further developed and refined each systematic review topic, specified screening criteria, literature search strategies, and data extraction forms.

The ERT performed literature searches, and conducted abstract and article screening. The ERT also coordinated the methodological and analytic processes of the report. In addition, it defined and standardized the methodology in relation to these searches and data extraction, and produced summaries of the evidence. Throughout the project, the ERT offered suggestions for guideline development, led discussions on systematic review, literature searches, data extraction, assessment of quality and applicability of articles, evidence synthesis, grading of evidence and recommendations, and consensus development. With input from the Work Group, the ERT finalized eligible studies, performed all data extraction, and summarized data into summary tables. They also created preliminary evidence profiles (described below), which were completed by the Work Group members. The Work Group members reviewed all included articles, data extraction forms, and summary tables for accuracy and completeness. The Work Group took the primary role of writing the recommendations and rationale statements, and retained final responsibility for the content of the recommendation statements and the accompanying narrative.

For questions of treatments in GN, systematic reviews of the eligible RCTs were undertaken (Table 32). For these topics, the ERT created detailed data-extraction forms and extracted information on baseline data for the populations,

Table 32 | Screening criteria for systematic review topics of nontreatment and treatment

PICOD criteria	
Chapter 3: SSNS in Children	
Population	Steroid sensitive (Any definition), Children, biopsy not required, Define Nephrotic Syndrome: Urine Prot:Cr Ratio & Serum albumin
Intervention	Long course or alternate day prednisone
Comparator	Short course or daily prednisone
Outcomes	Proteinuria, Complete Remission, Relapse
Study design	RCTs; No minimum follow-up
Minimum N of Subjects	No minimum N
FRNS in Children	
Population	Steroid resistance, Children, biopsy not required, Define Nephrotic Syndrome: Urine Prot:Cr Ratio & Serum albumin
Intervention	Cyclosporine, Cytoxan, Chlorambucil, Tacrolimus (Prograf), Rituximab, MMF, Levamisole, Plasmapheresis, Mizoribine, AZA
Comparator	Prednisone and other comparators depending on the study
Outcomes	Proteinuria, Complete Remission, Relapse
Study design	RCTs No minimum follow-up Nonrandomized comparative studies Retrospective comparative or prospective or retrospective single arm cohort Minimum duration: 6 months
Minimum N of Subjects	No minimum N
SDNS in Children	
Population	Steroid resistance, Children, biopsy not required, Define Nephrotic Syndrome: Urine Prot:Cr Ratio & Serum albumin
Intervention	Cyclosporine, Cytoxan, Chlorambucil, Tacrolimus (Prograf), Rituximab, MMF, Levamisole, Plasmapheresis, Mizoribine, AZA
Comparator	Prednisone and other comparators depending on the study
Outcomes	Proteinuria, Complete Remission, Relapse
Study design	RCTs No minimum follow-up Nonrandomized comparative studies Retrospective comparative or prospective or retrospective single arm cohort Minimum duration: 6 months
Minimum N of Subjects	No minimum N
Chapter 4: SRNS in Children	
Population	Steroid resistance (define), Children, biopsy not required, Define Nephrotic Syndrome: Urine Prot:Cr Ratio & Serum albumin
Intervention	Cyclosporine, Cytoxan, Chlorambucil, Tacrolimus (Prograf), Rituximab, MMF, Levamisole, Plasmapheresis, Mizoribine, AZA
Comparator	Prednisone, other comparators depending on the study
Outcomes	Proteinuria, Complete Remission, Relapse
Study design	RCTs No minimum follow-up Nonrandomized comparative studies Retrospective comparative or prospective or retrospective single arm cohort Minimum duration: 6 months
Minimum N of Subjects	No minimum N
Chapter 5: MCD in Adults (biopsy proven)	
Population	Minimal Change Disease, biopsy-proven, Define Nephrotic Syndrome: Urine Prot:Cr Ratio & Serum albumin
Intervention	Short course prednisone and Long course prednisone and Cyclosporine, Cytoxan, Chlorambucil, Tacrolimus (Prograf), Rituximab, MMF, Levamisole, Plasmapheresis, Mizoribine, AZA
Comparator	No treatment, Short course prednisone, Prednisone and other comparators depending on study
Outcomes	Change in Proteinuria, Complete Remission, Partial Remission, Relapse, GFR, SCr doubling, ESRD, Death
Study design	RCTs No minimum follow-up Nonrandomized comparative studies Retrospective comparative or prospective or retrospective single arm cohort Minimum duration: 6 months
Minimum N of Subjects	N ≥ 10/arm

Table 32 continued on following page

Table 32 | Continued

PICOD criteria	
Chapter 6: FSGS in Adults	
Population	Population FSGS, by biopsy and list FSGS subtypes, Adults, Define Nephrotic Syndrome: Urine Prot:Cr Ratio & Serum albumin
Intervention	Long course prednisone, Cyclosporine +/-ACE-I, MMF +/- ACE-I, Prograf +/- ACE-I, Rituximab +/- ACE-I, Lamivudine +/-ACE-I, Plasmapheresis +/- ACE-I-levamisole, Mizoribine, AZA
Comparator	Any treatment
Outcomes	Change in Proteinuria, Complete Remission, Partial Remission, Relapse, GFR, SCr doubling, ESRD, Death
Study design	RCTs No minimum follow-up Nonrandomized comparative studies Retrospective comparative or prospective or retrospective single arm cohort Minimum duration: 6 mo
Minimum N of Subjects	N ≥ 10/arm
Chapter 7: MN	
Population	Biopsy-proven MN
Intervention	Steroids alone (any regimen), Alkylating agent (Cyclophosphamide or Chlorambucil), CNI (Cyclosporine or Tacrolimus +/-steroids), IVIG, ACE-I or ARBs (+/-steroids), AZA or Mizoribine (+/- steroids), Alkylating agent, MMF (+/- steroids), ACTH, Rituximab, Eculizumab, Sirolimus, Pentoxifylline, any combination
Comparator	Steroids, No treatment, ACE-I or ARBs, Calcineurin inhibitor (Tac, CsA), Alkylating agents
Outcomes	CNI, steroids only, no treatment, any combination, any other treatment All cause mortality, ESRD, CKD 5, RRT, etc., Progression of CKD, SCr increase/GFR decrease, Change in CKD stage, Disease remission, Partial disease remission, Protocol-driven additional treatment of GN, Disease relapse, Quality of life, Proteinuria, Adverse Events: Including cancer, thromboembolic complications, pulmonary embolism, CVD especially acute MI
Study design	RCTs; Minimum duration ≥6 months for remissions/AE, 5 years for survival
Minimum N of Subjects	N ≥ 10/arm
Chapter 8: MPGN	
Population	Biopsy-proven MPGN
Intervention	Rituximab, Eculizumab, CNI (CsA, Tac), MMF, Sirolimus, ACE-I & ARBs, Pentoxifylline, IVIG, Treatment of relapse (any), Steroid therapy (any regimen)
Comparator	Any
Outcomes	Complete & partial remission, Relapse, Categorical changes in proteinuria, Categorical changes in kidney function (Cr, GFR), ESRD, Death/survival, Adverse events
Study design	RCTs Minimum follow-up 6 mo Nonrandomized comparative studies Prospective or retrospective Minimum duration: 12 mo
Minimum N of Subjects	N ≥ 20
Chapter 9: Infection-Related MN	
Population	Patients with infection associated GN, biopsy-proven, Postinfectious GN
Intervention	Antiviral (lamivudine, ribavirin or interferon) for HBV, HCV, Anti-parasitic agents for malaria or other helminthic/protozoal infections. For post infectious GN: any intervention
Comparator	Any treatment
Outcomes	All cause mortality, ESRD, CKD 5, RRT, etc., Progression of CKD, SCr increase/GFR decrease, Change in CKD stage, Disease remission, Partial disease remission, Protocol-driven additional treatment of GN, Disease relapse, Quality of life, Proteinuria, AE: Including cancer, thromboembolic complications, pulmonary embolism, CVD especially acute MI
Study design	RCTs; No minimum duration of follow-up
Minimum N of Subjects	For post-infectious: N ≥ 10 for RCTs, N ≥ 20 for observational
Chapter 10: IgAN	
Population	Biopsy-proven IgAN, Primary disease only (exclude secondary disease)
Intervention	Any
Comparator	Any, regardless of ACE-I use, BP control, etc.
Outcomes	All cause mortality, ESRD, CKD 5, RRT, etc., Progression of CKD, SCr increase/GFR decrease, Change in CKD stage, Disease remission, Protocol-driven additional treatment of GN, Disease relapse, Proteinuria
Study design	RCTs; Minimum follow-up: 6 months
Minimum N of Subjects	N ≥ 10

Table 32 continued on following page

Table 32 | Continued

PICOD criteria	
Chapter 11: HSP Nephritis	
Population	Biopsy-proven HSP
Intervention	Any (for RCTs and nonrandomized comparative studies)
Comparator	Any (for RCTs and nonrandomized comparative studies)
Outcomes	All cause mortality, ESRD, CKD 5, RRT, etc., Progression of CKD, SCr increase/GFR decrease, Change in CKD stage, Disease remission, Protocol-driven additional treatment of GN, Disease relapse, Proteinuria
Study design	RCTs and nonrandomized comparative studies
Minimum N of Subjects	N ≥ 10
Chapter 12: LN Induction Therapy	
Population	Biopsy-proven Lupus nephritis, class III, IV, V, (also any combination of class V + III or V + IV), Adults and pediatric
Intervention	MMF, Cyclophosphamide, Rituximab, Long duration Cyclophosphamide, i.v. cyclophosphamide, Cyclosporine/Tacrolimus + MMF + Prednisone
Comparator	Hydroxychloroquine (class V) as a concomitant therapy with other drug therapies Cyclophosphamide (p.o. or i.v.), Azathioprine, Cyclophosphamide, EURO protocol cyclophosphamide, p.o. cyclophosphamide, Cyclophosphamide. No addition of hydroxychloroquine
Outcomes	Mortality, Need for RRT/ renal survival, Proteinuria, Kidney function preservation in terms of SCr/eGFR such as doubling of SCr — as categorical outcome, Remission and Relapse, Preservation of menses (fertility), Thrombotic and thromboembolic events, Alopecia and other adverse events
Study design	RCTs Minimum follow-up: 6 months Nonrandomized comparative studies Prospective study design Minimum follow-up: 6 months
Minimum N of Subjects	N ≥ 10/arm for RCTs and N ≥ 30 for nonrandomized comparative studies
Chapter 12: LN Maintenance Therapy	
Population	Biopsy-proven Lupus nephritis, class III, IV, V, (also any combination of class V+III or V+IV), Both adults and pediatric
Intervention	RCTs: Maintenance therapy 1. MMF, 2. MMF, 3. Steroids, Hydroxychloroquine Nonrandomized comparative studies: Etanercept, TNF alpha antagonists (e.g., infliximab, etc), CTLA4-Ig and derivatives, Campath, Abetimus (LJP394)
Comparator	Cyclophosphamide, Azathioprine, Placebo/ No Rx
Outcomes	Mortality, Need for RRT/ renal survival, Proteinuria, Kidney function preservation in terms of SCr/eGFR such as doubling of SCr — as categorical outcome, Remission and Relapse, Preservation of menses (fertility), Thrombotic and thromboembolic events, Alopecia and other adverse events
Study design	RCTs Minimum follow-up: 12 months Nonrandomized comparative studies Prospective study design Minimum follow-up: 12 months
Minimum N of Subjects	N ≥ 10/arm for RCTs and N ≥ 30 for nonrandomized comparative studies
Chapter 13: Treatment of Pauci-immune Focal and Segmental Necrotizing GN	
Population	Adults or pediatric population, ANCA Vasculitis, biopsy-proven, Positive ANCA, Wegener's granulomatosis, microscopic polyangiitis, pauci-immune GN). Churg Strauss syndrome
Intervention	RCTs: Cyclophosphamide+steroids, Cyclophosphamide+steroids+Plasmapheresis/IVIG, MMF, i.v. cyclophosphamide regimens, Pulsed cyclophosphamide, Rituximab Maintenance: Azathioprine, MMF, Cyclophosphamide, Methotrexate, Cyclosporine, Leflunomide For nonrandomized comparative studies: MMF, Rituximab, Infliximab, Campath, Abetcept, Cyclosporine, IVIG, Leflunomide Plasmapheresis or immunoadsorption
Comparator	Cyclophosphamide, Cyclophosphamide+steroids, Cyclophosphamide, p.o. cyclophosphamide regimens, Continuous p.o. cyclophosphamide Maintenance: Any comparator
Outcomes	Mortality, Kidney survival, Relapse, Disease free survival, Thromboembolism, Proteinuria Coming off dialysis
Study design	RCTs: Minimum follow-up: 6 months; For maintenance therapy trials, duration at least 1 year Nonrandomized comparative studies: Prospective or Retrospective study design Minimum follow-up: 6 months
Minimum N of Subjects	Any N for RCTs and N ≥ 30 for nonrandomized comparative studies

Table 32 continued on following page

Table 32 | Continued

PICOD criteria	
Chapter 14: Treatment of Anti-GBM GN	
Population	Anti-GBM disease, biopsy-proven, Anti-GBM antibody, Adults or pediatric population Either renal or combined pulmonary renal involvement
Intervention	Prednisone+Cyclophosphamide + Plasmapheresis, Prednisone + cyclophosphamide+Immunoabsorption
Comparator	Prednisone + Cyclophosphamide, Prednisone+Cyclophosphamide
Outcomes	Mortality, Recovery of kidney function, Proteinuria
Study design	Any; No minimum follow-up
Minimum no. of Subjects	No minimum N

ACE-I, angiotensin-converting enzyme inhibitors; ACTH, adrenocorticotropic hormone; AE, adverse events; ANCA, anti-neutrophil cytoplasmic antibody; ARB, angiotensin-receptor blocker; AZA, azathioprine; BP, blood pressure; CKD, chronic kidney disease; CNI, calcineurin inhibitors; Cr, creatinine; CsA, cyclosporine; CTLA-4-Ig, CTLA-4 Ig fusion protein; CVD, cardiovascular disease; Cyc, cyclophosphamide; eGFR, estimated glomerular filtration rate; ESRD, end-stage renal disease; FRNS, frequently relapsing nephrotic syndrome; FSGS, focal segmental glomerulonephritis; GFR, glomerular filtration rate; GN, glomerulonephritis; HBV, hepatitis B virus; HCV, hepatitis C virus; HSP, Henoch-Schönlein purpura; IgAN, immunoglobulin A nephropathy; i.v., intravenous; IVIG, intravenous immunoglobulin; LN, lupus nephritis; MCD, minimal-change disease; MI, myocardial infarction; MMF, mycophenolate mofetil; MN, membranous nephropathy; mo, month; MPGN, membranoproliferative glomerulonephritis; N, number; PICOD, population, intervention, comparison, outcomes, design (study); p.o., oral; Prot, proteinuria; RCT, randomized controlled trials; RRT, renal replacement therapy; Rx, treatment; SCr, serum creatinine; SDNS, steroid-dependent nephrotic syndrome; SRNS, steroid-resistant nephrotic syndrome; SSNS; steroid-sensitive nephrotic syndrome; Tac, tacrolimus.

interventions, study design, results, and provided an assessment of quality of study and outcomes. The ERT then tabulated studies in summary tables, and assigned grades for the quality of the evidence in consultation with the Work Group.

Refinement of Topics

At the first 3-day meeting, Work Group members added comments to the scope-of-work document as prepared by the Work Group Chairs and ERT, until the initial working document included all topics of interest to the Work Group. The inclusive, combined set of questions formed the basis for the deliberation and discussion that followed. The Work Group aimed to ensure that all topics deemed clinically relevant and worthy of review were identified and addressed. The major topic areas of interest for the care of GN included IgAN, lupus and vasculitis, MCD and FSGS, and MN, MPGN, and infection.

At the initiation of the guideline development process, it was agreed that these guidelines would focus on patients who have GN. Thus, all topics, systematic reviews, and study eligibility criteria were restricted to patients with a biopsy-proven diagnosis of GN, with exceptions for diseases that do not require biopsy confirmation.

Based on the list of topics, the Work Group and ERT developed a list of specific research questions for which systematic review would be performed. For each systematic review topic, the Work Group Co-Chairs and the ERT formulated well-defined systematic review research questions using a well-established system.⁷⁵⁸ For each question, explicit criteria were agreed on for the population, intervention or predictor, comparator, outcomes of interest, and study design features. A list of outcomes of interest was generated.

The Work Group and the ERT agreed upon specific outcomes of interest: all-cause mortality, ESRD, disease remission, relapse, proteinuria, kidney function, and adverse

events. ESRD and mortality were ranked as being of critical importance. The Work Group ranked patient-centered clinical outcomes (such as death, ESRD, remission and categorical proteinuria and kidney function changes) as more important than intermediate outcomes (such as continuous outcomes of proteinuria and kidney function). Categorical outcomes are those that describe when a patient moves from one health state (e.g., macroalbuminuria) to another (e.g., no albuminuria). Continuous outcomes would be evaluations of the laboratory values alone (e.g., change in proteinuria in mg/dl). The outcomes were further categorized as being of critical, high, or moderate clinical importance to patients with GN. The specific criteria used for each topic are described below in the description of the review topics. In general, eligibility criteria were determined based on clinical value, relevance to the guidelines and clinical practice, determination whether a set of studies would affect recommendations or the strength of evidence, and practical issues, such as available time and resources.

Literature Searches and Article Selection

Searches were conducted in MEDLINE and Cochrane through January 20, 2011. All searches were also supplemented by articles identified by Work Group members through November 2011. For detailed search strategies, please see Online Appendix 1.

Search results were screened by the ERT for relevance using predefined eligibility criteria, described below. For questions related to treatment, the systematic search aimed to identify RCTs as described in Table 32. For some topics, nonrandomized comparative trials were also reviewed, in addition to RCTs, to strengthen the evidence base.

For most topics, the minimum sample size was > 10. For MCD and FSGS, because of sparse data, smaller studies were included.

Table 33 | Literature search yield of RCTs

Topic	Abstracts identified ^a	Studies retrieved	Studies data-extracted	No. of systematic reviews	No. of summary tables ^b	No. of evidence profiles ^b
Total	13,516	418	94	12	72	18

RCTs, randomized controlled trials.

^aAll topics and all study designs combined.

^bAvailable at: www.kdigo.org/clinical_practice_guidelines/GN.php.

For most topics, the minimum duration of follow-up of 6 months was chosen based on clinical reasoning. For the treatments of interest, the proposed effects on patient-important clinical outcomes require long-term exposure and, typically, would not be expected to become evident before several months of follow-up.

In addition, a search was conducted for data on predictors of kidney failure, kidney function, and remission. Only associations from multivariable regression analyses were considered. These “predictor studies” were not graded for quality. For these topics, the ERT completed its search in October 5, 2009 and did not update the search.

Included were studies of all patients with glomerular diseases, excluding those with diabetic nephropathy, thrombotic microangiopathy, amyloidosis, Alport’s and other hereditary glomerular diseases, paraproteinemia, and recurrence of GN following kidney transplantation.

Interventions of interest included all treatments for GN, including drugs, herbs, dietary supplements, tonsillectomy, infection prophylaxis, and postdiagnosis tests to determine treatment.

A list of pertinent, published systematic reviews relevant to GN guidelines was generated, organized by topic, and reviewed with the Work Group. If an existing systematic review adequately addressed a question of interest as determined by the Work Group, this was used instead of a *de novo* systematic review by the ERT. These systematic reviews were then used as the starting points for building the evidence base and supplemented with articles from the ERT’s own searches. If these reviews were deemed to adequately address topics of interest (even if only selected outcomes were reviewed), *de novo* searches on these topics were limited to the time period since the end of literature search within the systematic reviews.

Editorials, letters, stand-alone abstracts, unpublished reports, and articles published in non-peer-reviewed journals were excluded. The Work Group also decided to exclude publications from journal supplements.

Literature yield for systematic review topics. Table 33 summarizes the numbers of abstracts screened, articles retrieved, studies data extracted, and studies included in summary tables.

Data extraction. The ERT designed data-extraction forms to tabulate information on various aspects of the primary studies. Data fields for all topics included study setting, patient demographics, eligibility criteria, type of GN, numbers of subjects randomized, study design, study funding

Table 34 | Hierarchy of outcomes

Hierarchy ^a	Outcomes ^b
Critical importance	Mortality, ESRD, CKD 5, RRT
High importance	Progression of CKD, Disease remission, Protocol-driven additional treatment of GN, Disease relapse, Quality of life
Moderate importance	Partial disease remission, Proteinuria

CKD, chronic kidney disease; ESRD, end-stage renal disease; GN, glomerulonephritis; RRT, renal replacement therapy.

^aOutcomes of lesser importance are excluded from review.

^bThis categorization was the consensus of the Work Group for the purposes of this GN guideline only. The lists are not meant to reflect outcome ranking for other areas of kidney disease management. The Work Group acknowledges that not all clinicians, patients or families, or societies would rank all outcomes the same.

source, descriptions of interventions (or predictors), description of outcomes, statistical methods used, results, quality of outcomes (as described below), limitations to generalizability, and free-text fields for comments and assessment of biases.

Summary tables

Summary tables were developed to tabulate the data from studies pertinent to each question of intervention. Each summary table contains a brief description of the outcome, baseline characteristics of the population, intervention, comparator results, and methodological quality of each outcome. Baseline characteristics include a description of the study size, country of residence, and baseline kidney function and proteinuria. Intervention and concomitant therapies, and the results, were all captured. The studies were listed by outcome within the table, based on the hierarchy of important outcomes (Table 34). Categorical and continuous outcomes were summarized in separate sets of tables. Work Group members were asked to proof all data in summary tables on RCTs and non-RCTs. Separate sets of summary tables were created for predictor studies. Summary tables are available at www.kdigo.org/clinical_practice_guidelines/GN.php.

Evaluation of individual studies. *Study size and duration:* The study (sample) size is used as a measure of the weight of the evidence. In general, large studies provide more precise estimates. Similarly, longer-duration studies may be of better quality and more applicable, depending on other factors.

Methodological quality: Methodological quality (internal validity) refers to the design, conduct, and reporting of the outcomes of a clinical study. A three-level classification of

Table 35 | Classification of study quality

Good quality:	Low risk of bias and no obvious reporting errors, complete reporting of data. Must be prospective. If study of intervention, must be RCT.
Fair quality:	Moderate risk of bias, but problems with study/paper are unlikely to cause major bias. If study of intervention, must be prospective.
Poor quality:	High risk of bias or cannot exclude possible significant biases. Poor methods, incomplete data, reporting errors. Prospective or retrospective.

RCT, randomized controlled trial.

study quality was used (Table 35). Given the potential differences in quality of a study for its primary and other outcomes, the methodological quality was assessed for each outcome. Variations of this system have been used in most KDOQI and all KDIGO guidelines, and have been recommended for the US Agency for Healthcare Research and Quality Evidence-based Practice Center program (http://effectivehealthcare.ahrq.gov/repFiles/2007_10DraftMethodsGuide.pdf). Each study was given an overall quality grade. Each reported outcome was then evaluated and given an individual quality grade depending on reporting and methodological issues specific to that outcome. However, the quality grade of an individual outcome could not exceed the quality grade for the overall study.

Results: The results data for each outcome of interest were extracted including baseline values (when relevant), final values (or number of events), and net differences (between interventions). These included net change in values, RR, OR, HR, and risk difference, as reported by the studies. The CI values of the net differences and their statistical significance were also extracted. When necessary, for categorical outcomes, RR and their 95% CI were calculated based on available data. The calculated data were distinguished from the reported data in the summary tables.

Evidence profiles. Evidence profiles were constructed by the ERT and reviewed and confirmed with the Work Group members. These profiles serve to make transparent to the reader the thinking process of the Work Group in systematically combining evidence and judgments. Each evidence profile was reviewed by Work Group members. Decisions were based on facts and findings from the primary studies listed in corresponding summary tables, as well as selected existing systematic reviews, and judgments of the Work Group. Judgments about the quality, consistency, and directness of evidence were often complex, as were judgments about the importance of an outcome or the summary of effects sizes. The evidence profiles provided a structured transparent approach to grading, rather than a rigorous method of quantitatively summing up grades.

Evidence profiles were constructed for research questions addressed by at least two studies. When the body of evidence for a particular comparison of interest consisted of only one study, either an RCT or a systematic review, the summary table provides the final level of synthesis.

Grading the quality of evidence and the strength of a recommendation. A structured approach, based on GRADE,⁷⁵⁹⁻⁷⁶¹ and facilitated by the use of evidence profiles, was used in order to grade the quality of the overall evidence and the strength of recommendations. For each topic, the discussion on grading of the quality of the evidence was led by the ERT, and the discussion regarding the strength of the recommendations was led by the Work Group Co-Chairs. The “strength of a recommendation” indicates the extent to which one can be confident that adherence to the recommendation will do more good than harm. The “quality of a body of evidence” refers to the extent to which our confidence in an estimate of effect is sufficient to support a particular recommendation.⁷⁶⁰

Grading the quality of evidence for each outcome: Following the GRADE method, the quality of a body of evidence pertaining to a particular outcome of interest was initially categorized based on study design. For questions of interventions, the initial quality grade was “High” when the body of evidence consisted of RCTs. In theory, the initial grade would have been “Low” if the evidence consisted of observational studies or “Very Low” if it consisted of studies of other study designs; however, the quality of bodies of evidence was formally determined only for topics where we performed systematic reviews of RCTs. The grade for the quality of evidence for each intervention/outcome pair was decreased if there were serious limitations to the methodological quality of the aggregate of studies, if there were important inconsistencies in the results across studies, if there was uncertainty about the directness of evidence including limited applicability of the findings to the population of interest, if the data were imprecise (a low event rate [0 or 1 event] in either arm or CI spanning a range <0.5 to >2.0) or sparse (only one study or total $N < 100$), or if there was thought to be a high likelihood of bias. The final grade for the quality of the evidence for an intervention/outcome pair could be one of the following four grades: “High”, “Moderate”, “Low”, or “Very Low” (Table 36). The quality of grading for topics relying on systematic reviews are based on quality items recorded in the systematic review.

Grading the overall quality of evidence: The quality of the overall body of evidence was then determined based on the quality grades for all outcomes of interest, taking into account explicit judgments about the relative importance of each outcome, weighting critical outcomes more than high or moderate. The resulting four final categories for the quality of overall evidence were: “A”, “B”, “C” or “D” (Table 37). This evidence grade is indicated within each recommendation.

Assessment of the net health benefit across all important clinical outcomes: The net health benefit was determined based on the anticipated balance of benefits and harm across all clinically important outcomes. The assessment of net medical benefit was affected by the judgment of the Work Group. The assessment of net health benefit is summarized in Table 38.

Table 36 | GRADE system for grading quality of evidence

Step 1: Starting grade for quality of evidence based on study design	Step 2: Reduce grade	Step 3: Raise grade	Final grade for quality of evidence and definition
Randomized trials = High	<i>Study quality</i> -1 level if serious limitations -2 levels if very serious limitations	<i>Strength of association</i> +1 level if strong ^a , no plausible confounders +2 levels if very strong ^b , no major threats to validity	High = Further research is unlikely to change confidence in the estimate of the effect
Observational study = Low	<i>Consistency</i> -1 level if important inconsistency <i>Directness</i> -1 level if some uncertainty -2 levels if major uncertainty	<i>Other</i> +1 level if evidence of a dose-response gradient +1 level if all residual plausible confounders would have reduced the observed effect	Moderate = Further research is likely to have an important impact on confidence in the estimate of effect, and may change the estimate Low = Further research is very likely to have an important impact on confidence in the estimate, and may change the estimate
Any other evidence = Very Low	<i>Other</i> -1 level if sparse or imprecise data ^c -1 level if high probability of reporting bias		Very Low = Any estimate of effect is very uncertain

GRADE, Grading of Recommendations Assessment, Development, and Evaluation.

^aStrong evidence of association is defined as “significant relative risk of >2 (<0.5)” based on consistent evidence from two or more observational studies, with no plausible confounders.

^bVery strong evidence of association is defined as “significant relative risk of >5 (<0.2)” based on direct evidence with no major threats to validity.

^cSparse if there is only one study or if total N <100. Imprecise if there is a low event rate (0 or 1 event) in either arm or confidence interval spanning a range <0.5 to >2.0. Adapted by permission from Macmillan Publishers Ltd: Kidney International. Uhlig K, Macleod A, Craig J *et al.* Grading evidence and recommendations for clinical practice guidelines in nephrology. A position statement from Kidney Disease: Improving Global Outcomes (KDIGO). *Kidney Int* 2006; 70: 2058–2065⁷⁶¹; accessed <http://www.nature.com/ki/journal/v70/n12/pdf/5001875a.pdf>.

Table 37 | Final grade for overall quality of evidence

Grade	Quality of evidence	Meaning
A	High	We are confident that the true effect lies close to that of the estimate of the effect.
B	Moderate	The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
C	Low	The true effect may be substantially different from the estimate of the effect.
D	Very Low	The estimate of effect is very uncertain, and often will be far from the truth.

Grading the strength of the recommendations: The strength of a recommendation is graded as Level 1 or Level 2. Table 39 shows the KDIGO nomenclature for grading the strength of a recommendation, and the implications of each level for patients, clinicians, and policy-makers. Recommendations can be for or against doing something. Table 40 shows that the strength of a recommendation is determined not just by the quality of the evidence, but also by other—often complex—judgments regarding the size of the net medical benefit, values, and preferences, and costs. Formal decision analyses including cost analysis were not conducted.

Ungraded statements: This category was designed to allow the Work Group to issue general advice. Typically an ungraded statement meets the following criteria: it provides guidance based on common sense; it provides reminders of the obvious; it is not sufficiently specific to allow application of evidence to the issue and, therefore, it is not based on systematic evidence review. Common examples include

Table 38 | Balance of benefits and harm

When there was evidence to determine the balance of medical benefits and harm of an intervention to a patient, conclusions were categorized as follows:

- **Net benefits** = the intervention clearly does more good than harm
- **Trade-offs** = there are important trade-offs between the benefits and harm
- **Uncertain trade-offs** = it is not clear whether the intervention does more good than harm
- **No net benefits** = the intervention clearly does not do more good than harm

recommendations about frequency of testing, referral to specialists, and routine medical care. We strove to minimize the use of ungraded recommendations.

This grading scheme with two levels for the strength of a recommendation together with four levels of grading the quality of the evidence, and the option of an ungraded statement for general guidance, was adopted by the KDIGO Board in December 2008. The Work Group took the primary role of writing the recommendations and rationale statements, and retained final responsibility for the content of the guideline statements and the accompanying narrative. The ERT reviewed draft recommendations and grades for consistency with the conclusions of the evidence review.

Format for recommendations. Each section contains one or more specific recommendations. Within each recommendation, the strength of recommendation is indicated as level 1 or level 2, and the quality of the supporting evidence is shown as A, B, C, or D. These are followed by a brief background with relevant definitions of terms, then the

Table 39 | KDIGO nomenclature and description for grading recommendations

Grade ^a	Implications		
	Patients	Clinicians	Policy
Level 1 “We recommend”	Most people in your situation would want the recommended course of action and only a small proportion would not.	Most patients should receive the recommended course of action.	The recommendation can be evaluated as a candidate for developing a policy or a performance measure.
Level 2 “We suggest”	The majority of people in your situation would want the recommended course of action, but many would not.	Different choices will be appropriate for different patients. Each patient needs help to arrive at a management decision consistent with her or his values and preferences.	The recommendation is likely to require substantial debate and involvement of stakeholders before policy can be determined.

^aThe additional category “Not Graded” was used, typically, to provide guidance based on common sense or where the topic does not allow adequate application of evidence. The most common examples include recommendations regarding monitoring intervals, counseling, and referral to other clinical specialists. The ungraded recommendations are generally written as simple declarative statements, but are not meant to be interpreted as being stronger recommendations than Level 1 or 2 recommendations.

Table 40 | Determinants of strength of recommendation

Factor	Comment
Balance between desirable and undesirable effects	The larger the difference between the desirable and undesirable effects, the more likely a strong recommendation is warranted. The narrower the gradient, the more likely a weak recommendation is warranted.
Quality of the evidence	The higher the quality of evidence, the more likely a strong recommendation is warranted.
Values and preferences	The more variability in values and preferences, or more uncertainty in values and preferences, the more likely a weak recommendation is warranted.
Costs (resource allocation)	The higher the costs of an intervention—that is, the more resources consumed—the less likely a strong recommendation is warranted.

rationale starting with a “chain of logic”, which consists of declarative sentences summarizing the key points of the evidence base, and the judgments supporting the recommendation. This is followed by a narrative in support of the rationale. In relevant sections, research recommendations suggest future research to resolve current uncertainties.

Limitations of Approach

While the literature searches were intended to be comprehensive, they were not exhaustive. MEDLINE and various Cochrane databases were the only databases searched. Hand searches of journals were not performed, and review articles and textbook chapters were not systematically searched. However, important studies known to the domain experts that were missed by the electronic literature searches were added to retrieved articles and reviewed by the Work Group. Not all topics and subtopics covered by these guidelines could be systematically reviewed. Decisions to restrict the topics were made to focus the systematic reviews on those topics where existing evidence was thought to be likely to provide support for the guidelines. Although nonrandomized studies were reviewed, the majority of the ERT and Work Group resources were devoted to review of the randomized trials, since these were deemed to be most likely to provide data to support level 1 recommendations with very high- or

high- (A or B) quality evidence. Where randomized trials were lacking, it was deemed to be sufficiently unlikely that studies previously unknown to the Work Group would result in higher-quality level 1 recommendations.

Review of the Guideline Development Process

Several tools and checklists have been developed to assess the quality of the methodological process for systematic review and guideline development. These include the Appraisal of Guidelines for Research and Evaluation (AGREE) criteria,⁷⁶² the Conference on Guideline Standardization (COGS) checklist,⁷⁶³ and the Institute of Medicine’s recent *Standards for Systematic Reviews*⁷⁶⁴ and *Clinical Practice Guidelines We Can Trust*.⁷⁶⁵ Online Appendices 2 and 3 show the COGS criteria that correspond to the AGREE checklist and the Institute of Medicine standards, and how each one of them is addressed in this guideline.

SUPPLEMENTARY MATERIAL

Appendix 1: Online search strategies.
Appendix 2: The Conference on Guideline Standardization (COGS) checklist for reporting clinical practice guidelines.
Appendix 3: Concurrence with Institute of Medicine standards for systematic reviews and for guidelines.
 Supplementary material is linked to the online version of the paper at http://www.kdigo.org/clinical_practice_guidelines/GN.php

Biographic and Disclosure Information

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Daniel C Cattran, MD, FRCPC (Work Group Co-Chair), is a graduate of the University of Toronto Medical School and completed his postgraduate training both in Toronto, Canada and Sydney, Australia. He is currently a Professor of Medicine at the University of Toronto and a senior scientist at the Toronto General Research Institute. His administrative roles have included Chairman of the Royal College of Canada specialty program in nephrology, the renal transplant program of the Toronto General Hospital, and Director of the postgraduate education program in nephrology at the University of Toronto. Dr. Cattran is a member of postgraduate education committee of the American Society of Nephrology and he also currently serves on the KDIGO Board.

Dr. Cattran's major research work has been in field of GN. He was the principal organizer and present Chair of the Toronto Glomerulonephritis Registry, which currently includes over 11,000 cases of biopsy-proven GN. His current research activities also include chairing the steering committee of NEPTUNE, an NIH-sponsored North American Consortium of 15 Centers focused on investigating the molecular mechanisms of the nephrotic syndrome and in particular the histologic variants, MN and FSGS. His own research is currently examining the role of ACTH as new therapy for IMN, and Dr. Cattran is lead investigator of a North American validation study of the new Oxford classification of IgAN. Grant support for his work has come from the Kidney Foundation of Canada, PSI, the National Institutes of Health, and the Canadian Institutes for Health Research. He has published over 190 articles in peer-reviewed journals and has been the principal author of more than 20 book chapters, as well as multiple reviews related to the natural history, outcome, and treatment studies in GN.

In recognition of his career in clinical investigation, the Kidney Foundation of Canada recently awarded him their prestigious Medal for Research Excellence. He has also been active in volunteer work, in particular, the Kidney Foundation of Canada and has held a number of positions including the chair of their Medical Advisory Board. The Foundation's award, "Volunteer of the Year", acknowledged his contributions to this organization. He has also held a number of positions in the Canadian Society of Nephrology, including a term as President.

Advisor/Consultant: Genentech; Osprey; Questcor; Roche; Vifor
Speaker: Novartis
Grant/Research Support: Amgen

John Feehally, DM, FRCP (Work Group Co-Chair), is Professor of Renal Medicine at The John Walls Renal Unit, Leicester General Hospital, UK. He received training in nephrology in Manchester and Leicester, UK, and in Boston, MA, USA, and was appointed Consultant Nephrologist at Leicester General Hospital in 1988. In 1999 he became Honorary Professor of Renal Medicine at the University of Leicester, UK. His particular clinical interests include topics such as GN and kidney transplantation. He has an active laboratory research program with a focus on immune renal disease, particularly IgAN, and maintains an epidemiological and clinical research interest in ethnic variations in renal disease.

Professor Feehally is Co-Editor of *Comprehensive Clinical Nephrology, 4th Edition*. He is President of the International Society of Nephrology (2011-2013), served as President of the Renal Association in the UK (2004-2007), and has been a member of the Renal Advisory Group at the UK Department of Health since 2003.

Dr Feehally reported no relevant financial relationships

H Terence Cook, MBBS, MRCP, MRCPath, FRCPath, FMedSci, is Professor of Renal Pathology at Imperial College of Medicine and Deputy Director of the Centre for Complement and Inflammation Research at Imperial College, London, UK. Dr. Cook completed his undergraduate studies at New College, University of Oxford and received his medical degree from St. Mary's Hospital Medical School in London, UK. His major research interests include the studying of pathological mechanisms of injury in glomerulonephritis and the role of macrophages, antibodies, Fc receptors, complement, and other mediators in the disease process. He also maintains an active interest in the use of histological features from human renal biopsies to predict response to treatments. In particular, he is presently conducting transcriptome analysis from renal biopsies for the diagnosis of transplant rejection. Dr. Cook is currently the President of Renal Pathology Society and a member of committees including, ISN COMGAN Subcommittee on Renal Pathology; Royal College of Pathologists Ethics Committee; and Renal Association International Committee. He has authored more than 200 publications and served as a consensus working group member of the International IgA Nephropathy Network, which recently developed the Oxford Classification of IgA Nephropathy.

Advisor/Consultant: Roche

Fernando C Fervenza, MD, PhD, is Professor of Medicine and Section Head, Parenchymal Renal Division at Mayo Clinic College of Medicine in Rochester, MN, USA. He received his medical training at the Medical School of the Pontificia Universidade, Brazil and completed his doctoral degree from University of Oxford, UK and fellowship studies from Stanford University. His primary research interest lies in the area of parenchymal renal disease with a focus on the glomerulopathies. Specifically, Dr. Fervenza is a current principal investigator in a number of clinical trials examining the efficacy of ocrelizumab in class III or IV nephritis; the use of rituximab as induction therapy in patients with lupus membranous patients; and the effectiveness of ACTH in lowering proteinuria in patients with IMN. In addition to authoring more than 100 peer-reviewed publications, Dr. Fervenza has been actively involved in the mentoring of residents, nephrology fellows, and visiting physicians. Since 2001, he has organized an annual nephrology up-to-date course in Brazil with the aim of fostering scientific improvement in the Brazilian nephrology community. In recognition for his multitude of contributions, Dr. Fervenza was awarded the Career Development Award in 2007 by the Mayo Foundation and most recently received the Laureate Award from the Mayo Clinic.

Advisor/Consultant: Genentech; Questcor
Grant/Research Support: Genentech; Novartis; Questcor; Roche; Teva

Jürgen Floege, MD, graduated from the Hannover Medical School in Germany in 1984 and subsequently received his clinical training at the Hannover Medical School. His particular interest in renal diseases and renal replacement therapies developed during various research periods in physiology, pharmacology, nephrology, and pathology at the Hannover Medical School, Germany; the Albert Einstein College of Medicine, New York; and the University of Washington, Seattle, WA, USA. He was appointed as head of the Division of Nephrology and Immunology at the University of Aachen, Germany in 1999. In 2001, he became the Vice Dean of the Medical School, and since 2004, a Director of a government-funded center grant on chronic inflammation.

Professor Floege is an active member of several nephrology societies, including the American Society of Nephrology, ISN, and the European Renal Association (ERA-EDTA). He is a current member of the ERA-EDTA scientific advisory board, Co-Chair of the World Congress of Nephrology (Vancouver 2011) and former ERA-EDTA and ISN council member. In addition, he is a founding member and vice president of the German Society of Nephrology, since 2008. Together with Professors Richard Johnson and John Feehally he is editor of the best-selling textbook *Comprehensive Clinical Nephrology*. Finally, Professor Floege is one of two deputy editors of the ERA-EDTA journal *Nephrology Dialysis Transplantation* and a member of the editorial board of

several other journals, including *Journal of the American Society of Nephrology*, *Kidney International*, *Nature Clinical Practice Nephrology*, *Journal of Nephrology*, and *Clinical Nephrology*.

His research interests encompass both basic research (i.e., studies on growth factors, cytokines, angiogenesis, stem cells and fibrosis in the course of renal disease) as well as clinical problems such as immune-mediated renal disease, bone and mineral disorders and cardiovascular risk factors in dialysis patients. Dr. Floege's scientific work encompasses 300 original papers, reviews and editorials, and 40 book chapters.

Advisor/Consultant: Amgen; Boehringer Ingelheim; Fresenius; Genzyme; Pharmalink; Vifor
Speaker: Amgen; Fresenius; Genzyme; Vifor

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Advisor/Consultant: Aspreva (Vifor Pharma); BioMarin; Bristol-Myers Squibb; ChemoCentryx; Eli Lilly; FibroGen; Genentech; La Jolla Pharmaceutical; Lighthouse Learning; National Institutes of Health; Novartis; Questcor; Wyeth
Board of Directors/Advisory Board: American Renal Associates; Los Angeles Biomedical Research Institute; University Kidney Research Organization; Wyeth
Ownership Interests: La Jolla Pharmaceutical; Reata
Honoraria: American Society of Nephrology
Employment: American Journal of Nephrology; American Society of Nephrology; Lighthouse Learning; UpToDate
Royalties: Oxford University Press

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Dr Hodson reported no relevant financial relationships

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Dr Jha reported no relevant financial relationships

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Prof. Li had been President of the Organizing Committees for the ISN 2004 Conference on Prevention of Progression of Kidney Diseases and the 11th International Congress of International Society for Peritoneal Dialysis in 2006. He was also the Scientific Vice-President and Program Chair for the 2nd Congress of the International Society for Hemodialysis in 2009. Prof. Li is now the Chairman of the Organizing Committee for the World Congress of Nephrology 2013, which will be held in Hong Kong.

Prof. Li is the founding Editor-in-Chief of the *Hong Kong Journal of Nephrology*, Deputy Editor of *Nephrology*, and Editor of *Nephrology Dialysis Transplantation* and the *International Journal of Artificial Organs*. He is on the Editorial Boards of *Clinical Nephrology*, *Peritoneal Dialysis International*, *Nephron Clinical Practice*, *Chinese Journal of Nephrology*, *Dialysis & Transplantation*, *Medical Progress*, *Indian Journal of Peritoneal Dialysis*, and is a regular reviewer for all the major nephrology journals. He has published over 380 original and review articles in peer-reviewed journals, two books and 17 book chapters, and has given lectures to over 100 international congresses and meetings.

His research interests include many aspects of peritoneal dialysis, such as residual renal function, cardiovascular disease, connectology, peritonitis, biocompatible solutions adequacy; cardiovascular mortality in dialysis patients; IgAN; prevention of progression of CKD; diabetes in kidney failure; immunogenetics of nephropathies; and drug pharmacokinetics and complications after transplantation.

Advisor/Consultant: Baxter Healthcare
Speaker: Baxter Healthcare; Fresenius; Roche
Grant/Research Support: Baxter Healthcare

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Dr. Liu was appointed Professor of Medicine at Nanjing University in 1996 and became Adjunct Professor of Medicine at Brown University in 2008. In 2003, she was also elected as Academician in Chinese Academy of Engineering. Her primary interest is in the field of renal disease, with special interest in GN, including IgAN, LN, MN, FSGS, and diabetic and metabolic renal disease. She has published 390 articles, authored two books, and contributed chapters to nephrology textbooks. Dr. Liu also served on the editorial boards of several peer-reviewed journals, including as editor-in-chief of the *Chinese Journal of Nephrology Dialysis & Transplantation*. She was honored with the National Science and Technology Progress Award of China; the National Young Investigator Award and National Outstanding Individual Award in Science and Technology from the China Association for Science and Technology; and the Guanghua Engineering & Technological Science Award from Chinese Academy of Engineering. She is the President-Elect of the Chinese Society of Nephrology.

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Grant/Research Support: Alexion

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Advisor/Consultant: Aspreva (Vifor Pharma); Novartis; Roche

Speaker: Astellas; Novartis; Roche

Grant/Research Support: Astellas; Novartis; Roche; Wyeth

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Advisor/Consultant: Biogen Idec; Centocor; Genentech; Osprey; Questcor; Teijan Pharmaceuticals; Teva
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Advisor/Consultant: Alexion; Genzyme
Speaker: Amgen; Genzyme
Grant/Research Support: Alexion; Amgen; Genzyme; Roche

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Advisor/Consultant: Affymax; Amgen; Hexal Sandoz; Johnson & Johnson; Roche
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Advisor/Consultant: Litholink

Grant/Research Support: Bristol-Myers Squibb; Merck-Schering Plough

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Participation in the review does not necessarily constitute endorsement of the content of this report by the above individuals, or the organization or institution they represent.

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References

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REFERENCES

- Corwin HL, Schwartz MM, Lewis EJ. The importance of sample size in the interpretation of the renal biopsy. *Am J Nephrol* 1988; **8**: 85–89.
- Price CP, Newall RG, Boyd JC. Use of protein:creatinine ratio measurements on random urine samples for prediction of significant proteinuria: a systematic review. *Clin Chem* 2005; **51**: 1577–1586.
- Fine DM, Ziegenbein M, Petri M *et al.* A prospective study of protein excretion using short-interval timed urine collections in patients with lupus nephritis. *Kidney Int* 2009; **76**: 1284–1288.
- Branten AJ, Vervoort G, Wetzels JF. Serum creatinine is a poor marker of GFR in nephrotic syndrome. *Nephrol Dial Transplant* 2005; **20**: 707–711.
- Botev R, Mallie JP, Couchoud C *et al.* Estimating glomerular filtration rate: Cockcroft-Gault and Modification of Diet in Renal Disease formulas compared to renal inulin clearance. *Clin J Am Soc Nephrol* 2009; **4**: 899–906.
- Rovin BH, McKinley AM, Birmingham DJ. Can we personalize treatment for kidney diseases? *Clin J Am Soc Nephrol* 2009; **4**: 1670–1676.
- Upadhyay A, Earley A, Haynes SM *et al.* Systematic review: blood pressure target in chronic kidney disease and proteinuria as an effect modifier. *Ann Intern Med* 2011; **154**: 541–548.
- Agarwal A, Haddad N, Hebert LA. Progression of kidney disease: diagnosis and management. In: Molony DA, Craig JC (eds). *Evidence-based Nephrology*, 1st edn. John Wiley & Sons: Hoboken, NJ, 2008, pp 311–322.
- National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents. The fourth report on the diagnosis, evaluation, and treatment of high blood pressure in children and adolescents. *Pediatrics* 2004; **114**(Suppl 2): 555–576.
- Wuhl E, Trivelli A, Picca S *et al.* Strict blood-pressure control and progression of renal failure in children. *N Engl J Med* 2009; **361**: 1639–1650.
- Ogi M, Yokoyama H, Tomosugi N *et al.* Risk factors for infection and immunoglobulin replacement therapy in adult nephrotic syndrome. *Am J Kidney Dis* 1994; **24**: 427–436.
- Furth SL, Arbus GS, Hogg R *et al.* Varicella vaccination in children with nephrotic syndrome: a report of the Southwest Pediatric Nephrology Study Group. *J Pediatr* 2003; **142**: 145–148.
- Philibert D, Cattran D. Remission of proteinuria in primary glomerulonephritis: we know the goal but do we know the price? *Nat Clin Pract Nephrol* 2008; **4**: 550–559.
- McKinney PA, Feltbower RG, Brocklebank JT *et al.* Time trends and ethnic patterns of childhood nephrotic syndrome in Yorkshire, UK. *Pediatr Nephrol* 2001; **16**: 1040–1044.
- A Report of the International Study of Kidney Disease in Children. Primary nephrotic syndrome in children: clinical significance of histopathologic variants of minimal change and of diffuse mesangial hypercellularity. *Kidney Int* 1981; **20**: 765–771.
- Fakhouri F, Bocquet N, Taupin P *et al.* Steroid-sensitive nephrotic syndrome: from childhood to adulthood. *Am J Kidney Dis* 2003; **41**: 550–557.
- Koskimies O, Vilksa J, Rapola J *et al.* Long-term outcome of primary nephrotic syndrome. *Arch Dis Child* 1982; **57**: 544–548.
- Tarshish P, Tobin JN, Bernstein J *et al.* Prognostic significance of the early course of minimal change nephrotic syndrome: report of the International Study of Kidney Disease in Children. *J Am Soc Nephrol* 1997; **8**: 769–776.
- Arneil GC. 164 children with nephrosis. *Lancet* 1961; **2**: 1103–1110.
- Ruth EM, Kemper MJ, Leumann EP *et al.* Children with steroid-sensitive nephrotic syndrome come of age: long-term outcome. *J Pediatr* 2005; **147**: 202–207.
- Bhimma R, Coovadia HM, Adhikari M. Nephrotic syndrome in South African children: changing perspectives over 20 years. *Pediatr Nephrol* 1997; **11**: 429–434.
- Kim JS, Bellew CA, Silverstein DM *et al.* High incidence of initial and late steroid resistance in childhood nephrotic syndrome. *Kidney Int* 2005; **68**: 1275–1281.
- Arneil GC. The nephrotic syndrome. *Pediatr Clin North Am* 1971; **18**: 547–559.
- Alternate-day versus intermittent prednisone in frequently relapsing nephrotic syndrome. A report of 'Arbeitsgemeinschaft fur Padiatrische Nephrologie'. *Lancet* 1979; **1**: 401–403.
- Hodson EM, Knight JF, Willis NS *et al.* Corticosteroid therapy for nephrotic syndrome in children. *Cochrane Database Syst Rev* 2005: CD001533.
- Feber J, Al-Matrafi J, Farhadi E *et al.* Prednisone dosing per body weight or body surface area in children with nephrotic syndrome: is it equivalent? *Pediatr Nephrol* 2009; **24**: 1027–1031.
- The primary nephrotic syndrome in children. Identification of patients with minimal change nephrotic syndrome from initial response to prednisone. A report of the International Study of Kidney Disease in Children. *J Pediatr* 1981; **98**: 561–564.
- Short versus standard prednisone therapy for initial treatment of idiopathic nephrotic syndrome in children. Arbeitsgemeinschaft fur Padiatrische Nephrologie. *Lancet* 1988; **1**: 380–383.
- Alternate-day prednisone is more effective than intermittent prednisone in frequently relapsing nephrotic syndrome. A report of 'Arbeitsgemeinschaft fur Padiatrische Nephrologie'. *Eur J Pediatr* 1981; **135**: 229–237.
- Broyer M, Guest G, Gagnadoux MF. Growth rate in children receiving alternate-day corticosteroid treatment after kidney transplantation. *J Pediatr* 1992; **120**: 721–725.
- Letavernier B, Letavernier E, Leroy S *et al.* Prediction of high-degree steroid dependency in pediatric idiopathic nephrotic syndrome. *Pediatr Nephrol* 2008; **23**: 2221–2226.
- Noer MS. Predictors of relapse in steroid-sensitive nephrotic syndrome. *Southeast Asian J Trop Med Public Health* 2005; **36**: 1313–1320.
- Lewis MA, Baildom EM, Davis N *et al.* Nephrotic syndrome: from toddlers to twenties. *Lancet* 1989; **1**: 255–259.
- Andersen RF, Thrane N, Noergaard K *et al.* Early age at debut is a predictor of steroid-dependent and frequent relapsing nephrotic syndrome. *Pediatr Nephrol* 2010; **25**: 1299–1304.
- Constantinescu AR, Shah HB, Foote EF *et al.* Predicting first-year relapses in children with nephrotic syndrome. *Pediatrics* 2000; **105**: 492–495.
- Abeyagunawardena AS, Trompeter RS. Increasing the dose of prednisolone during viral infections reduces the risk of relapse in nephrotic syndrome: a randomised controlled trial. *Arch Dis Child* 2008; **93**: 226–228.
- Gulati A, Sinha A, Sreenivas V *et al.* Daily corticosteroids reduce infection-associated relapses in frequently relapsing nephrotic syndrome: a randomized controlled trial. *Clin J Am Soc Nephrol* 2011; **6**: 63–69.
- Elzouki AY, Jaiswal OP. Long-term, small dose prednisone therapy in frequently relapsing nephrotic syndrome of childhood. Effect on remission, statural growth, obesity, and infection rate. *Clin Pediatr (Phila)* 1988; **27**: 387–392.
- Consensus statement on management and audit potential for steroid responsive nephrotic syndrome. Report of a Workshop by the British Association for Paediatric Nephrology and Research Unit, Royal College of Physicians. *Arch Dis Child* 1994; **70**: 151–157.
- Bagga A, Ali U, Banerjee S *et al.* Management of steroid sensitive nephrotic syndrome: revised guidelines. *Indian Pediatr* 2008; **45**: 203–214.
- Srivastava RN, Vasudev AS, Bagga A *et al.* Long-term, low-dose prednisolone therapy in frequently relapsing nephrotic syndrome. *Pediatr Nephrol* 1992; **6**: 247–250.
- Kyrieleis HA, Lowik MM, Pronk I *et al.* Long-term outcome of biopsy-proven, frequently relapsing minimal-change nephrotic syndrome in children. *Clin J Am Soc Nephrol* 2009; **4**: 1593–1600.
- Latta K, von Schnakenburg C, Ehrich JH. A meta-analysis of cytotoxic treatment for frequently relapsing nephrotic syndrome in children. *Pediatr Nephrol* 2001; **16**: 271–282.
- Niaudet P, Habib R, Tete MJ *et al.* Cyclosporin in the treatment of idiopathic nephrotic syndrome in children. *Pediatr Nephrol* 1987; **1**: 566–573.

45. Boyer O, Moulder JK, Grandin L *et al.* Short- and long-term efficacy of levamisole as adjunctive therapy in childhood nephrotic syndrome. *Pediatr Nephrol* 2008; **23**: 575–580.
46. Hino S, Takemura T, Okada M *et al.* Follow-up study of children with nephrotic syndrome treated with a long-term moderate dose of cyclosporine. *Am J Kidney Dis* 1998; **31**: 932–939.
47. Leroy V, Baudouin V, Alberti C *et al.* Growth in boys with idiopathic nephrotic syndrome on long-term cyclosporin and steroid treatment. *Pediatr Nephrol* 2009; **24**: 2393–2400.
48. Mowry JA, McCarthy ET. Cyclosporine in glomerular disease. *Semin Nephrol* 1996; **16**: 548–554.
49. Hodson EM, Willis NS, Craig JC. Non-corticosteroid treatment for nephrotic syndrome in children. *Cochrane Database Syst Rev* 2008; CD002290.
50. Kyrieleis HA, Levtschenko EN, Wetzels JF. Long-term outcome after cyclophosphamide treatment in children with steroid-dependent and frequently relapsing minimal change nephrotic syndrome. *Am J Kidney Dis* 2007; **49**: 592–597.
51. Azib S, Macher MA, Kwon T *et al.* Cyclophosphamide in steroid-dependent nephrotic syndrome. *Pediatr Nephrol* 2011; **26**: 927–932.
52. Cyclophosphamide treatment of steroid dependent nephrotic syndrome: comparison of eight week with 12 week course. Report of Arbeitsgemeinschaft fur Padiatrische Nephrologie. *Arch Dis Child* 1987; **62**: 1102–1106.
53. Williams SA, Makker SP, Ingelfinger JR *et al.* Long-term evaluation of chlorambucil plus prednisone in the idiopathic nephrotic syndrome of childhood. *N Engl J Med* 1980; **302**: 929–933.
54. Wetzels JF. Cyclophosphamide-induced gonadal toxicity: a treatment dilemma in patients with lupus nephritis? *Neth J Med* 2004; **62**: 347–352.
55. Miller DG. Alkylating agents and human spermatogenesis. *JAMA* 1971; **217**: 1662–1665.
56. Weiss R. Randomized double-blind placebo controlled, multi-center trial of levamisole for children with frequently relapsing/steroid dependent nephrotic syndrome (abstract). *J Am Soc Nephrol* 1993; **4**: 289.
57. Fu LS, Shien CY, Chi CS. Levamisole in steroid-sensitive nephrotic syndrome children with frequent relapses and/or steroid dependency: comparison of daily and every-other-day usage. *Nephron Clin Pract* 2004; **97**: c137–c141.
58. Hafeez F, Ahmed TM, Samina U. Levamisole in steroid dependent and frequently relapsing nephrotic syndrome. *J Coll Physicians Surg Pak* 2006; **16**: 35–37.
59. Kemper MJ, Amon O, Timmermann K *et al.* [The treatment with levamisole of frequently recurring steroid-sensitive idiopathic nephrotic syndrome in children]. *Dtsch Med Wochenschr* 1998; **123**: 239–243.
60. Palcoux JB, Niaudet P, Goumy P. Side effects of levamisole in children with nephrosis. *Pediatr Nephrol* 1994; **8**: 263–264.
61. Niaudet P. Comparison of cyclosporin and chlorambucil in the treatment of steroid-dependent idiopathic nephrotic syndrome: a multicentre randomized controlled trial. The French Society of Paediatric Nephrology. *Pediatr Nephrol* 1992; **6**: 1–3.
62. Ponticelli C, Edefonti A, Ghio L *et al.* Cyclosporin versus cyclophosphamide for patients with steroid-dependent and frequently relapsing idiopathic nephrotic syndrome: a multicentre randomized controlled trial. *Nephrol Dial Transplant* 1993; **8**: 1326–1332.
63. Yoshioka K, Ohashi Y, Sakai T *et al.* A multicenter trial of mizoribine compared with placebo in children with frequently relapsing nephrotic syndrome. *Kidney Int* 2000; **58**: 317–324.
64. El-Husseini A, El-Basuony F, Mahmoud I *et al.* Long-term effects of cyclosporine in children with idiopathic nephrotic syndrome: a single-centre experience. *Nephrol Dial Transplant* 2005; **20**: 2433–2438.
65. Hulton SA, Neuhaus TJ, Dillon MJ *et al.* Long-term cyclosporin A treatment of minimal-change nephrotic syndrome of childhood. *Pediatr Nephrol* 1994; **8**: 401–403.
66. Niaudet P, Broyer M, Habib R. Treatment of idiopathic nephrotic syndrome with cyclosporin A in children. *Clin Nephrol* 1991; **35**(Suppl 1): S31–S36.
67. Ishikura K, Ikeda M, Hattori S *et al.* Effective and safe treatment with cyclosporine in nephrotic children: a prospective, randomized multicenter trial. *Kidney Int* 2008; **73**: 1167–1173.
68. Filler G. How should microemulsified Cyclosporine A (Neoral) therapy in patients with nephrotic syndrome be monitored? *Nephrol Dial Transplant* 2005; **20**: 1032–1034.
69. Sinha MD, MacLeod R, Rigby E *et al.* Treatment of severe steroid-dependent nephrotic syndrome (SDNS) in children with tacrolimus. *Nephrol Dial Transplant* 2006; **21**: 1848–1854.
70. Dotsch J, Dittrich K, Plank C *et al.* Is tacrolimus for childhood steroid-dependent nephrotic syndrome better than ciclosporin A? *Nephrol Dial Transplant* 2006; **21**: 1761–1763.
71. Iijima K, Hamahira K, Tanaka R *et al.* Risk factors for cyclosporine-induced tubulointerstitial lesions in children with minimal change nephrotic syndrome. *Kidney Int* 2002; **61**: 1801–1805.
72. Kranz B, Vester U, Buscher R *et al.* Cyclosporine-A-induced nephrotoxicity in children with minimal-change nephrotic syndrome: long-term treatment up to 10 years. *Pediatr Nephrol* 2008; **23**: 581–586.
73. El-Husseini A, El-Basuony F, Mahmoud I *et al.* Impact of the cyclosporine-ketoconazole interaction in children with steroid-dependent idiopathic nephrotic syndrome. *Eur J Clin Pharmacol* 2006; **62**: 3–8.
74. Dorresteyn EM, Kist-van Holthe JE, Levtschenko EN *et al.* Mycophenolate mofetil versus cyclosporine for remission maintenance in nephrotic syndrome. *Pediatr Nephrol* 2008; **23**: 2013–2020.
75. Hogg RJ, Fitzgibbons L, Bruck J *et al.* Clinical trial of mycophenolate mofetil (MMF) for frequent relapsing nephrotic syndrome in children (abstract). *Pediatr Nephrol* 2004; **19**: C66.
76. Afzal K, Bagga A, Menon S *et al.* Treatment with mycophenolate mofetil and prednisolone for steroid-dependent nephrotic syndrome. *Pediatr Nephrol* 2007; **22**: 2059–2065.
77. Barletta GM, Smoyer WE, Bunchman TE *et al.* Use of mycophenolate mofetil in steroid-dependent and -resistant nephrotic syndrome. *Pediatr Nephrol* 2003; **18**: 833–837.
78. Ettenger R, Bartosh S, Choi L *et al.* Pharmacokinetics of enteric-coated mycophenolate sodium in stable pediatric renal transplant recipients. *Pediatr Transplant* 2005; **9**: 780–787.
79. Ravani P, Magnasco A, Edefonti A *et al.* Short-term effects of rituximab in children with steroid- and calcineurin-dependent nephrotic syndrome: a randomized controlled trial. *Clin J Am Soc Nephrol* 2011; **6**: 1308–1315.
80. Guignon V, Dallochio A, Baudouin V *et al.* Rituximab treatment for severe steroid- or cyclosporine-dependent nephrotic syndrome: a multicentric series of 22 cases. *Pediatr Nephrol* 2008; **23**: 1269–1279.
81. Prytula A, Iijima K, Kamei K *et al.* Rituximab in refractory nephrotic syndrome. *Pediatr Nephrol* 2010; **25**: 461–468.
82. Chaumais MC, Garnier A, Chalard F *et al.* Fatal pulmonary fibrosis after rituximab administration. *Pediatr Nephrol* 2009; **24**: 1753–1755.
83. Gulati S, Sharma AP, Sharma RK *et al.* Do current recommendations for kidney biopsy in nephrotic syndrome need modifications? *Pediatr Nephrol* 2002; **17**: 404–408.
84. Gulati S, Sural S, Sharma RK *et al.* Spectrum of adolescent-onset nephrotic syndrome in Indian children. *Pediatr Nephrol* 2001; **16**: 1045–1048.
85. Baqi N, Singh A, Balachandra S *et al.* The paucity of minimal change disease in adolescents with primary nephrotic syndrome. *Pediatr Nephrol* 1998; **12**: 105–107.
86. Gipson DS, Chin H, Presler TP *et al.* Differential risk of remission and ESRD in childhood FSGS. *Pediatr Nephrol* 2006; **21**: 344–349.
87. Gorenssek MJ, Lebel MH, Nelson JD. Peritonitis in children with nephrotic syndrome. *Pediatrics* 1988; **81**: 849–856.
88. Ulinski T, Leroy S, Dubrel M *et al.* High serological response to pneumococcal vaccine in nephrotic children at disease onset on high-dose prednisone. *Pediatr Nephrol* 2008; **23**: 1107–1113.
89. Aoun B, Wannous H, Azema C *et al.* Polysaccharide pneumococcal vaccination of nephrotic children at disease onset-long-term data. *Pediatr Nephrol* 2010; **25**: 1773–1774.
90. The Australian immunisation handbook. Australian Government Department of Health and Ageing, Office of Health Protection: Woden, ACT, 2008.
91. American Academy of Pediatrics. Section 1: Active and passive immunization. In: Pickering LK, Baker CJ, Long SS, McMillan JA (eds). *Red Book: 2006 Report of the Committee on Infectious Diseases*, 27th edn. Elk Grove Village, IL, 2006, pp 1–103.
92. Trachtman H, Fine R, Friedman A *et al.* Quality of life in children with focal segmental glomerulosclerosis: baseline findings. Report of the FSGS clinical trial (CT) (abstract). *J Am Soc Nephrol* 2009; **20**: 147A.
93. Kerlin BA, Blatt NB, Fuh B *et al.* Epidemiology and risk factors for thromboembolic complications of childhood nephrotic syndrome: a Midwest Pediatric Nephrology Consortium (MWPNC) study. *J Pediatr* 2009; **155**: 105–110, 110 e101.
94. Soeiro EM, Koch VH, Fujimura MD *et al.* Influence of nephrotic state on the infectious profile in childhood idiopathic nephrotic syndrome. *Rev Hosp Clin Fac Med Sao Paulo* 2004; **59**: 273–278.
95. Uncu N, Bulbul M, Yildiz N *et al.* Primary peritonitis in children with nephrotic syndrome: results of a 5-year multicenter study. *Eur J Pediatr* 2010; **169**: 73–76.

96. USRDS 2003. *Annual data report: Atlas of end-stage renal disease in the United States*. US Renal Data System, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases: Bethesda, MD, 2003.
97. Prospective, controlled trial of cyclophosphamide therapy in children with nephrotic syndrome. Report of the International study of Kidney Disease in Children. *Lancet* 1974; **2**: 423-427.
98. Tarshish P, Tobin JN, Bernstein J *et al*. Cyclophosphamide does not benefit patients with focal segmental glomerulosclerosis. A report of the International Study of Kidney Disease in Children. *Pediatr Nephrol* 1996; **10**: 590-593.
99. Gipson DS, Massengill SF, Yao L *et al*. Management of childhood onset nephrotic syndrome. *Pediatrics* 2009; **124**: 747-757.
100. Abrantes MM, Cardoso LS, Lima EM *et al*. Predictive factors of chronic kidney disease in primary focal segmental glomerulosclerosis. *Pediatr Nephrol* 2006; **21**: 1003-1012.
101. Chitalia VC, Wells JE, Robson RA *et al*. Predicting renal survival in primary focal glomerulosclerosis from the time of presentation. *Kidney Int* 1999; **56**: 2236-2242.
102. Cosio FG, Hernandez RA. Favorable prognostic significance of raised serum C3 concentration in patients with idiopathic focal glomerulosclerosis. *Clin Nephrol* 1996; **45**: 146-152.
103. Troyanov S, Wall CA, Miller JA *et al*. Focal and segmental glomerulosclerosis: definition and relevance of a partial remission. *J Am Soc Nephrol* 2005; **16**: 1061-1068.
104. Hogg RJ, Furth S, Lemley KV *et al*. National Kidney Foundation's Kidney Disease Outcomes Quality Initiative clinical practice guidelines for chronic kidney disease in children and adolescents: evaluation, classification, and stratification. *Pediatrics* 2003; **111**: 1416-1421.
105. Chernin G, Heeringa SF, Gbadegesin R *et al*. Low prevalence of NPHS2 mutations in African American children with steroid-resistant nephrotic syndrome. *Pediatr Nephrol* 2008; **23**: 1455-1460.
106. Karle SM, Uetz B, Ronner V *et al*. Novel mutations in NPHS2 detected in both familial and sporadic steroid-resistant nephrotic syndrome. *J Am Soc Nephrol* 2002; **13**: 388-393.
107. Faul C, Donnelly M, Merscher-Gomez S *et al*. The actin cytoskeleton of kidney podocytes is a direct target of the antiproteinuric effect of cyclosporine A. *Nat Med* 2008; **14**: 931-938.
108. Garin EH, Orak JK, Hiott KL *et al*. Cyclosporine therapy for steroid-resistant nephrotic syndrome. A controlled study. *Am J Dis Child* 1988; **142**: 985-988.
109. Lieberman KV, Tejani A. A randomized double-blind placebo-controlled trial of cyclosporine in steroid-resistant idiopathic focal segmental glomerulosclerosis in children. *J Am Soc Nephrol* 1996; **7**: 56-63.
110. Ponticelli C, Rizzoni G, Edefonti A *et al*. A randomized trial of cyclosporine in steroid-resistant idiopathic nephrotic syndrome. *Kidney Int* 1993; **43**: 1377-1384.
111. Gipson DS, Trachtman H, Kaskel FJ *et al*. Clinical trial of focal segmental glomerulosclerosis in children and young adults. *Kidney Int* 2011; **80**: 868-878.
112. Caridi G, Perfumo F, Ghiggeri GM. NPHS2 (Podocin) mutations in nephrotic syndrome. Clinical spectrum and fine mechanisms. *Pediatr Res* 2005; **57**: 54R-61R.
113. Choudhry S, Bagga A, Hari P *et al*. Efficacy and safety of tacrolimus versus cyclosporine in children with steroid-resistant nephrotic syndrome: a randomized controlled trial. *Am J Kidney Dis* 2009; **53**: 760-769.
114. Winn MP. Not all in the family: mutations of podocin in sporadic steroid-resistant nephrotic syndrome. *J Am Soc Nephrol* 2002; **13**: 577-579.
115. Bagga A, Mudigoudar BD, Hari P *et al*. Enalapril dosage in steroid-resistant nephrotic syndrome. *Pediatr Nephrol* 2004; **19**: 45-50.
116. Li Z, Duan C, He J *et al*. Mycophenolate mofetil therapy for children with steroid-resistant nephrotic syndrome. *Pediatr Nephrol* 2010; **25**: 883-888.
117. Hari P, Bagga A, Mantan M. Short term efficacy of intravenous dexamethasone and methylprednisolone therapy in steroid resistant nephrotic syndrome. *Indian Pediatr* 2004; **41**: 993-1000.
118. de Mello VR, Rodrigues MT, Mastrocinque TH *et al*. Mycophenolate mofetil in children with steroid/cyclophosphamide-resistant nephrotic syndrome. *Pediatr Nephrol* 2010; **25**: 453-460.
119. Hodson EM, Craig JC. Therapies for steroid-resistant nephrotic syndrome. *Pediatr Nephrol* 2008; **23**: 1391-1394.
120. Plank C, Kalb V, Hinkes B *et al*. Cyclosporin A is superior to cyclophosphamide in children with steroid-resistant nephrotic syndrome—a randomized controlled multicentre trial by the Arbeitsgemeinschaft für Pädiatrische Nephrologie. *Pediatr Nephrol* 2008; **23**: 1483-1493.
121. Nachman PH, Jennette JC, Falk RJ. Primary glomerular diseases. In: Brenner BM (ed). *Brenner and Rector's The Kidney*, 8th edn. Saunders/Elsevier: Philadelphia, PA, 2008, pp 987-1066.
122. Arneil GC, Lam CN. Long-term assessment of steroid therapy in childhood nephrosis. *Lancet* 1966; **2**: 819-821.
123. Black DA, Rose G, Brewer DB. Controlled trial of prednisone in adult patients with the nephrotic syndrome. *Br Med J* 1970; **3**: 421-426.
124. Coggins CH. Adult minimal change nephropathy: experience of the collaborative study of glomerular disease. *Trans Am Clin Climatol Assoc* 1986; **97**: 18-26.
125. Huang JJ, Hsu SC, Chen FF *et al*. Adult-onset minimal change disease among Taiwanese: clinical features, therapeutic response, and prognosis. *Am J Nephrol* 2001; **21**: 28-34.
126. Radhakrishnan J, Appel AS, Valeri A *et al*. The nephrotic syndrome, lipids, and risk factors for cardiovascular disease. *Am J Kidney Dis* 1993; **22**: 135-142.
127. McIntyre P, Craig JC. Prevention of serious bacterial infection in children with nephrotic syndrome. *J Paediatr Child Health* 1998; **34**: 314-317.
128. Mahmoodi BK, ten Kate MK, Waanders F *et al*. High absolute risks and predictors of venous and arterial thromboembolic events in patients with nephrotic syndrome: results from a large retrospective cohort study. *Circulation* 2008; **117**: 224-230.
129. Mak SK, Short CD, Mallick NP. Long-term outcome of adult-onset minimal-change nephropathy. *Nephrol Dial Transplant* 1996; **11**: 2192-2201.
130. Waldman M, Crew RJ, Valeri A *et al*. Adult minimal-change disease: clinical characteristics, treatment, and outcomes. *Clin J Am Soc Nephrol* 2007; **2**: 445-453.
131. Korbet SM, Schwartz MM, Lewis EJ. Minimal-change glomerulopathy of adulthood. *Am J Nephrol* 1988; **8**: 291-297.
132. Nolasco F, Cameron JS, Heywood EF *et al*. Adult-onset minimal change nephrotic syndrome: a long-term follow-up. *Kidney Int* 1986; **29**: 1215-1223.
133. Tse KC, Lam MF, Yip PS *et al*. Idiopathic minimal change nephrotic syndrome in older adults: steroid responsiveness and pattern of relapses. *Nephrol Dial Transplant* 2003; **18**: 1316-1320.
134. Appel GB, Radhakrishnan J, d'Agati V. Secondary glomerular diseases. In: Brenner BM (ed). *Brenner and Rector's The Kidney*, 8th edn. Saunders/Elsevier: Philadelphia, PA, 2008, pp 1067-1146.
135. Hodson EM, Willis NS, Craig JC. Corticosteroid therapy for nephrotic syndrome in children. *Cochrane Database Syst Rev* 2007: CD001533.
136. Palmer SC, Nand K, Strippoli GF. Interventions for minimal change disease in adults with nephrotic syndrome. *Cochrane Database Syst Rev* 2008: CD001537.
137. Al-Khader AA, Lien JW, Aber GM. Cyclophosphamide alone in the treatment of adult patients with minimal change glomerulonephritis. *Clin Nephrol* 1979; **11**: 26-30.
138. Uldall PR, Feest TG, Morley AR *et al*. Cyclophosphamide therapy in adults with minimal-change nephrotic syndrome. *Lancet* 1972; **1**: 1250-1253.
139. Matsumoto H, Nakao T, Okada T *et al*. Favorable outcome of low-dose cyclosporine after pulse methylprednisolone in Japanese adult minimal-change nephrotic syndrome. *Intern Med* 2004; **43**: 668-673.
140. Li X, Li H, Chen J *et al*. Tacrolimus as a steroid-sparing agent for adults with steroid-dependent minimal change nephrotic syndrome. *Nephrol Dial Transplant* 2008; **23**: 1919-1925.
141. Meyrier A, Condamine MC, Broneer D. Treatment of adult idiopathic nephrotic syndrome with cyclosporin A: minimal-change disease and focal-segmental glomerulosclerosis. Collaborative Group of the French Society of Nephrology. *Clin Nephrol* 1991; **35**(Suppl 1): S37-S42.
142. Eguchi A, Takei T, Yoshida T *et al*. Combined cyclosporine and prednisolone therapy in adult patients with the first relapse of minimal-change nephrotic syndrome. *Nephrol Dial Transplant* 2010; **25**: 124-129.
143. Meyrier A, Niaudet P, Brodehl J. *Optimal use of Sandimmun in Nephrotic Syndrome*. Springer: Berlin, Germany, 1993.
144. Meyrier A, Noel LH, Auriche P *et al*. Long-term renal tolerance of cyclosporin A treatment in adult idiopathic nephrotic syndrome. Collaborative Group of the Societe de Nephrologie. *Kidney Int* 1994; **45**: 1446-1456.
145. Choi MJ, Eustace JA, Gimenez LF *et al*. Mycophenolate mofetil treatment for primary glomerular diseases. *Kidney Int* 2002; **61**: 1098-1114.
146. Fujinaga S, Ohtomo Y, Hirano D *et al*. Mycophenolate mofetil therapy for childhood-onset steroid dependent nephrotic syndrome after long-term cyclosporine: extended experience in a single center. *Clin Nephrol* 2009; **72**: 268-273.

147. Siu YP, Tong MK, Leung K *et al*. The use of enteric-coated mycophenolate sodium in the treatment of relapsing and steroid-dependent minimal change disease. *J Nephrol* 2008; **21**: 127–131.
148. Jennette JC, Falk RJ. Adult minimal change glomerulopathy with acute renal failure. *Am J Kidney Dis* 1990; **16**: 432–437.
149. Lechner BL, Bockenhauer D, Iragorri S *et al*. The risk of cardiovascular disease in adults who have had childhood nephrotic syndrome. *Pediatr Nephrol* 2004; **19**: 744–748.
150. Yalavarthy R, Smith ML, Edelstein C. Acute kidney injury complicating minimal change disease: the case for careful use of diuretics and angiotensin-converting enzyme inhibitors. *Nephrology (Carlton)* 2007; **12**: 529–531.
151. Colquitt JL, Kirby J, Green C *et al*. The clinical effectiveness and cost-effectiveness of treatments for children with idiopathic steroid-resistant nephrotic syndrome: a systematic review. *Health Technol Assess* 2007; **11**: iii–iv, ix–xi, 1–93.
152. D'Agati V. Pathologic classification of focal segmental glomerulosclerosis. *Semin Nephrol* 2003; **23**: 117–134.
153. Braden GL, Mulhern JG, O'Shea MH *et al*. Changing incidence of glomerular diseases in adults. *Am J Kidney Dis* 2000; **35**: 878–883.
154. Haas M, Meehan SM, Karrison TG *et al*. Changing etiologies of unexplained adult nephrotic syndrome: a comparison of renal biopsy findings from 1976 to 1979 and 1995 to 1997. *Am J Kidney Dis* 1997; **30**: 621–631.
155. Deegens JK, Steenbergen EJ, Wetzels JF. Review on diagnosis and treatment of focal segmental glomerulosclerosis. *Neth J Med* 2008; **66**: 3–12.
156. Deegens JK, Dijkman HB, Borm GF *et al*. Podocyte foot process effacement as a diagnostic tool in focal segmental glomerulosclerosis. *Kidney Int* 2008; **74**: 1568–1576.
157. Aucella F, De Bonis P, Gatta G *et al*. Molecular analysis of NPHS2 and ACTN4 genes in a series of 33 Italian patients affected by adult-onset nonfamilial focal segmental glomerulosclerosis. *Nephron Clin Pract* 2005; **99**: c31–c36.
158. Caridi G, Bertelli R, Scolari F *et al*. Podocin mutations in sporadic focal-segmental glomerulosclerosis occurring in adulthood. *Kidney Int* 2003; **64**: 365.
159. Gigante M, Pontrelli P, Montemurro E *et al*. CD2AP mutations are associated with sporadic nephrotic syndrome and focal segmental glomerulosclerosis (FSGS). *Nephrol Dial Transplant* 2009; **24**: 1858–1864.
160. He N, Zahirieh A, Mei Y *et al*. Recessive NPHS2 (Podocin) mutations are rare in adult-onset idiopathic focal segmental glomerulosclerosis. *Clin J Am Soc Nephrol* 2007; **2**: 31–37.
161. Machuca E, Hummel A, Nevo F *et al*. Clinical and epidemiological assessment of steroid-resistant nephrotic syndrome associated with the NPHS2 R229Q variant. *Kidney Int* 2009; **75**: 727–735.
162. Santin S, Ars E, Rossetti S *et al*. TRPC6 mutational analysis in a large cohort of patients with focal segmental glomerulosclerosis. *Nephrol Dial Transplant* 2009; **24**: 3089–3096.
163. Santin S, Garcia-Maset R, Ruiz P *et al*. Nephrin mutations cause childhood- and adult-onset focal segmental glomerulosclerosis. *Kidney Int* 2009; **76**: 1268–1276.
164. Genovese G, Friedman DJ, Ross MD *et al*. Association of trypanolytic ApoL1 variants with kidney disease in African Americans. *Science* 2010; **329**: 841–845.
165. Cameron JS, Turner DR, Ogg CS *et al*. The long-term prognosis of patients with focal segmental glomerulosclerosis. *Clin Nephrol* 1978; **10**: 213–218.
166. Korbet SM, Schwartz MM, Lewis EJ. Primary focal segmental glomerulosclerosis: clinical course and response to therapy. *Am J Kidney Dis* 1994; **23**: 773–783.
167. Velosa JA, Donadio Jr JV, Holley KE. Focal sclerosing glomerulonephropathy: a clinicopathologic study. *Mayo Clin Proc* 1975; **50**: 121–133.
168. Banfi G, Moriggi M, Sabadini E *et al*. The impact of prolonged immunosuppression on the outcome of idiopathic focal-segmental glomerulosclerosis with nephrotic syndrome in adults. A collaborative retrospective study. *Clin Nephrol* 1991; **36**: 53–59.
169. Cattran DC, Rao P. Long-term outcome in children and adults with classic focal segmental glomerulosclerosis. *Am J Kidney Dis* 1998; **32**: 72–79.
170. Korbet SM. Treatment of primary focal segmental glomerulosclerosis. *Kidney Int* 2002; **62**: 2301–2310.
171. Rydel JJ, Korbet SM, Borok RZ *et al*. Focal segmental glomerular sclerosis in adults: presentation, course, and response to treatment. *Am J Kidney Dis* 1995; **25**: 534–542.
172. Goumenos DS, Tsagalis G, El Nahas AM *et al*. Immunosuppressive treatment of idiopathic focal segmental glomerulosclerosis: a five-year follow-up study. *Nephron Clin Pract* 2006; **104**: c75–c82.
173. Pei Y, Cattran D, Delmore T *et al*. Evidence suggesting under-treatment in adults with idiopathic focal segmental glomerulosclerosis. Regional Glomerulonephritis Registry Study. *Am J Med* 1987; **82**: 938–944.
174. Stirling CM, Mathieson P, Boulton-Jones JM *et al*. Treatment and outcome of adult patients with primary focal segmental glomerulosclerosis in five UK renal units. *QJM* 2005; **98**: 443–449.
175. Wehrmann M, Bohle A, Held H *et al*. Long-term prognosis of focal sclerosing glomerulonephritis. An analysis of 250 cases with particular regard to tubulointerstitial changes. *Clin Nephrol* 1990; **33**: 115–122.
176. Caridi G, Gigante M, Ravani P *et al*. Clinical features and long-term outcome of nephrotic syndrome associated with heterozygous NPHS1 and NPHS2 mutations. *Clin J Am Soc Nephrol* 2009; **4**: 1065–1072.
177. Beaufils H, Alphonse JC, Guedon J *et al*. Focal glomerulosclerosis: natural history and treatment. A report of 70 cases. *Nephron* 1978; **21**: 75–85.
178. Praga M, Martinez MA, Andres A *et al*. Acute renal failure and tubular dysfunction associated with minimal change nephrotic syndrome. *Nephrol Dial Transplant* 1989; **4**: 914–916.
179. Deegens JK, Assmann KJ, Steenbergen EJ *et al*. Idiopathic focal segmental glomerulosclerosis: a favourable prognosis in untreated patients? *Neth J Med* 2005; **63**: 393–398.
180. Gupta K, Iskandar SS, Daeiagh P *et al*. Distribution of pathologic findings in individuals with nephrotic proteinuria according to serum albumin. *Nephrol Dial Transplant* 2008; **23**: 1595–1599.
181. Duncan N, Dhaygude A, Owen J *et al*. Treatment of focal and segmental glomerulosclerosis in adults with tacrolimus monotherapy. *Nephrol Dial Transplant* 2004; **19**: 3062–3067.
182. Cattran DC, Alexopoulos E, Heering P *et al*. Cyclosporin in idiopathic glomerular disease associated with the nephrotic syndrome: workshop recommendations. *Kidney Int* 2007; **72**: 1429–1447.
183. Shiiki H, Nishino T, Uyama H *et al*. Clinical and morphological predictors of renal outcome in adult patients with focal and segmental glomerulosclerosis (FSGS). *Clin Nephrol* 1996; **46**: 362–368.
184. Braun N, Schmutzler F, Lange C *et al*. Immunosuppressive treatment for focal segmental glomerulosclerosis in adults. *Cochrane Database of Systematic Reviews* 2008: CD003233.
185. Cattran DC, Appel GB, Hebert LA *et al*. A randomized trial of cyclosporine in patients with steroid-resistant focal segmental glomerulosclerosis. North America Nephrotic Syndrome Study Group. *Kidney Int* 1999; **56**: 2220–2226.
186. Ghiggeri GM, Catarsi P, Scolari F *et al*. Cyclosporine in patients with steroid-resistant nephrotic syndrome: an open-label, nonrandomized, retrospective study. *Clin Ther* 2004; **26**: 1411–1418.
187. Heering P, Braun N, Mullejans R *et al*. Cyclosporine A and chlorambucil in the treatment of idiopathic focal segmental glomerulosclerosis. *Am J Kidney Dis* 2004; **43**: 10–18.
188. Ittel TH, Clasen W, Fuhs M *et al*. Long-term ciclosporine A treatment in adults with minimal change nephrotic syndrome or focal segmental glomerulosclerosis. *Clin Nephrol* 1995; **44**: 156–162.
189. Melocoton TL, Kamil ES, Cohen AH *et al*. Long-term cyclosporine A treatment of steroid-resistant and steroid-dependent nephrotic syndrome. *Am J Kidney Dis* 1991; **18**: 583–588.
190. Segarra A, Vila J, Pou L *et al*. Combined therapy of tacrolimus and corticosteroids in cyclosporin-resistant or -dependent idiopathic focal glomerulosclerosis: a preliminary uncontrolled study with prospective follow-up. *Nephrol Dial Transplant* 2002; **17**: 655–662.
191. Abe S, Amagasaki Y, Konishi K *et al*. Idiopathic membranous glomerulonephritis: aspects of geographical differences. *J Clin Pathol* 1986; **39**: 1193–1198.
192. Cahen R, Francois B, Trollet P *et al*. Aetiology of membranous glomerulonephritis: a prospective study of 82 adult patients. *Nephrol Dial Transplant* 1989; **4**: 172–180.
193. Schwartz MM. Membranous glomerulonephritis. In: Jennette JC, Olson JL, Schwartz MM (eds). *Heptinstall's Pathology of the Kidney*, 6th edn, vol. 1. Lippincott Williams & Wilkins: Philadelphia, PA, 2007, pp 205–251.
194. Kuroki A, Shibata T, Honda H *et al*. Glomerular and serum IgG subclasses in diffuse proliferative lupus nephritis, membranous lupus nephritis, and idiopathic membranous nephropathy. *Intern Med* 2002; **41**: 936–942.
195. Ohtani H, Wakui H, Komatsuda A *et al*. Distribution of glomerular IgG subclass deposits in malignancy-associated membranous nephropathy. *Nephrol Dial Transplant* 2004; **19**: 574–579.
196. Zeng CH, Chen HM, Wang RS *et al*. Etiology and clinical characteristics of membranous nephropathy in Chinese patients. *Am J Kidney Dis* 2008; **52**: 691–698.

197. Honkanen E. Survival in idiopathic membranous glomerulonephritis. *Clin Nephrol* 1986; **25**: 122–128.
198. Ehrenreich T, Porush JG, Churg J *et al*. Treatment of idiopathic membranous nephropathy. *N Engl J Med* 1976; **295**: 741–746.
199. Lefaucheur C, Stengel B, Nochy D *et al*. Membranous nephropathy and cancer: Epidemiologic evidence and determinants of high-risk cancer association. *Kidney Int* 2006; **70**: 1510–1517.
200. Beck Jr LH, Bonegio RG, Lambeau G *et al*. M-type phospholipase A2 receptor as target antigen in idiopathic membranous nephropathy. *N Engl J Med* 2009; **361**: 11–21.
201. Glasscock RJ. Secondary membranous glomerulonephritis. *Nephrol Dial Transplant* 1992; **7**(Suppl 1): 64–71.
202. Gluck MC, Gallo G, Lowenstein J *et al*. Membranous glomerulonephritis. Evolution of clinical and pathologic features. *Ann Intern Med* 1973; **78**: 1–12.
203. Burstein DM, Korbet SM, Schwartz MM. Membranous glomerulonephritis and malignancy. *Am J Kidney Dis* 1993; **22**: 5–10.
204. Jha V, Ganguli A, Saha TK *et al*. A randomized, controlled trial of steroids and cyclophosphamide in adults with nephrotic syndrome caused by idiopathic membranous nephropathy. *J Am Soc Nephrol* 2007; **18**: 1899–1904.
205. Passerini P, Ponticelli C. Membranous nephropathy. In: Ponticelli C, Glasscock R (eds). *Treatment of Primary Glomerulonephritis*, 2nd edn. Oxford University Press: Oxford, UK, 2009, pp 261–312.
206. Glasscock RJ. Diagnosis and natural course of membranous nephropathy. *Semin Nephrol* 2003; **23**: 324–332.
207. Cameron JS. Membranous nephropathy and its treatment. *Nephrol Dial Transplant* 1992; **7**(Suppl 1): 72–79.
208. Cattran DC. Idiopathic membranous glomerulonephritis. *Kidney Int* 2001; **59**: 1983–1994.
209. Donadio Jr JV, Torres VE, Velosa JA *et al*. Idiopathic membranous nephropathy: the natural history of untreated patients. *Kidney Int* 1988; **33**: 708–715.
210. Erwin DT, Donadio Jr JV, Holley KE. The clinical course of idiopathic membranous nephropathy. *Mayo Clin Proc* 1973; **48**: 697–712.
211. Hopper Jr J, Trew PA, Biava CG. Membranous nephropathy: its relative benignity in women. *Nephron* 1981; **29**: 18–24.
212. Murphy BF, Fairley KF, Kincaid-Smith PS. Idiopathic membranous glomerulonephritis: long-term follow-up in 139 cases. *Clin Nephrol* 1988; **30**: 175–181.
213. Row PG, Cameron JS, Turner DR *et al*. Membranous nephropathy. Long-term follow-up and association with neoplasia. *Q J Med* 1975; **44**: 207–239.
214. Schieppati A, Mosconi L, Perna A *et al*. Prognosis of untreated patients with idiopathic membranous nephropathy. *N Engl J Med* 1993; **329**: 85–89.
215. Polanco N, Gutierrez E, Covarsi A *et al*. Spontaneous remission of nephrotic syndrome in idiopathic membranous nephropathy. *J Am Soc Nephrol* 2010; **21**: 697–704.
216. Cattran D. Management of membranous nephropathy: when and what for treatment. *J Am Soc Nephrol* 2005; **16**: 1188–1194.
217. Cattran DC, Reich HN, Beanlands HJ *et al*. The impact of sex in primary glomerulonephritis. *Nephrol Dial Transplant* 2008; **23**: 2247–2253.
218. Pei Y, Cattran D, Greenwood C. Predicting chronic renal insufficiency in idiopathic membranous glomerulonephritis. *Kidney Int* 1992; **42**: 960–966.
219. Cattran DC, Pei Y, Greenwood CM *et al*. Validation of a predictive model of idiopathic membranous nephropathy: its clinical and research implications. *Kidney Int* 1997; **51**: 901–907.
220. Fervenza FC, Sethi S, Specks U. Idiopathic membranous nephropathy: diagnosis and treatment. *Clin J Am Soc Nephrol* 2008; **3**: 905–919.
221. Laluck Jr BJ, Cattran DC. Prognosis after a complete remission in adult patients with idiopathic membranous nephropathy. *Am J Kidney Dis* 1999; **33**: 1026–1032.
222. Troyanov S, Wall CA, Miller JA *et al*. Idiopathic membranous nephropathy: definition and relevance of a partial remission. *Kidney Int* 2004; **66**: 1199–1205.
223. Kosmadakis G, Filiopoulos V, Georgoulis C *et al*. Comparison of the influence of angiotensin-converting enzyme inhibitor lisinopril and angiotensin II receptor antagonist losartan in patients with idiopathic membranous nephropathy and nephrotic syndrome. *Scand J Urol Nephrol* 2010; **44**: 251–256.
224. Reichert LJ, Koene RA, Wetzels JF. Urinary excretion of beta 2-microglobulin predicts renal outcome in patients with idiopathic membranous nephropathy. *J Am Soc Nephrol* 1995; **6**: 1666–1669.
225. Reichert LJ, Koene RA, Wetzels JF. Urinary IgG excretion as a prognostic factor in idiopathic membranous nephropathy. *Clin Nephrol* 1997; **48**: 79–84.
226. Donadio Jr JV, Holley KE, Anderson CF *et al*. Controlled trial of cyclophosphamide in idiopathic membranous nephropathy. *Kidney Int* 1974; **6**: 431–439.
227. Murphy BF, McDonald I, Fairley KF *et al*. Randomized controlled trial of cyclophosphamide, warfarin and dipyridamole in idiopathic membranous glomerulonephritis. *Clin Nephrol* 1992; **37**: 229–234.
228. Shearman JD, Yin ZG, Aarons I *et al*. The effect of treatment with prednisolone or cyclophosphamide-warfarin-dipyridamole combination on the outcome of patients with membranous nephropathy. *Clin Nephrol* 1988; **30**: 320–329.
229. Ponticelli C, Zucchelli P, Imbasciati E *et al*. Controlled trial of methylprednisolone and chlorambucil in idiopathic membranous nephropathy. *N Engl J Med* 1984; **310**: 946–950.
230. Falk RJ, Hogan SL, Muller KE *et al*. Treatment of progressive membranous glomerulopathy. A randomized trial comparing cyclophosphamide and corticosteroids with corticosteroids alone. The Glomerular Disease Collaborative Network. *Ann Intern Med* 1992; **116**: 438–445.
231. McQuarrie EP, Stirling CM, Geddes CC. Idiopathic membranous nephropathy and nephrotic syndrome: outcome in the era of evidence-based therapy. *Nephrol Dial Transplant* 2012; **27**: 235–242.
232. Ponticelli C, Zucchelli P, Passerini P *et al*. A randomized trial of methylprednisolone and chlorambucil in idiopathic membranous nephropathy. *N Engl J Med* 1989; **320**: 8–13.
233. Ponticelli C, Zucchelli P, Passerini P *et al*. A 10-year follow-up of a randomized study with methylprednisolone and chlorambucil in membranous nephropathy. *Kidney Int* 1995; **48**: 1600–1604.
234. Ponticelli C, Zucchelli P, Passerini P *et al*. Methylprednisolone plus chlorambucil as compared with methylprednisolone alone for the treatment of idiopathic membranous nephropathy. The Italian Idiopathic Membranous Nephropathy Treatment Study Group. *N Engl J Med* 1992; **327**: 599–603.
235. Ponticelli C, Altieri P, Scolari F *et al*. A randomized study comparing methylprednisolone plus chlorambucil versus methylprednisolone plus cyclophosphamide in idiopathic membranous nephropathy. *J Am Soc Nephrol* 1998; **9**: 444–450.
236. Hogan SL, Muller KE, Jennette JC *et al*. A review of therapeutic studies of idiopathic membranous glomerulopathy. *Am J Kidney Dis* 1995; **25**: 862–875.
237. Imperiale TF, Goldfarb S, Berns JS. Are cytotoxic agents beneficial in idiopathic membranous nephropathy? A meta-analysis of the controlled trials. *J Am Soc Nephrol* 1995; **5**: 1553–1558.
238. Jindal K, West M, Bear R *et al*. Long-term benefits of therapy with cyclophosphamide and prednisone in patients with membranous glomerulonephritis and impaired renal function. *Am J Kidney Dis* 1992; **19**: 61–67.
239. Perna A, Schieppati A, Zamora J *et al*. Immunosuppressive treatment for idiopathic membranous nephropathy: a systematic review. *Am J Kidney Dis* 2004; **44**: 385–401.
240. West ML, Jindal KK, Bear RA *et al*. A controlled trial of cyclophosphamide in patients with membranous glomerulonephritis. *Kidney Int* 1987; **32**: 579–584.
241. Hofstra JM, Branten AJ, Wirtz JJ *et al*. Early versus late start of immunosuppressive therapy in idiopathic membranous nephropathy: a randomized controlled trial. *Nephrol Dial Transplant* 2010; **25**: 129–136.
242. Branten AJ, Reichert LJ, Koene RA *et al*. Oral cyclophosphamide versus chlorambucil in the treatment of patients with membranous nephropathy and renal insufficiency. *QJM* 1998; **91**: 359–366.
243. du Buf-Vereijken PW, Branten AJ, Wetzels JF. Cytotoxic therapy for membranous nephropathy and renal insufficiency: improved renal survival but high relapse rate. *Nephrol Dial Transplant* 2004; **19**: 1142–1148.
244. Rose GA, Black DAK, Members of Working Party. Controlled trial of azathioprine and prednisone in chronic renal disease. Report by Medical Research Council Working Party. *Br Med J* 1971; **2**: 239–241.
245. Western Canadian Glomerulonephritis Study Group. Controlled trial of azathioprine in the nephrotic syndrome secondary to idiopathic membranous glomerulonephritis. *Can Med Assoc J* 1976; **115**: 1209–1210.
246. Lagrue G, Bernard D, Bariety J *et al*. [Treatment with chlorambucil and azathioprine in primary glomerulonephritis. Results of a 'controlled' study]. *J Urol Nephrol (Paris)* 1975; **81**: 655–672.
247. Ambalavanan S, Fauvel JP, Sibley RK *et al*. Mechanism of the antiproteinuric effect of cyclosporine in membranous nephropathy. *J Am Soc Nephrol* 1996; **7**: 290–298.

248. Guasch A, Suranyi M, Newton L *et al*. Short-term responsiveness of membranous glomerulopathy to cyclosporine. *Am J Kidney Dis* 1992; **20**: 472–481.
249. Cattran DC, Appel GB, Hebert LA *et al*. Cyclosporine in patients with steroid-resistant membranous nephropathy: a randomized trial. *Kidney Int* 2001; **59**: 1484–1490.
250. Alexopoulos E, Papagianni A, Tsamelashvili M *et al*. Induction and long-term treatment with cyclosporin A in membranous glomerulonephritis with the nephrotic syndrome (abstract). *J Am Soc Nephrol* 2005; **16**: 780A.
251. Cattran DC, Greenwood C, Ritchie S *et al*. A controlled trial of cyclosporine in patients with progressive membranous nephropathy. Canadian Glomerulonephritis Study Group. *Kidney Int* 1995; **47**: 1130–1135.
252. DeSanto NG, Capodicasa G, Giordano C. Treatment of idiopathic membranous nephropathy unresponsive to methylprednisolone and chlorambucil with cyclosporin. *Am J Nephrol* 1987; **7**: 74–76.
253. Rostoker G, Belghiti D, Ben Maadi A *et al*. Long-term cyclosporin A therapy for severe idiopathic membranous nephropathy. *Nephron* 1993; **63**: 335–341.
254. Praga M, Barrio V, Juarez GF *et al*. Tacrolimus monotherapy in membranous nephropathy: a randomized controlled trial. *Kidney Int* 2007; **71**: 924–930.
255. Bruns FJ, Adler S, Fraley DS *et al*. Sustained remission of membranous glomerulonephritis after cyclophosphamide and prednisone. *Ann Intern Med* 1991; **114**: 725–730.
256. Mathieson PW, Turner AN, Maidment CG *et al*. Prednisolone and chlorambucil treatment in idiopathic membranous nephropathy with deteriorating renal function. *Lancet* 1988; **2**: 869–872.
257. Torres A, Dominguez-Gil B, Carreno A *et al*. Conservative versus immunosuppressive treatment of patients with idiopathic membranous nephropathy. *Kidney Int* 2002; **61**: 219–227.
258. Warwick GL, Geddes CG, Boulton-Jones JM. Prednisolone and chlorambucil therapy for idiopathic membranous nephropathy with progressive renal failure. *Q J Med* 1994; **87**: 223–229.
259. Chen M, Li H, Li XY *et al*. Tacrolimus combined with corticosteroids in treatment of nephrotic idiopathic membranous nephropathy: a multicenter randomized controlled trial. *Am J Med Sci* 2010; **339**: 233–238.
260. A controlled study of short-term prednisone treatment in adults with membranous nephropathy. Collaborative Study of the Adult Idiopathic Nephrotic Syndrome. *N Engl J Med* 1979; **301**: 1301–1306.
261. Cattran DC, Delmore T, Roscoe J *et al*. A randomized controlled trial of prednisone in patients with idiopathic membranous nephropathy. *N Engl J Med* 1989; **320**: 210–215.
262. Shiiki H, Saito T, Nishitani Y *et al*. Prognosis and risk factors for idiopathic membranous nephropathy with nephrotic syndrome in Japan. *Kidney Int* 2004; **65**: 1400–1407.
263. Branten AJ, du Buf-Vereijken PW, Vervloet M *et al*. Mycophenolate mofetil in idiopathic membranous nephropathy: a clinical trial with comparison to a historic control group treated with cyclophosphamide. *Am J Kidney Dis* 2007; **50**: 248–256.
264. Chan TM, Lin AW, Tang SC *et al*. Prospective controlled study on mycophenolate mofetil and prednisolone in the treatment of membranous nephropathy with nephrotic syndrome. *Nephrology (Carlton)* 2007; **12**: 576–581.
- 264a. Senthil Nayagam L, Ganguli A, Rathi M *et al*. Mycophenolate mofetil or standard therapy for membranous nephropathy and focal segmental glomerulosclerosis: a pilot study. *Nephrol Dial Transplant* 2008; **23**: 1926–1930.
265. Dussol B, Morange S, Burtey S *et al*. Mycophenolate mofetil monotherapy in membranous nephropathy: a 1-year randomized controlled trial. *Am J Kidney Dis* 2008; **52**: 699–705.
266. Remuzzi G, Chiurciu C, Abbate M *et al*. Rituximab for idiopathic membranous nephropathy. *Lancet* 2002; **360**: 923–924.
267. Ruggenti P, Chiurciu C, Brusegan V *et al*. Rituximab in idiopathic membranous nephropathy: a one-year prospective study. *J Am Soc Nephrol* 2003; **14**: 1851–1857.
268. Ruggenti P, Chiurciu C, Abbate M *et al*. Rituximab for idiopathic membranous nephropathy: who can benefit? *Clin J Am Soc Nephrol* 2006; **1**: 738–748.
269. Fervenza FC, Cosio FG, Erickson SB *et al*. Rituximab treatment of idiopathic membranous nephropathy. *Kidney Int* 2008; **73**: 117–125.
270. Cravedi P, Ruggenti P, Sghirlanzoni MC *et al*. Titrating rituximab to circulating B cells to optimize lymphocytolytic therapy in idiopathic membranous nephropathy. *Clin J Am Soc Nephrol* 2007; **2**: 932–937.
271. Fervenza FC, Abraham RS, Erickson SB *et al*. Rituximab therapy in idiopathic membranous nephropathy: a 2-year study. *Clin J Am Soc Nephrol* 2010; **5**: 2188–2198.
272. Berg AL, Arnadottir M. ACTH-induced improvement in the nephrotic syndrome in patients with a variety of diagnoses. *Nephrol Dial Transplant* 2004; **19**: 1305–1307.
273. Berg AL, Nilsson-Ehle P, Arnadottir M. Beneficial effects of ACTH on the serum lipoprotein profile and glomerular function in patients with membranous nephropathy. *Kidney Int* 1999; **56**: 1534–1543.
274. Ponticelli C, Passerini P, Salvadori M *et al*. A randomized pilot trial comparing methylprednisolone plus a cytotoxic agent versus synthetic adrenocorticotrophic hormone in idiopathic membranous nephropathy. *Am J Kidney Dis* 2006; **47**: 233–240.
275. Ahmed S, Rahman M, Alam MR *et al*. Methyl prednisolone plus chlorambucil as compared with prednisolone alone for the treatment of idiopathic membranous nephropathy. A preliminary study. *Bangladesh Renal J* 1994; **13**: 51–54.
276. Reichert LJ, Huysmans FT, Assmann K *et al*. Preserving renal function in patients with membranous nephropathy: daily oral chlorambucil compared with intermittent monthly pulses of cyclophosphamide. *Ann Intern Med* 1994; **121**: 328–333.
277. Bomback AS, Derebail VK, McGregor JG *et al*. Rituximab therapy for membranous nephropathy: a systematic review. *Clin J Am Soc Nephrol* 2009; **4**: 734–744.
278. Nasr SH, Said SM, Valeri AM *et al*. Membranous glomerulonephritis with ANCA-associated necrotizing and crescentic glomerulonephritis. *Clin J Am Soc Nephrol* 2009; **4**: 299–308.
279. Troxell ML, Saxena AB, Kambham N. Concurrent anti-glomerular basement membrane disease and membranous glomerulonephritis: a case report and literature review. *Clin Nephrol* 2006; **66**: 120–127.
280. Waldman M, Austin III HA. Controversies in the treatment of idiopathic membranous nephropathy. *Nat Rev Nephrol* 2009; **5**: 469–479.
281. Ponticelli C, Passerini P, Altieri P *et al*. Remissions and relapses in idiopathic membranous nephropathy. *Nephrol Dial Transplant* 1992; **7**(Suppl 1): 85–90.
282. Suki WN, Trimarchi H, Frommer JP. Relapsing membranous nephropathy. Response to therapy of relapses compared to that of the original disease. *Am J Nephrol* 1999; **19**: 474–479.
283. du Buf-Vereijken PW, Wetzels JF. Efficacy of a second course of immunosuppressive therapy in patients with membranous nephropathy and persistent or relapsing disease activity. *Nephrol Dial Transplant* 2004; **19**: 2036–2043.
284. Fauschou M, Sorensen IJ, Mellemkjaer L *et al*. Malignancies in Wegener's granulomatosis: incidence and relation to cyclophosphamide therapy in a cohort of 293 patients. *J Rheumatol* 2008; **35**: 100–105.
285. Segarra A, Praga M, Ramos N *et al*. Successful treatment of membranous glomerulonephritis with rituximab in calcineurin inhibitor-dependent patients. *Clin J Am Soc Nephrol* 2009; **4**: 1083–1088.
286. Nephrotic syndrome in children: prediction of histopathology from clinical and laboratory characteristics at time of diagnosis. A report of the International Study of Kidney Disease in Children. *Kidney Int* 1978; **13**: 159–165.
287. USRDS 2008. *Annual data report: Atlas of chronic kidney disease*. Atlas of end-stage renal disease. US Renal Data System, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases: Bethesda, MD, 2008.
288. Menon S, Valentini RP. Membranous nephropathy in children: clinical presentation and therapeutic approach. *Pediatr Nephrol* 2010; **25**: 1419–1428.
289. Makker SP. Treatment of membranous nephropathy in children. *Semin Nephrol* 2003; **23**: 379–385.
290. Watson AR, Rance CP, Bain J. Long term effects of cyclophosphamide on testicular function. *Br Med J (Clin Res Ed)* 1985; **291**: 1457–1460.
291. Habib R, Kleinknecht C, Gubler MC. Extramembranous glomerulonephritis in children: report of 50 cases. *J Pediatr* 1973; **82**: 754–766.
292. Olbing H, Greifer I, Bennett BP *et al*. Idiopathic membranous nephropathy in children. *Kidney Int* 1973; **3**: 381–390.
293. Chan WC, Tsao YC. Diffuse membranous glomerulonephritis in children. *J Clin Pathol* 1966; **19**: 464–469.
294. Trainin EB, Boichis H, Spitzer A *et al*. Idiopathic membranous nephropathy. Clinical course in children. *N Y State J Med* 1976; **76**: 357–360.
295. Latham P, Poucell S, Koresaar A *et al*. Idiopathic membranous glomerulopathy in Canadian children: a clinicopathologic study. *J Pediatr* 1982; **101**: 682–685.

296. Ramirez F, Brouhard BH, Travis LB *et al*. Idiopathic membranous nephropathy in children. *J Pediatr* 1982; **101**: 677–681.
297. Tsukahara H, Takahashi Y, Yoshimoto M *et al*. Clinical course and outcome of idiopathic membranous nephropathy in Japanese children. *Pediatr Nephrol* 1993; **7**: 387–391.
298. Lee BH, Cho HY, Kang HG *et al*. Idiopathic membranous nephropathy in children. *Pediatr Nephrol* 2006; **21**: 1707–1715.
299. Chen A, Frank R, Vento S *et al*. Idiopathic membranous nephropathy in pediatric patients: presentation, response to therapy, and long-term outcome. *BMC Nephrol* 2007; **8**: 11.
300. Valentini RP, Mattoo TK, Kapur G *et al*. Membranous glomerulonephritis: treatment response and outcome in children. *Pediatr Nephrol* 2009; **24**: 301–308.
301. Bellomo R, Atkins RC. Membranous nephropathy and thromboembolism: is prophylactic anticoagulation warranted? *Nephron* 1993; **63**: 249–254.
302. Glassock RJ. Prophylactic anticoagulation in nephrotic syndrome: a clinical conundrum. *J Am Soc Nephrol* 2007; **18**: 2221–2225.
303. Sarasin FP, Schifferli JA. Prophylactic oral anticoagulation in nephrotic patients with idiopathic membranous nephropathy. *Kidney Int* 1994; **45**: 578–585.
304. Glassock RJ. Membranoproliferative glomerulonephritis. In: Molony DA, Craig JC (eds). *Evidence-based Nephrology*, 1st edn. John Wiley & Sons: Hoboken, NJ, 2008, pp 183–195.
305. Glassock RJ. Membranoproliferative glomerulonephritis. In: Ponticelli C, Glassock R (eds). *Treatment of Primary Glomerulonephritis*, 2nd edn. Oxford University Press: Oxford, UK, 2009, pp 375–398.
306. West CD, McAdams AJ, McConville JM *et al*. Hypocomplementemic and normocomplementemic persistent (chronic) glomerulonephritis; clinical and pathologic characteristics. *J Pediatr* 1965; **67**: 1089–1112.
307. Fakhouri F, Fremeaux-Bacchi V, Noel LH *et al*. C3 glomerulopathy: a new classification. *Nat Rev Nephrol* 2010; **6**: 494–499.
308. Sethi S, Fervenza FC. Membranoproliferative glomerulonephritis: pathogenetic heterogeneity and proposal for a new classification. *Semin Nephrol* 2011; **31**: 341–348.
309. Appel GB, Cook HT, Hageman G *et al*. Membranoproliferative glomerulonephritis type II (dense deposit disease): an update. *J Am Soc Nephrol* 2005; **16**: 1392–1403.
310. Holley KE, Donadio JV. Membranoproliferative glomerulonephritis. In: Tisher CC, Brenner BM (eds). *Renal Pathology (with Clinical and Functional Correlations)*, 2nd edn. JB Lippincott and Co: Philadelphia, PA, 1994, pp 294–329.
311. Servais A, Fremeaux-Bacchi V, Salomon R *et al*. Mutations in complement regulatory genes, Factor H, I and CD46 and C3 nephritic factor predispose to membranoproliferative glomerulonephritis with isolated mesangial C3 deposition (abstract). *J Am Soc Nephrol* 2005; **16**: 51A.
312. Schwartz R, Rother U, Anders D *et al*. Complement analysis in children with idiopathic membranoproliferative glomerulonephritis: a long-term follow-up. *Pediatr Allergy Immunol* 2001; **12**: 166–172.
313. Smith RJ, Alexander J, Barlow PN *et al*. New approaches to the treatment of dense deposit disease. *J Am Soc Nephrol* 2007; **18**: 2447–2456.
314. Asinobi AO, Gbadegesin RA, Adeyemo AA *et al*. The predominance of membranoproliferative glomerulonephritis in childhood nephrotic syndrome in Ibadan, Nigeria. *West Afr J Med* 1999; **18**: 203–206.
315. Donadio Jr JV, Anderson CF, Mitchell III JC *et al*. Membranoproliferative glomerulonephritis. A prospective clinical trial of platelet-inhibitor therapy. *N Engl J Med* 1984; **310**: 1421–1426.
316. Donadio Jr JV, Offord KP. Reassessment of treatment results in membranoproliferative glomerulonephritis, with emphasis on life-table analysis. *Am J Kidney Dis* 1989; **14**: 445–451.
317. Emre S, Sirin A, Alpaya H *et al*. Pulse methylprednisolone therapy in children with membranoproliferative glomerulonephritis. *Acta Paediatr Jpn* 1995; **37**: 626–629.
318. Zauner I, Bohler J, Braun N *et al*. Effect of aspirin and dipyridamole on proteinuria in idiopathic membranoproliferative glomerulonephritis: a multicentre prospective clinical trial. Collaborative Glomerulonephritis Therapy Study Group (CGTS). *Nephrol Dial Transplant* 1994; **9**: 619–622.
319. McEnery PT. Membranoproliferative glomerulonephritis: the Cincinnati experience—cumulative renal survival from 1957 to 1989. *J Pediatr* 1990; **116**: S109–S114.
320. McEnery PT, McAdams AJ, West CD. The effect of prednisone in a high-dose, alternate-day regimen on the natural history of idiopathic membranoproliferative glomerulonephritis. *Medicine (Baltimore)* 1985; **64**: 401–424.
321. Tarshish P, Bernstein J, Tobin JN *et al*. Treatment of mesangiocapillary glomerulonephritis with alternate-day prednisone—a report of the International Study of Kidney Disease in Children. *Pediatr Nephrol* 1992; **6**: 123–130.
322. Warady BA, Guggenheim SJ, Sedman A *et al*. Prednisone therapy of membranoproliferative glomerulonephritis in children. *J Pediatr* 1985; **107**: 702–707.
323. Bergstein JM, Andreoli SP. Response of type I membranoproliferative glomerulonephritis to pulse methylprednisolone and alternate-day prednisone therapy. *Pediatr Nephrol* 1995; **9**: 268–271.
324. Cattran DC, Cardella CJ, Roscoe JM *et al*. Results of a controlled drug trial in membranoproliferative glomerulonephritis. *Kidney Int* 1985; **27**: 436–441.
325. Chapman SJ, Cameron JS, Chantler C *et al*. Treatment of mesangiocapillary glomerulonephritis in children with combined immunosuppression and anticoagulation. *Arch Dis Child* 1980; **55**: 446–451.
326. Faedda R, Satta A, Tanda F *et al*. Immunosuppressive treatment of membranoproliferative glomerulonephritis. *Nephron* 1994; **67**: 59–65.
327. Jones G, Juszczak M, Kingdon E *et al*. Treatment of idiopathic membranoproliferative glomerulonephritis with mycophenolate mofetil and steroids. *Nephrol Dial Transplant* 2004; **19**: 3160–3164.
328. Levin A. Management of membranoproliferative glomerulonephritis: evidence-based recommendations. *Kidney Int Suppl* 1999; **70**: S41–S46.
329. Tiller D, Clarkson AR, Mathew T. A prospective randomized trial of the use of cyclophosphamide, dipyridamole and warfarin in membranous and membranoproliferative glomerulonephritis. In: Robinson R, Glassock R, Tisher CC, Andreoli T, *et al*. (eds). *Proceedings of the 8th International Congress of Nephrology*. Karger: Basel, Switzerland, 1981, pp 345–351.
330. Montseny JJ, Meyrier A, Kleinknecht D *et al*. The current spectrum of infectious glomerulonephritis. Experience with 76 patients and review of the literature. *Medicine (Baltimore)* 1995; **74**: 63–73.
331. Moroni G, Pozzi C, Quaglini S *et al*. Long-term prognosis of diffuse proliferative glomerulonephritis associated with infection in adults. *Nephrol Dial Transplant* 2002; **17**: 1204–1211.
332. Nasr SH, Markowitz GS, Stokes MB *et al*. Acute postinfectious glomerulonephritis in the modern era: experience with 86 adults and review of the literature. *Medicine (Baltimore)* 2008; **87**: 21–32.
333. Moroni G, Ponticelli C. Acute post-infectious glomerulonephritis. In: Ponticelli C, Glassock R (eds). *Treatment of Primary Glomerulonephritis*, 2nd edn. Oxford University Press: Oxford, UK, 2009, pp 153–177.
334. Rodriguez-Isturbe B, Musser JM. The current state of poststreptococcal glomerulonephritis. *J Am Soc Nephrol* 2008; **19**: 1855–1864.
335. Batsford SR, Mezzano S, Mihatsch M *et al*. Is the nephritogenic antigen in post-streptococcal glomerulonephritis pyrogenic exotoxin B (SPE B) or GAPDH? *Kidney Int* 2005; **68**: 1120–1129.
336. Yoshizawa N, Yamakami K, Fujino M *et al*. Nephritis-associated plasmin receptor and acute poststreptococcal glomerulonephritis: characterization of the antigen and associated immune response. *J Am Soc Nephrol* 2004; **15**: 1785–1793.
337. Baldwin DS. Poststreptococcal glomerulonephritis. A progressive disease? *Am J Med* 1977; **62**: 1–11.
338. Habib G, Hoen B, Tornos P *et al*. Guidelines on the prevention, diagnosis, and treatment of infective endocarditis (new version 2009): the Task Force on the Prevention, Diagnosis, and Treatment of Infective Endocarditis of the European Society of Cardiology (ESC). Endorsed by the European Society of Clinical Microbiology and Infectious Diseases (ESCMID) and the International Society of Chemotherapy (ISC) for Infection and Cancer. *Eur Heart J* 2009; **30**: 2369–2413.
339. Hoen B, Alla F, Selton-Suty C *et al*. Changing profile of infective endocarditis: results of a 1-year survey in France. *JAMA* 2002; **288**: 75–81.
340. Koya D, Shibuya K, Kikkawa R *et al*. Successful recovery of infective endocarditis-induced rapidly progressive glomerulonephritis by steroid therapy combined with antibiotics: a case report. *BMC Nephrol* 2004; **5**: 18.
341. Iwata Y, Ohta S, Kawai K *et al*. Shunt nephritis with positive titers for ANCA specific for proteinase 3. *Am J Kidney Dis* 2004; **43**: e11–e16.
342. Kidney Disease: Improving Global Outcomes. KDIGO clinical practice guidelines for the prevention, diagnosis, evaluation, and treatment of hepatitis C in chronic kidney disease. *Kidney Int Suppl* 2008: S1–S99.
343. Alter MJ. Epidemiology of hepatitis C virus infection. *World J Gastroenterol* 2007; **13**: 2436–2441.
344. Poynard T, Yuen MF, Ratziu V *et al*. Viral hepatitis C. *Lancet* 2003; **362**: 2095–2100.

345. Williams R. Global challenges in liver disease. *Hepatology* 2006; **44**: 521–526.
346. Perico N, Cattaneo D, Bikbov B *et al*. Hepatitis C infection and chronic renal diseases. *Clin J Am Soc Nephrol* 2009; **4**: 207–220.
347. Johnson RJ, Gretch DR, Yamabe H *et al*. Membranoproliferative glomerulonephritis associated with hepatitis C virus infection. *N Engl J Med* 1993; **328**: 465–470.
348. Meyers CM, Seeff LB, Stehman-Breen CO *et al*. Hepatitis C and renal disease: an update. *Am J Kidney Dis* 2003; **42**: 631–657.
349. Roccatello D, Fornasieri A, Giachino O *et al*. Multicenter study on hepatitis C virus-related cryoglobulinemic glomerulonephritis. *Am J Kidney Dis* 2007; **49**: 69–82.
350. D'Amico G. Renal involvement in hepatitis C infection: cryoglobulinemic glomerulonephritis. *Kidney Int* 1998; **54**: 650–671.
351. Arase Y, Ikeda K, Murahima N *et al*. Glomerulonephritis in autopsy cases with hepatitis C virus infection. *Intern Med* 1998; **37**: 836–840.
352. Kamar N, Izopet J, Alric L *et al*. Hepatitis C virus-related kidney disease: an overview. *Clin Nephrol* 2008; **69**: 149–160.
353. Markowitz GS, Cheng JT, Colvin RB *et al*. Hepatitis C viral infection is associated with fibrillary glomerulonephritis and immunotactoid glomerulopathy. *J Am Soc Nephrol* 1998; **9**: 2244–2252.
354. Sabry A, A EA, Sheashaa H *et al*. HCV associated glomerulopathy in Egyptian patients: clinicopathological analysis. *Virology* 2005; **334**: 10–16.
355. Ghany MG, Strader DB, Thomas DL *et al*. Diagnosis, management, and treatment of hepatitis C: an update. *Hepatology* 2009; **49**: 1335–1374.
356. Fried MW, Shiffman ML, Reddy KR *et al*. Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. *N Engl J Med* 2002; **347**: 975–982.
357. Hadziyannis SJ, Sette Jr H, Morgan TR *et al*. Peginterferon-alpha2a and ribavirin combination therapy in chronic hepatitis C: a randomized study of treatment duration and ribavirin dose. *Ann Intern Med* 2004; **140**: 346–355.
358. Manns MP, McHutchison JG, Gordon SC *et al*. Peginterferon alfa-2b plus ribavirin compared with interferon alfa-2b plus ribavirin for initial treatment of chronic hepatitis C: a randomised trial. *Lancet* 2001; **358**: 958–965.
359. Johnson RJ, Gretch DR, Couser WG *et al*. Hepatitis C virus-associated glomerulonephritis. Effect of alpha-interferon therapy. *Kidney Int* 1994; **46**: 1700–1704.
360. Misiani R, Bellavita P, Fenili D *et al*. Interferon alfa-2a therapy in cryoglobulinemia associated with hepatitis C virus. *N Engl J Med* 1994; **330**: 751–756.
361. Cresta P, Musset L, Cacoub P *et al*. Response to interferon alpha treatment and disappearance of cryoglobulinaemia in patients infected by hepatitis C virus. *Gut* 1999; **45**: 122–128.
362. Komatsuda A, Imai H, Wakui H *et al*. Clinicopathological analysis and therapy in hepatitis C virus-associated nephropathy. *Intern Med* 1996; **35**: 529–533.
363. Mazza C, Panarello G, Carniello S *et al*. Interferon versus steroids in patients with hepatitis C virus-associated cryoglobulinaemic glomerulonephritis. *Dig Liver Dis* 2000; **32**: 708–715.
364. Cid MC, Hernandez-Rodriguez J, Robert J *et al*. Interferon-alpha may exacerbate cryoglobulinemia-related ischemic manifestations: an adverse effect potentially related to its anti-angiogenic activity. *Arthritis Rheum* 1999; **42**: 1051–1055.
365. Suzuki T, Yonemura K, Miyaji T *et al*. Progressive renal failure and blindness due to retinal hemorrhage after interferon therapy for hepatitis C virus-associated membranoproliferative glomerulonephritis. *Intern Med* 2001; **40**: 708–712.
366. Garini G, Allegri L, Lannuzzella F *et al*. HCV-related cryoglobulinemic glomerulonephritis: implications of antiviral and immunosuppressive therapies. *Acta Biomed* 2007; **78**: 51–59.
367. Bruchfeld A, Lindahl K, Stahle L *et al*. Interferon and ribavirin treatment in patients with hepatitis C-associated renal disease and renal insufficiency. *Nephrol Dial Transplant* 2003; **18**: 1573–1580.
368. Garini G, Allegri L, Carnevali L *et al*. Interferon-alpha in combination with ribavirin as initial treatment for hepatitis C virus-associated cryoglobulinemic membranoproliferative glomerulonephritis. *Am J Kidney Dis* 2001; **38**: E35.
369. Rossi P, Bertani T, Baio P *et al*. Hepatitis C virus-related cryoglobulinemic glomerulonephritis: long-term remission after antiviral therapy. *Kidney Int* 2003; **63**: 2236–2241.
370. Sabry AA, Sobh MA, Sheashaa HA *et al*. Effect of combination therapy (ribavirin and interferon) in HCV-related glomerulopathy. *Nephrol Dial Transplant* 2002; **17**: 1924–1930.
371. Alric L, Plaisier E, Thebault S *et al*. Influence of antiviral therapy in hepatitis C virus-associated cryoglobulinemic MPGN. *Am J Kidney Dis* 2004; **43**: 617–623.
372. Cacoub P, Saadoun D, Limal N *et al*. PEGylated interferon alfa-2b and ribavirin treatment in patients with hepatitis C virus-related systemic vasculitis. *Arthritis Rheum* 2005; **52**: 911–915.
373. Mazza C, Zorat F, Caizzi M *et al*. Treatment with peg-interferon alfa-2b and ribavirin of hepatitis C virus-associated mixed cryoglobulinemia: a pilot study. *J Hepatol* 2005; **42**: 632–638.
374. Saadoun D, Resche-Rigon M, Thibault V *et al*. Antiviral therapy for hepatitis C virus-associated mixed cryoglobulinemia vasculitis: a long-term followup study. *Arthritis Rheum* 2006; **54**: 3696–3706.
375. Fabrizi F, Bruchfeld A, Mangano S *et al*. Interferon therapy for HCV-associated glomerulonephritis: meta-analysis of controlled trials. *Int J Artif Organs* 2007; **30**: 212–219.
376. Charles ED, Dustin LB. Hepatitis C virus-induced cryoglobulinemia. *Kidney Int* 2009; **76**: 818–824.
377. Koziolok MJ, Scheel A, Bramlage C *et al*. Effective treatment of hepatitis C-associated immune-complex nephritis with cryoprecipitate apheresis and antiviral therapy. *Clin Nephrol* 2007; **67**: 245–249.
378. Ahmed MS, Wong CF. Should rituximab be the rescue therapy for refractory mixed cryoglobulinemia associated with hepatitis C? *J Nephrol* 2007; **20**: 350–356.
379. Cacoub P, Delluc A, Saadoun D *et al*. Anti-CD20 monoclonal antibody (rituximab) treatment for cryoglobulinemic vasculitis: where do we stand? *Ann Rheum Dis* 2008; **67**: 283–287.
380. Sansonno D, De Re V, Lauletta G *et al*. Monoclonal antibody treatment of mixed cryoglobulinemia resistant to interferon alpha with an anti-CD20. *Blood* 2003; **101**: 3818–3826.
381. Saadoun D, Resche-Rigon M, Sene D *et al*. Rituximab combined with Peg-interferon-ribavirin in refractory hepatitis C virus-associated cryoglobulinaemia vasculitis. *Ann Rheum Dis* 2008; **67**: 1431–1436.
382. Garini G, Allegri L, Carnevali ML *et al*. Successful treatment of severe/active cryoglobulinaemic membranoproliferative glomerulonephritis associated with hepatitis C virus infection by means of the sequential administration of immunosuppressive and antiviral agents. *Nephrol Dial Transplant* 2006; **21**: 3333–3334.
383. Iannuzzella F, Vaglio A, Garini G. Management of hepatitis C virus-related mixed cryoglobulinemia. *Am J Med* 2010; **123**: 400–408.
384. Saadoun D, Resche Rigon M, Sene D *et al*. Rituximab plus Peg-interferon-alpha/ribavirin compared with Peg-interferon-alpha/ribavirin in hepatitis C-related mixed cryoglobulinemia. *Blood* 2010; **116**: 326–334; quiz 504–525.
385. European Association For The Study Of The Liver. EASL Clinical Practice Guidelines: management of chronic hepatitis B. *J Hepatol* 2009; **50**: 227–242.
386. Sorrell MF, Belongia EA, Costa J *et al*. National Institutes of Health Consensus Development Conference Statement: management of hepatitis B. *Ann Intern Med* 2009; **150**: 104–110.
387. Olsen SK, Brown Jr RS. Hepatitis B treatment: Lessons for the nephrologist. *Kidney Int* 2006; **70**: 1897–1904.
388. Appel G. Viral infections and the kidney: HIV, hepatitis B, and hepatitis C. *Cleve Clin J Med* 2007; **74**: 353–360.
389. Lok AS, McMahon BJ. Chronic hepatitis B: update 2009. *Hepatology* 2009; **50**: 661–662.
390. Sepkowitz KA. One disease, two epidemics—AIDS at 25. *N Engl J Med* 2006; **354**: 2411–2414.
391. Kimmel PL, Barisoni L, Kopp JB. Pathogenesis and treatment of HIV-associated renal diseases: lessons from clinical and animal studies, molecular pathologic correlations, and genetic investigations. *Ann Intern Med* 2003; **139**: 214–226.
392. Wyatt CM, Klotman PE. HIV-1 and HIV-associated nephropathy 25 years later. *Clin J Am Soc Nephrol* 2007; **2**(Suppl 1): S20–S24.
393. Genovese G, Tonna SJ, Knob AU *et al*. A risk allele for focal segmental glomerulosclerosis in African Americans is located within a region containing APOL1 and MYH9. *Kidney Int* 2010; **78**: 698–704.
394. Cohen SD, Kimmel PL. Immune complex renal disease and human immunodeficiency virus infection. *Semin Nephrol* 2008; **28**: 535–544.
395. Szczec LA, Gupta SK, Habash R *et al*. The clinical epidemiology and course of the spectrum of renal diseases associated with HIV infection. *Kidney Int* 2004; **66**: 1145–1152.
396. Szczec LA, Hoover DR, Feldman JG *et al*. Association between renal disease and outcomes among HIV-infected women receiving or not receiving antiretroviral therapy. *Clin Infect Dis* 2004; **39**: 1199–1206.

397. El-Sadr WM, Lundgren JD, Neaton JD *et al.* CD4+ count-guided interruption of antiretroviral treatment. *N Engl J Med* 2006; **355**: 2283–2296.
398. Kalayjian RC, Franceschini N, Gupta SK *et al.* Suppression of HIV-1 replication by antiretroviral therapy improves renal function in persons with low CD4 cell counts and chronic kidney disease. *AIDS* 2008; **22**: 481–487.
399. Krawczyk CS, Holmberg SD, Moorman AC *et al.* Factors associated with chronic renal failure in HIV-infected ambulatory patients. *AIDS* 2004; **18**: 2171–2178.
400. Peters PJ, Moore DM, Mermin J *et al.* Antiretroviral therapy improves renal function among HIV-infected Ugandans. *Kidney Int* 2008; **74**: 925–929.
401. Reid A, Stohr W, Walker AS *et al.* Severe renal dysfunction and risk factors associated with renal impairment in HIV-infected adults in Africa initiating antiretroviral therapy. *Clin Infect Dis* 2008; **46**: 1271–1281.
402. Gupta SK, Parker RA, Robbins GK *et al.* The effects of highly active antiretroviral therapy on albuminuria in HIV-infected persons: results from a randomized trial. *Nephrol Dial Transplant* 2005; **20**: 2237–2242.
403. Gupta SK, Smurzynski M, Franceschini N *et al.* The effects of HIV type-1 viral suppression and non-viral factors on quantitative proteinuria in the highly active antiretroviral therapy era. *Antivir Ther* 2009; **14**: 543–549.
404. Longenecker CT, Scherzer R, Bacchetti P *et al.* HIV viremia and changes in kidney function. *AIDS* 2009; **23**: 1089–1096.
405. Wyatt CM, Morgello S, Katz-Malamed R *et al.* The spectrum of kidney disease in patients with AIDS in the era of antiretroviral therapy. *Kidney Int* 2009; **75**: 428–434.
406. Wyatt CM, Winston JA, Malvestutto CD *et al.* Chronic kidney disease in HIV infection: an urban epidemic. *AIDS* 2007; **21**: 2101–2103.
407. Haas M, Kaul S, Eustace JA. HIV-associated immune complex glomerulonephritis with “lupus-like” features: a clinicopathologic study of 14 cases. *Kidney Int* 2005; **67**: 1381–1390.
408. Fine DM, Perazella MA, Lucas GM *et al.* Kidney biopsy in HIV: beyond HIV-associated nephropathy. *Am J Kidney Dis* 2008; **51**: 504–514.
409. Gertholtz TE, Goetsch SJ, Katz I. HIV-related nephropathy: a South African perspective. *Kidney Int* 2006; **69**: 1885–1891.
410. Han TM, Naicker S, Ramdial PK *et al.* A cross-sectional study of HIV-seropositive patients with varying degrees of proteinuria in South Africa. *Kidney Int* 2006; **69**: 2243–2250.
411. Cohen SD, Kimmel PL. Renal biopsy is necessary for the diagnosis of HIV-associated renal diseases. *Nat Clin Pract Nephrol* 2009; **5**: 22–23.
412. Babut-Gay ML, Echard M, Kleinknecht D *et al.* Zidovudine and nephropathy with human immunodeficiency virus (HIV) infection. *Ann Intern Med* 1989; **111**: 856–857.
413. Ifudu O, Rao TK, Tan CC *et al.* Zidovudine is beneficial in human immunodeficiency virus associated nephropathy. *Am J Nephrol* 1995; **15**: 217–221.
414. Kirchner JT. Resolution of renal failure after initiation of HAART: 3 cases and a discussion of the literature. *AIDS Read* 2002; **12**: 103–105, 110–102.
415. Szczech LA, Edwards LJ, Sanders LL *et al.* Protease inhibitors are associated with a slowed progression of HIV-related renal diseases. *Clin Nephrol* 2002; **57**: 336–341.
416. Lucas GM, Eustace JA, Sozio S *et al.* Highly active antiretroviral therapy and the incidence of HIV-1-associated nephropathy: a 12-year cohort study. *AIDS* 2004; **18**: 541–546.
417. Atta MG, Gallant JE, Rahman MH *et al.* Antiretroviral therapy in the treatment of HIV-associated nephropathy. *Nephrol Dial Transplant* 2006; **21**: 2809–2813.
418. Kalayjian RC. The treatment of HIV-associated nephropathy. *Adv Chronic Kidney Dis* 2010; **17**: 59–71.
419. Eustace JA, Nuermberger E, Choi M *et al.* Cohort study of the treatment of severe HIV-associated nephropathy with corticosteroids. *Kidney Int* 2000; **58**: 1253–1260.
420. Laradi A, Mallet A, Beaufils H *et al.* HIV-associated nephropathy: outcome and prognosis factors. Groupe d' Etudes Nephrologiques d'Ile de France. *J Am Soc Nephrol* 1998; **9**: 2327–2335.
421. Smith MC, Austen JL, Carey JT *et al.* Prednisone improves renal function and proteinuria in human immunodeficiency virus-associated nephropathy. *Am J Med* 1996; **101**: 41–48.
422. Ingulli E, Tejani A, Fikrig S *et al.* Nephrotic syndrome associated with acquired immunodeficiency syndrome in children. *J Pediatr* 1991; **119**: 710–716.
423. Yahaya I, Uthman AO, Uthman MM. Interventions for HIV-associated nephropathy. *Cochrane Database Syst Rev* 2009: CD007183.
424. Elewa U, Sandri AM, Rizza SA *et al.* Treatment of HIV-associated nephropathies. *Nephron Clin Pract* 2011; **118**: c346–c354.
425. Novak JE, Szczech LA (eds.) HIV and kidney disease. *Adv Chronic Kidney Dis* 2010; **17**: 1–111.
426. Chitsulo L, Engels D, Montresor A *et al.* The global status of schistosomiasis and its control. *Acta Trop* 2000; **77**: 41–51.
427. Chugh KS, Harries AD, Dahniya MH *et al.* Urinary schistosomiasis in Maiduguri, north east Nigeria. *Ann Trop Med Parasitol* 1986; **80**: 593–599.
428. Abdurrahman MB, Attah B, Narayana PT. Clinicopathological features of hepatosplenic schistosomiasis in children. *Ann Trop Paediatr* 1981; **1**: 5–11.
429. Abu-Romeh SH, van der Meulen J, Cozma MC *et al.* Renal diseases in Kuwait. Experience with 244 renal biopsies. *Int Urol Nephrol* 1989; **21**: 25–29.
430. Andrade ZA, Andrade SG, Sadigursky M. Renal changes in patients with hepatosplenic schistosomiasis. *Am J Trop Med Hyg* 1971; **20**: 77–83.
431. Chandra Shekhar K, Pathmanathan R. Schistosomiasis in Malaysia. *Rev Infect Dis* 1987; **9**: 1026–1037.
432. Falcao HA, Gould DB. Immune complex nephropathy in schistosomiasis. *Ann Intern Med* 1975; **83**: 148–154.
433. Musa AM, Asha HA, Veress B. Nephrotic syndrome in Sudanese patients with schistosomiasis mansoni infection. *Ann Trop Med Parasitol* 1980; **74**: 615–618.
434. Queiroz PF, Brito E, Martinelli R *et al.* Nephrotic syndrome in patients with *Schistosoma mansoni* infection. *Am J Trop Med Hyg* 1973; **22**: 622–628.
435. Rocha H, Cruz T, Brito E *et al.* Renal involvement in patients with hepatosplenic *Schistosomiasis mansoni*. *Am J Trop Med Hyg* 1976; **25**: 108–115.
436. Sobh MA, Moustafa FE, el-Housseini F *et al.* Schistosomal specific nephropathy leading to end-stage renal failure. *Kidney Int* 1987; **31**: 1006–1011.
437. Barsoum RS. Schistosomal glomerulopathies. *Kidney Int* 1993; **44**: 1–12.
438. Barsoum RS, Abdel-Rahman AY, Francis MR *et al.* Patterns of glomerular injury associated with hepato-splenic schistosomiasis. Proceedings of the XII Egyptian Congress of Nephrology. *Cairo, Egypt* 1992.
439. Sobh M, Moustafa F, el-Arbagy A *et al.* Nephropathy in asymptomatic patients with active *Schistosoma mansoni* infection. *Int Urol Nephrol* 1990; **22**: 37–43.
440. Rabello AL, Lambertucci JR, Freire MH *et al.* Evaluation of proteinuria in an area of Brazil endemic for schistosomiasis using a single urine sample. *Trans R Soc Trop Med Hyg* 1993; **87**: 187–189.
441. Eltout IA, Ghalib HW, Sualaiman S *et al.* Significance of eosinophilia in urinary schistosomiasis. A study using Hansel's stain and electron microscopy. *Am J Clin Pathol* 1989; **92**: 329–338.
442. Martinelli R, Pereira LJ, Brito E *et al.* Renal involvement in prolonged *Salmonella* bacteremia: the role of schistosomal glomerulopathy. *Rev Inst Med Trop Sao Paulo* 1992; **34**: 193–198.
443. Bassily S, Farid Z, Barsoum RS *et al.* Renal biopsy in *Schistosoma-Salmonella* associated nephrotic syndrome. *J Trop Med Hyg* 1976; **79**: 256–258.
444. Lambertucci JR, Godoy P, Neves J *et al.* Glomerulonephritis in *Salmonella-Schistosoma mansoni* association. *Am J Trop Med Hyg* 1988; **38**: 97–102.
445. Ross AG, Bartley PB, Sleight AC *et al.* Schistosomiasis. *N Engl J Med* 2002; **346**: 1212–1220.
446. Martinelli R, Pereira LJ, Brito E *et al.* Clinical course of focal segmental glomerulosclerosis associated with hepatosplenic schistosomiasis mansoni. *Nephron* 1995; **69**: 131–134.
447. Sobh MA, Moustafa FE, Sally SM *et al.* A prospective, randomized therapeutic trial for schistosomal specific nephropathy. *Kidney Int* 1989; **36**: 904–907.
448. Abdul-Fattah MM, Yossef SM, Ebraheem ME *et al.* Schistosomal glomerulopathy: a putative role for commonly associated *Salmonella* infection. *J Egypt Soc Parasitol* 1995; **25**: 165–173.
449. Martinelli R, Pereira LJ, Rocha H. The influence of anti-parasitic therapy on the course of the glomerulopathy associated with *Schistosomiasis mansoni*. *Clin Nephrol* 1987; **27**: 229–232.
450. Sobh MA, Moustafa FE, Sally SM *et al.* Characterisation of kidney lesions in early schistosomal-specific nephropathy. *Nephrol Dial Transplant* 1988; **3**: 392–398.
451. Nussenzveig I, De Brito T, Carneiro CR *et al.* Human *Schistosoma mansoni*-associated glomerulopathy in Brazil. *Nephrol Dial Transplant* 2002; **17**: 4–7.
452. Bariety J, Barbier M, Laigre MC *et al.* [Proteinuria and loaiasis. Histologic, optic and electronic study of a case]. *Bull Mem Soc Med Hop Paris* 1967; **118**: 1015–1025.

453. Chugh KS, Singhal PC, Tewari SC *et al.* Acute glomerulonephritis associated with filariasis. *Am J Trop Med Hyg* 1978; **27**: 630–631.
454. Date A, Gunasekaran V, Kirubakaran MG *et al.* Acute eosinophilic glomerulonephritis with Bancroftian filariasis. *Postgrad Med J* 1979; **55**: 905–907.
455. Ngu JL, Chatelanat F, Leke R *et al.* Nephropathy in Cameroon: evidence for filarial derived immune-complex pathogenesis in some cases. *Clin Nephrol* 1985; **24**: 128–134.
456. Pillay VK, Kirch E, Kurtzman NA. Glomerulopathy associated with filarial loiasis. *JAMA* 1973; **225**: 179.
457. Pakasa NM, Nseka NM, Nyimi LM. Secondary collapsing glomerulopathy associated with Loa loa filariasis. *Am J Kidney Dis* 1997; **30**: 836–839.
458. Ormerod AD, Petersen J, Hussey JK *et al.* Immune complex glomerulonephritis and chronic anaerobic urinary infection—complications of filariasis. *Postgrad Med J* 1983; **59**: 730–733.
459. Hall CL, Stephens L, Peat D *et al.* Nephrotic syndrome due to loiasis following a tropical adventure holiday: a case report and review of the literature. *Clin Nephrol* 2001; **56**: 247–250.
460. Dreyer G, Ottesen EA, Galdino E *et al.* Renal abnormalities in microfilaremic patients with Bancroftian filariasis. *Am J Trop Med Hyg* 1992; **46**: 745–751.
461. Langhammer J, Birk HW, Zahner H. Renal disease in lymphatic filariasis: evidence for tubular and glomerular disorders at various stages of the infection. *Trop Med Int Health* 1997; **2**: 875–884.
462. Cruel T, Arborio M, Schill H *et al.* [Nephropathy and filariasis from Loa loa. Apropos of 1 case of adverse reaction to a dose of ivermectin]. *Bull Soc Pathol Exot* 1997; **90**: 179–181.
463. Ngu JL, Adam M, Leke R *et al.* Proteinuria associated with diethylcarbamazine treatment of onchocerciasis (abstract). *Lancet* 1980; **315**: 710.
464. Abel L, Ioly V, Jeni P *et al.* Apheresis in the management of loiasis with high microfilariaemia and renal disease. *Br Med J (Clin Res Ed)* 1986; **292**: 24.
465. Barsoum RS. Malarial nephropathies. *Nephrol Dial Transplant* 1998; **13**: 1588–1597.
466. Eiam-Ong S. Malarial nephropathy. *Semin Nephrol* 2003; **23**: 21–33.
467. Olowu WA, Adelusola KA, Adefehinti O *et al.* Quartan malaria-associated childhood nephrotic syndrome: now a rare clinical entity in malaria endemic Nigeria. *Nephrol Dial Transplant* 2010; **25**: 794–801.
468. Doe JY, Funk M, Mengel M *et al.* Nephrotic syndrome in African children: lack of evidence for ‘tropical nephrotic syndrome’? *Nephrol Dial Transplant* 2006; **21**: 672–676.
469. Seggie J, Davies PG, Ninin D *et al.* Patterns of glomerulonephritis in Zimbabwe: survey of disease characterised by nephrotic proteinuria. *Q J Med* 1984; **53**: 109–118.
470. Roberts IS, Cook HT, Troyanov S *et al.* The Oxford classification of IgA nephropathy: pathology definitions, correlations, and reproducibility. *Kidney Int* 2009; **76**: 546–556.
471. Li PK, Ho KK, Szeto CC *et al.* Prognostic indicators of IgA nephropathy in the Chinese—clinical and pathological perspectives. *Nephrol Dial Transplant* 2002; **17**: 64–69.
472. Nair R, Walker PD. Is IgA nephropathy the commonest primary glomerulopathy among young adults in the USA? *Kidney Int* 2006; **69**: 1455–1458.
473. Go AS, Chertow GM, Fan D *et al.* Chronic kidney disease and the risks of death, cardiovascular events, and hospitalization. *N Engl J Med* 2004; **351**: 1296–1305.
474. Donadio JV, Bergstralh EJ, Grande JP *et al.* Proteinuria patterns and their association with subsequent end-stage renal disease in IgA nephropathy. *Nephrol Dial Transplant* 2002; **17**: 1197–1203.
475. Geddes CC, Rauta V, Gronhagen-Riska C *et al.* A tricontinental view of IgA nephropathy. *Nephrol Dial Transplant* 2003; **18**: 1541–1548.
476. Goto M, Wakai K, Kawamura T *et al.* A scoring system to predict renal outcome in IgA nephropathy: a nationwide 10-year prospective cohort study. *Nephrol Dial Transplant* 2009; **24**: 3068–3074.
477. Reich HN, Troyanov S, Scholey JW *et al.* Remission of proteinuria improves prognosis in IgA nephropathy. *J Am Soc Nephrol* 2007; **18**: 3177–3183.
478. Coppo R, Peruzzi L, Amore A *et al.* IgACE: a placebo-controlled, randomized trial of angiotensin-converting enzyme inhibitors in children and young people with IgA nephropathy and moderate proteinuria. *J Am Soc Nephrol* 2007; **18**: 1880–1888.
479. Cattran DC, Coppo R, Cook HT *et al.* The Oxford classification of IgA nephropathy: rationale, clinicopathological correlations, and classification. *Kidney Int* 2009; **76**: 534–545.
480. Szeto CC, Lai FM, To KF *et al.* The natural history of immunoglobulin a nephropathy among patients with hematuria and minimal proteinuria. *Am J Med* 2001; **110**: 434–437.
481. Coppo R, D’Amico G. Factors predicting progression of IgA nephropathies. *J Nephrol* 2005; **18**: 503–512.
482. Frisch G, Lin J, Rosenstock J *et al.* Mycophenolate mofetil (MMF) vs placebo in patients with moderately advanced IgA nephropathy: a double-blind randomized controlled trial. *Nephrol Dial Transplant* 2005; **20**: 2139–2145.
483. Harmankaya O, Ozturk Y, Basturk T *et al.* Efficacy of immunosuppressive therapy in IgA nephropathy presenting with isolated hematuria. *Int Urol Nephrol* 2002; **33**: 167–171.
484. Bartosik LP, Lajoie G, Sugar L *et al.* Predicting progression in IgA nephropathy. *Am J Kidney Dis* 2001; **38**: 728–735.
485. Kanno Y, Okada H, Saruta T *et al.* Blood pressure reduction associated with preservation of renal function in hypertensive patients with IgA nephropathy: a 3-year follow-up. *Clin Nephrol* 2000; **54**: 360–365.
486. Jafar TH, Schmid CH, Landa M *et al.* Angiotensin-converting enzyme inhibitors and progression of nondiabetic renal disease. A meta-analysis of patient-level data. *Ann Intern Med* 2001; **135**: 73–87.
487. Sarafidis PA, Khosla N, Bakris GL. Antihypertensive therapy in the presence of proteinuria. *Am J Kidney Dis* 2007; **49**: 12–26.
488. Fellin G, Gentile MG, Duca G *et al.* Renal function in IgA nephropathy with established renal failure. *Nephrol Dial Transplant* 1988; **3**: 17–23.
489. Ballardie FW, Roberts IS. Controlled prospective trial of prednisolone and cytotoxics in progressive IgA nephropathy. *J Am Soc Nephrol* 2002; **13**: 142–148.
490. Rekola S, Bergstrand A, Bucht H. Deterioration of GFR in IgA nephropathy as measured by ⁵¹Cr-EDTA clearance. *Kidney Int* 1991; **40**: 1050–1054.
491. D’Amico G, Minetti L, Ponticelli C *et al.* Prognostic indicators in idiopathic IgA mesangial nephropathy. *Q J Med* 1986; **59**: 363–378.
492. Boyce NW, Holdsworth SR, Thomson NM *et al.* Clinicopathological associations in mesangial IgA nephropathy. *Am J Nephrol* 1986; **6**: 246–252.
493. Freese P, Norden G, Nyberg G. Morphologic high-risk factors in IgA nephropathy. *Nephron* 1998; **79**: 420–425.
494. Hogg RJ, Silva FG, Wyatt RJ *et al.* Prognostic indicators in children with IgA nephropathy—report of the Southwest Pediatric Nephrology Study Group. *Pediatr Nephrol* 1994; **8**: 15–20.
495. Tumlin JA, Lohavichan V, Hennigar R. Crescentic, proliferative IgA nephropathy: clinical and histological response to methylprednisolone and intravenous cyclophosphamide. *Nephrol Dial Transplant* 2003; **18**: 1321–1329.
496. Katafuchi R, Oh Y, Hori K *et al.* An important role of glomerular segmental lesions on progression of IgA nephropathy: a multivariate analysis. *Clin Nephrol* 1994; **41**: 191–198.
497. Packham DK, Yan HD, Hewitson TD *et al.* The significance of focal and segmental hyalinosis and sclerosis (FSHS) and nephrotic range proteinuria in IgA nephropathy. *Clin Nephrol* 1996; **46**: 225–229.
498. Hsu CY, McCulloch CE, Iribarren C *et al.* Body mass index and risk for end-stage renal disease. *Ann Intern Med* 2006; **144**: 21–28.
499. Navaneethan SD, Yehner H, Moustarah F *et al.* Weight loss interventions in chronic kidney disease: a systematic review and meta-analysis. *Clin J Am Soc Nephrol* 2009; **4**: 1565–1574.
500. Bonnet F, Deprele C, Sassolas A *et al.* Excessive body weight as a new independent risk factor for clinical and pathological progression in primary IgA nephritis. *Am J Kidney Dis* 2001; **37**: 720–727.
501. Tanaka M, Tsujii T, Komiya T *et al.* Clinicopathological influence of obesity in IgA nephropathy: comparative study of 74 patients. *Contrib Nephrol* 2007; **157**: 90–93.
502. Coppo R, Troyanov S, Camilla R *et al.* The Oxford IgA nephropathy clinicopathological classification is valid for children as well as adults. *Kidney Int* 2010; **77**: 921–927.
503. Rauta V, Finne P, Fagerudd J *et al.* Factors associated with progression of IgA nephropathy are related to renal function—a model for estimating risk of progression in mild disease. *Clin Nephrol* 2002; **58**: 85–94.
504. Li PK, Leung CB, Chow KM *et al.* Hong Kong study using valsartan in IgA nephropathy (HKVIN): a double-blind, randomized, placebo-controlled study. *Am J Kidney Dis* 2006; **47**: 751–760.
505. Praga M, Gutierrez E, Gonzalez E *et al.* Treatment of IgA nephropathy with ACE inhibitors: a randomized and controlled trial. *J Am Soc Nephrol* 2003; **14**: 1578–1583.
506. Horita Y, Tadokoro M, Taura K *et al.* Prednisolone co-administered with losartan confers renoprotection in patients with IgA nephropathy. *Ren Fail* 2007; **29**: 441–446.

507. Russo D, Pisani A, Balletta MM *et al.* Additive antiproteinuric effect of converting enzyme inhibitor and losartan in normotensive patients with IgA nephropathy. *Am J Kidney Dis* 1999; **33**: 851–856.
508. Yang Y, Ohta K, Shimizu M *et al.* Treatment with low-dose angiotensin-converting enzyme inhibitor (ACEI) plus angiotensin II receptor blocker (ARB) in pediatric patients with IgA nephropathy. *Clin Nephrol* 2005; **64**: 35–40.
509. Pozzi C, Bolasco PG, Fogazzi GB *et al.* Corticosteroids in IgA nephropathy: a randomised controlled trial. *Lancet* 1999; **353**: 883–887.
510. Manno C, Torres DD, Rossini M *et al.* Randomized controlled clinical trial of corticosteroids plus ACE-inhibitors with long-term follow-up in proteinuric IgA nephropathy. *Nephrol Dial Transplant* 2009; **24**: 3694–3701.
511. Lv J, Zhang H, Chen Y *et al.* Combination therapy of prednisone and ACE inhibitor versus ACE-inhibitor therapy alone in patients with IgA nephropathy: a randomized controlled trial. *Am J Kidney Dis* 2009; **53**: 26–32.
512. Pozzi C, Andrulli S, Del Vecchio L *et al.* Corticosteroid effectiveness in IgA nephropathy: long-term results of a randomized, controlled trial. *J Am Soc Nephrol* 2004; **15**: 157–163.
513. Pozzi C, Locatelli F. Corticosteroids in IgA nephropathy (letter). *Lancet* 1999; **353**: 2159–2160.
514. Manno C, Gesualdo L, D'Altri C *et al.* Prospective randomized controlled multicenter trial on steroids plus ramipril in proteinuric IgA nephropathy. *J Nephrol* 2001; **14**: 248–252.
515. Hogg RJ, Lee J, Nardelli N *et al.* Clinical trial to evaluate omega-3 fatty acids and alternate day prednisone in patients with IgA nephropathy: report from the Southwest Pediatric Nephrology Study Group. *Clin J Am Soc Nephrol* 2006; **1**: 467–474.
516. Katafuchi R, Ikeda K, Mizumasa T *et al.* Controlled, prospective trial of steroid treatment in IgA nephropathy: a limitation of low-dose prednisolone therapy. *Am J Kidney Dis* 2003; **41**: 972–983.
517. Strippoli GF, Maione A, Schena FP *et al.* IgA nephropathy: a disease in search of a large-scale clinical trial to reliably inform practice. *Am J Kidney Dis* 2009; **53**: 5–8.
518. Kobayashi Y, Hiki Y, Kokubo T *et al.* Steroid therapy during the early stage of progressive IgA nephropathy. A 10-year follow-up study. *Nephron* 1996; **72**: 237–242.
519. Eitner F, Ackermann D, Hilgers RD *et al.* Supportive Versus Immunosuppressive Therapy of Progressive IgA nephropathy (STOP) IgAN trial: rationale and study protocol. *J Nephrol* 2008; **21**: 284–289.
520. Walker RG, Yu SH, Owen JE *et al.* The treatment of mesangial IgA nephropathy with cyclophosphamide, dipyridamole and warfarin: a two-year prospective trial. *Clin Nephrol* 1990; **34**: 103–107.
521. Woo KT, Lee GS. The treatment of mesangial IgA nephropathy with cyclophosphamide, dipyridamole and warfarin. *Clin Nephrol* 1991; **35**: 184.
522. Yoshikawa N, Ito H, Sakai T *et al.* A controlled trial of combined therapy for newly diagnosed severe childhood IgA nephropathy. The Japanese Pediatric IgA Nephropathy Treatment Study Group. *J Am Soc Nephrol* 1999; **10**: 101–109.
523. Pozzi C, Andrulli S, Pani A *et al.* Addition of azathioprine to corticosteroids does not benefit patients with IgA nephropathy. *J Am Soc Nephrol* 2010; **21**: 1783–1790.
524. Yoshikawa N, Honda M, Iijima K *et al.* Steroid treatment for severe childhood IgA nephropathy: a randomized, controlled trial. *Clin J Am Soc Nephrol* 2006; **1**: 511–517.
525. Maes BD, Oyen R, Claes K *et al.* Mycophenolate mofetil in IgA nephropathy: results of a 3-year prospective placebo-controlled randomized study. *Kidney Int* 2004; **65**: 1842–1849.
526. Tang S, Leung JC, Chan LY *et al.* Mycophenolate mofetil alleviates persistent proteinuria in IgA nephropathy. *Kidney Int* 2005; **68**: 802–812.
527. Tang SC, Tang AW, Wong SS *et al.* Long-term study of mycophenolate mofetil treatment in IgA nephropathy. *Kidney Int* 2010; **77**: 543–549.
528. Lv J, Zhang H, Cui Z *et al.* Delayed severe pneumonia in mycophenolate mofetil-treated patients with IgA nephropathy. *Nephrol Dial Transplant* 2008; **23**: 2868–2872.
529. Donadio Jr JV, Bergstralh EJ, Offord KP *et al.* A controlled trial of fish oil in IgA nephropathy. Mayo Nephrology Collaborative Group. *N Engl J Med* 1994; **331**: 1194–1199.
530. Donadio Jr JV, Grande JP, Bergstralh EJ *et al.* The long-term outcome of patients with IgA nephropathy treated with fish oil in a controlled trial. Mayo Nephrology Collaborative Group. *J Am Soc Nephrol* 1999; **10**: 1772–1777.
531. Alexopoulos E, Stangou M, Pantzaki A *et al.* Treatment of severe IgA nephropathy with omega-3 fatty acids: the effect of a “very low dose” regimen. *Ren Fail* 2004; **26**: 453–459.
532. Ferraro PM, Ferraccioli GF, Gambaro G *et al.* Combined treatment with renin-angiotensin system blockers and polyunsaturated fatty acids in proteinuric IgA nephropathy: a randomized controlled trial. *Nephrol Dial Transplant* 2009; **24**: 156–160.
533. Bennett WM, Walker RG, Kincaid-Smith P. Treatment of IgA nephropathy with eicosapentanoic acid (EPA): a two-year prospective trial. *Clin Nephrol* 1989; **31**: 128–131.
534. Pettersson EE, Rekola S, Berglund L *et al.* Treatment of IgA nephropathy with omega-3-polyunsaturated fatty acids: a prospective, double-blind, randomized study. *Clin Nephrol* 1994; **41**: 183–190.
535. Strippoli GF, Manno C, Schena FP. An “evidence-based” survey of therapeutic options for IgA nephropathy: assessment and criticism. *Am J Kidney Dis* 2003; **41**: 1129–1139.
536. Miller III ER, Juraschek SP, Appel LJ *et al.* The effect of n-3 long-chain polyunsaturated fatty acid supplementation on urine protein excretion and kidney function: meta-analysis of clinical trials. *Am J Clin Nutr* 2009; **89**: 1937–1945.
537. Hogg RJ, Fitzgibbons L, Atkins C *et al.* Efficacy of omega-3 fatty acids in children and adults with IgA nephropathy is dosage- and size-dependent. *Clin J Am Soc Nephrol* 2006; **1**: 1167–1172.
538. Donadio Jr JV, Larson TS, Bergstralh EJ *et al.* A randomized trial of high-dose compared with low-dose omega-3 fatty acids in severe IgA nephropathy. *J Am Soc Nephrol* 2001; **12**: 791–799.
539. Taji Y, Kuwahara T, Shikata S *et al.* Meta-analysis of antiplatelet therapy for IgA nephropathy. *Clin Exp Nephrol* 2006; **10**: 268–273.
540. Hotta O, Miyazaki M, Furuta T *et al.* Tonsillectomy and steroid pulse therapy significantly impact on clinical remission in patients with IgA nephropathy. *Am J Kidney Dis* 2001; **38**: 736–743.
541. Xie Y, Nishi S, Ueno M *et al.* The efficacy of tonsillectomy on long-term renal survival in patients with IgA nephropathy. *Kidney Int* 2003; **63**: 1861–1867.
542. Komatsu H, Fujimoto S, Hara S *et al.* Effect of tonsillectomy plus steroid pulse therapy on clinical remission of IgA nephropathy: a controlled study. *Clin J Am Soc Nephrol* 2008; **3**: 1301–1307.
543. Rasche FM, Schwarz A, Keller F. Tonsillectomy does not prevent a progressive course in IgA nephropathy. *Clin Nephrol* 1999; **51**: 147–152.
544. Kim SM, Moon KC, Oh KH *et al.* Clinicopathologic characteristics of IgA nephropathy with steroid-responsive nephrotic syndrome. *J Korean Med Sci* 2009; **24**(Suppl): S44–S49.
545. Lai KN, Lai FM, Chan KW *et al.* An overlapping syndrome of IgA nephropathy and lipoid nephrosis. *Am J Clin Pathol* 1986; **86**: 716–723.
546. Lai KN, Lai FM, Ho CP *et al.* Corticosteroid therapy in IgA nephropathy with nephrotic syndrome: a long-term controlled trial. *Clin Nephrol* 1986; **26**: 174–180.
547. Gutierrez E, Gonzalez E, Hernandez E *et al.* Factors that determine an incomplete recovery of renal function in macrohematuria-induced acute renal failure of IgA nephropathy. *Clin J Am Soc Nephrol* 2007; **2**: 51–57.
548. Praga M, Gutierrez-Millet V, Navas JJ *et al.* Acute worsening of renal function during episodes of macroscopic hematuria in IgA nephropathy. *Kidney Int* 1985; **28**: 69–74.
549. Bennett WM, Kincaid-Smith P. Macroscopic hematuria in mesangial IgA nephropathy: correlation with glomerular crescents and renal dysfunction. *Kidney Int* 1983; **23**: 393–400.
550. Abe T, Kida H, Yoshimura M *et al.* Participation of extracapillary lesions (ECL) in progression of IgA nephropathy. *Clin Nephrol* 1986; **25**: 37–41.
551. Tang Z, Wu Y, Wang QW *et al.* Idiopathic IgA nephropathy with diffuse crescent formation. *Am J Nephrol* 2002; **22**: 480–486.
552. Pankhurst T, Lepenies J, Nightingale P *et al.* Vasculitic IgA nephropathy: prognosis and outcome. *Nephron Clin Pract* 2009; **112**: c16–c24.
553. Coppo R, Basolo B, Roccatello D *et al.* Plasma exchange in progressive primary IgA nephropathy. *Int J Artif Organs* 1985; **8**(Suppl 2): 55–58.
554. Saulsbury FT. Clinical update: Henoch-Schonlein purpura. *Lancet* 2007; **369**: 976–978.
555. Narchi H. Risk of long term renal impairment and duration of follow up recommended for Henoch-Schonlein purpura with normal or minimal urinary findings: a systematic review. *Arch Dis Child* 2005; **90**: 916–920.
556. Saulsbury FT. Henoch-Schonlein purpura in children. Report of 100 patients and review of the literature. *Medicine (Baltimore)* 1999; **78**: 395–409.
557. Shin JI, Park JM, Shin YH *et al.* Predictive factors for nephritis, relapse, and significant proteinuria in childhood Henoch-Schonlein purpura. *Scand J Rheumatol* 2006; **35**: 56–60.

558. Goldstein AR, White RH, Akuse R *et al.* Long-term follow-up of childhood Henoch-Schonlein nephritis. *Lancet* 1992; **339**: 280-282.
559. Edstrom Halling S, Soderberg MP, Berg UB. Predictors of outcome in Henoch-Schonlein nephritis. *Pediatr Nephrol* 2010; **25**: 1101-1108.
560. Ronkainen J, Nuutinen M, Koskimies O. The adult kidney 24 years after childhood Henoch-Schonlein purpura: a retrospective cohort study. *Lancet* 2002; **360**: 666-670.
561. Zaffanello M, Fanos V. Treatment-based literature of Henoch-Schonlein purpura nephritis in childhood. *Pediatr Nephrol* 2009; **24**: 1901-1911.
562. Ronkainen J, Koskimies O, Ala-Houhala M *et al.* Early prednisone therapy in Henoch-Schonlein purpura: a randomized, double-blind, placebo-controlled trial. *J Pediatr* 2006; **149**: 241-247.
563. Niaudet P, Habib R. Methylprednisolone pulse therapy in the treatment of severe forms of Schonlein-Henoch purpura nephritis. *Pediatr Nephrol* 1998; **12**: 238-243.
564. Foster BJ, Bernard C, Drummond KN *et al.* Effective therapy for severe Henoch-Schonlein purpura nephritis with prednisone and azathioprine: a clinical and histopathologic study. *J Pediatr* 2000; **136**: 370-375.
565. Tarshish P, Bernstein J, Edelmann Jr CM. Henoch-Schonlein purpura nephritis: course of disease and efficacy of cyclophosphamide. *Pediatr Nephrol* 2004; **19**: 51-56.
566. Kawasaki Y, Suzuki J, Suzuki H. Efficacy of methylprednisolone and urokinase pulse therapy combined with or without cyclophosphamide in severe Henoch-Schoenlein nephritis: a clinical and histopathological study. *Nephrol Dial Transplant* 2004; **19**: 858-864.
567. Ronkainen J, Ala-Houhala M, Antikainen M *et al.* Cyclosporine A (CyA) versus MP pulses (MP) in the treatment of severe Henoch-Schonlein Nephritis (HSN) (abstract). *Pediatr Nephrol* 2006; **21**: 1531.
568. Jauhola O, Ronkainen J, Ala-Houhala M *et al.* Cyclosporine A (CyA) versus MP pulses in severe Henoch-Schonlein Nephritis (HSN): Outcome after 2 year follow up (abstract). *Pediatr Nephrol* 2008; **23**: 1584.
569. Bergstein J, Leiser J, Andreoli SP. Response of crescentic Henoch-Schoenlein purpura nephritis to corticosteroid and azathioprine therapy. *Clin Nephrol* 1998; **49**: 9-14.
570. Flynn JT, Smoyer WE, Bunchman TE *et al.* Treatment of Henoch-Schonlein Purpura glomerulonephritis in children with high-dose corticosteroids plus oral cyclophosphamide. *Am J Nephrol* 2001; **21**: 128-133.
571. Ronkainen J, Autio-Harmainen H, Nuutinen M. Cyclosporin A for the treatment of severe Henoch-Schonlein glomerulonephritis. *Pediatr Nephrol* 2003; **18**: 1138-1142.
572. Shin JI, Park JM, Shin YH *et al.* Cyclosporin A therapy for severe Henoch-Schonlein nephritis with nephrotic syndrome. *Pediatr Nephrol* 2005; **20**: 1093-1097.
573. Kawasaki Y, Suzuki J, Murai M *et al.* Plasmapheresis therapy for rapidly progressive Henoch-Schonlein nephritis. *Pediatr Nephrol* 2004; **19**: 920-923.
574. Shenoy M, Ognjanovic MV, Coulthard MG. Treating severe Henoch-Schonlein and IgA nephritis with plasmapheresis alone. *Pediatr Nephrol* 2007; **22**: 1167-1171.
575. Fuentes Y, Valverde S, Valesquez-Jones L *et al.* Comparison of azathioprine vs mofetil mycophenolate for Henoch-Schonlein nephritis treatment (abstract). *Pediatr Nephrol* 2010; **25**: 1802.
576. Chartapisak W, Opastiraku S, Willis NS *et al.* Prevention and treatment of renal disease in Henoch-Schonlein purpura: a systematic review. *Arch Dis Child* 2009; **94**: 132-137.
577. Chartapisak W, Opastiraku S, Hodson EM *et al.* Interventions for preventing and treating kidney disease in Henoch-Schonlein Purpura (HSP). *Cochrane Database Syst Rev* 2009; CD005128.
578. Dudley J, Smith G, Llewellyn-Edwards A *et al.* Randomised placebo controlled trial to assess the role of early prednisolone on the development and progression of Henoch-Schonlein Purpura Nephritis (abstract). *Pediatr Nephrol* 2007; **22**: 1457.
579. Blanco R, Martinez-Taboada VM, Rodriguez-Valverde V *et al.* Henoch-Schonlein purpura in adulthood and childhood: two different expressions of the same syndrome. *Arthritis Rheum* 1997; **40**: 859-864.
580. Coppo R, Andrulli S, Amore A *et al.* Predictors of outcome in Henoch-Schonlein nephritis in children and adults. *Am J Kidney Dis* 2006; **47**: 993-1003.
581. Shrestha S, Sumingan N, Tan J *et al.* Henoch Schonlein purpura with nephritis in adults: adverse prognostic indicators in a UK population. *QJM* 2006; **99**: 253-265.
582. Rauta V, Tornroth T, Gronhagen-Riska C. Henoch-Schoenlein nephritis in adults-clinical features and outcomes in Finnish patients. *Clin Nephrol* 2002; **58**: 1-8.
583. Hung SP, Yang YH, Lin YT *et al.* Clinical manifestations and outcomes of Henoch-Schonlein purpura: comparison between adults and children. *Pediatr Neonatol* 2009; **50**: 162-168.
584. Pillebout E, Thervet E, Hill G *et al.* Henoch-Schonlein Purpura in adults: outcome and prognostic factors. *J Am Soc Nephrol* 2002; **13**: 1271-1278.
585. Pillebout E, Alberti C, Guillemin L *et al.* Addition of cyclophosphamide to steroids provides no benefit compared with steroids alone in treating adult patients with severe Henoch Schonlein Purpura. *Kidney Int* 2010; **78**: 495-502.
586. Campbell Jr R, Cooper GS, Gilkeson GS. Two aspects of the clinical and humanistic burden of systemic lupus erythematosus: mortality risk and quality of life early in the course of disease. *Arthritis Rheum* 2008; **59**: 458-464.
587. Danila MI, Pons-Estel GJ, Zhang J *et al.* Renal damage is the most important predictor of mortality within the damage index: data from LUMINA LXIV, a multiethnic US cohort. *Rheumatology (Oxford)* 2009; **48**: 542-545.
588. Font J, Ramos-Casals M, Cervera R *et al.* Cardiovascular risk factors and the long-term outcome of lupus nephritis. *QJM* 2001; **94**: 19-26.
589. Al Arfaj AS, Khalil N. Clinical and immunological manifestations in 624 SLE patients in Saudi Arabia. *Lupus* 2009; **18**: 465-473.
590. Bastian HM, Roseman JM, McGwin Jr G *et al.* Systemic lupus erythematosus in three ethnic groups. XII. Risk factors for lupus nephritis after diagnosis. *Lupus* 2002; **11**: 152-160.
591. Seligman VA, Lum RF, Olson JL *et al.* Demographic differences in the development of lupus nephritis: a retrospective analysis. *Am J Med* 2002; **112**: 726-729.
592. Ward MM. Changes in the incidence of endstage renal disease due to lupus nephritis in the United States, 1996-2004. *J Rheumatol* 2009; **36**: 63-67.
593. Adler M, Chambers S, Edwards C *et al.* An assessment of renal failure in an SLE cohort with special reference to ethnicity, over a 25-year period. *Rheumatology (Oxford)* 2006; **45**: 1144-1147.
594. Al Arfaj AS, Khalil N, Al Saleh S. Lupus nephritis among 624 cases of systemic lupus erythematosus in Riyadh, Saudi Arabia. *Rheumatol Int* 2009; **29**: 1057-1067.
595. Gonzalez-Crespo MR, Lopez-Fernandez JI, Userra G *et al.* Outcome of silent lupus nephritis. *Semin Arthritis Rheum* 1996; **26**: 468-476.
596. Valente de Almeida R, Rocha de Carvalho JG, de Azevedo VF *et al.* Microalbuminuria and renal morphology in the evaluation of subclinical lupus nephritis. *Clin Nephrol* 1999; **52**: 218-229.
597. Zabaleta-Lanz ME, Munoz LE, Tapanes FJ *et al.* Further description of early clinically silent lupus nephritis. *Lupus* 2006; **15**: 845-851.
598. Kraft SW, Schwartz MM, Korbet SM *et al.* Glomerular podocytopeny in patients with systemic lupus erythematosus. *J Am Soc Nephrol* 2005; **16**: 175-179.
599. Austin III HA, Klippel JH, Balow JE *et al.* Therapy of lupus nephritis. Controlled trial of prednisone and cytotoxic drugs. *N Engl J Med* 1986; **314**: 614-619.
600. Boumpas DT, Austin III HA, Vaughn EM *et al.* Controlled trial of pulse methylprednisolone versus two regimens of pulse cyclophosphamide in severe lupus nephritis. *Lancet* 1992; **340**: 741-745.
601. Donadio Jr JV, Holley KE, Ferguson RH *et al.* Treatment of diffuse proliferative lupus nephritis with prednisone and combined prednisone and cyclophosphamide. *N Engl J Med* 1978; **299**: 1151-1155.
602. Gourley MF, Austin III HA, Scott D *et al.* Methylprednisolone and cyclophosphamide, alone or in combination, in patients with lupus nephritis. A randomized, controlled trial. *Ann Intern Med* 1996; **125**: 549-557.
603. Houssiau FA, Vasconcelos C, D'Cruz D *et al.* The 10-year follow-up data of the Euro-Lupus Nephritis Trial comparing low-dose and high-dose intravenous cyclophosphamide. *Ann Rheum Dis* 2010; **69**: 61-64.
604. Houssiau FA, Vasconcelos C, D'Cruz D *et al.* Immunosuppressive therapy in lupus nephritis: the Euro-Lupus Nephritis Trial, a randomized trial of low-dose versus high-dose intravenous cyclophosphamide. *Arthritis Rheum* 2002; **46**: 2121-2131.
605. McKinley A, Park E, Spetie D *et al.* Oral cyclophosphamide for lupus glomerulonephritis: an underused therapeutic option. *Clin J Am Soc Nephrol* 2009; **4**: 1754-1760.
606. Moroni G, Doria A, Mosca M *et al.* A randomized pilot trial comparing cyclosporine and azathioprine for maintenance therapy in diffuse lupus nephritis over four years. *Clin J Am Soc Nephrol* 2006; **1**: 925-932.
607. Chan TM, Tse KC, Tang CS *et al.* Long-term outcome of patients with diffuse proliferative lupus nephritis treated with prednisolone and oral cyclophosphamide followed by azathioprine. *Lupus* 2005; **14**: 265-272.

608. Mok CC, Ho CT, Chan KW *et al.* Outcome and prognostic indicators of diffuse proliferative lupus glomerulonephritis treated with sequential oral cyclophosphamide and azathioprine. *Arthritis Rheum* 2002; **46**: 1003–1013.
609. Mok CC, Ho CT, Siu YP *et al.* Treatment of diffuse proliferative lupus glomerulonephritis: a comparison of two cyclophosphamide-containing regimens. *Am J Kidney Dis* 2001; **38**: 256–264.
610. Moroni G, Quaglini S, Gallelli B *et al.* The long-term outcome of 93 patients with proliferative lupus nephritis. *Nephrol Dial Transplant* 2007; **22**: 2531–2539.
611. Chan TM, Li FK, Tang CS *et al.* Efficacy of mycophenolate mofetil in patients with diffuse proliferative lupus nephritis. Hong Kong-Guangzhou Nephrology Study Group. *N Engl J Med* 2000; **343**: 1156–1162.
612. Chan TM, Tse KC, Tang CS *et al.* Long-term study of mycophenolate mofetil as continuous induction and maintenance treatment for diffuse proliferative lupus nephritis. *J Am Soc Nephrol* 2005; **16**: 1076–1084.
613. Appel GB, Contreras G, Dooley MA *et al.* Mycophenolate mofetil versus cyclophosphamide for induction treatment of lupus nephritis. *J Am Soc Nephrol* 2009; **20**: 1103–1112.
614. Traitanon O, Avihingsanon Y, Kittikovit V *et al.* Efficacy of enteric-coated mycophenolate sodium in patients with resistant-type lupus nephritis: a prospective study. *Lupus* 2008; **17**: 744–751.
615. Grootsholten C, Ligtenberg G, Hagen EC *et al.* Azathioprine/methylprednisolone versus cyclophosphamide in proliferative lupus nephritis. A randomized controlled trial. *Kidney Int* 2006; **70**: 732–742.
616. Grootsholten C, Bajema IM, Florquin S *et al.* Treatment with cyclophosphamide delays the progression of chronic lesions more effectively than does treatment with azathioprine plus methylprednisolone in patients with proliferative lupus nephritis. *Arthritis Rheum* 2007; **56**: 924–937.
617. Zavada J, Pesickova S, Rysava R *et al.* Cyclosporine A or intravenous cyclophosphamide for lupus nephritis: the Cyclofa-Lune study. *Lupus* 2010; **19**: 1281–1289.
618. Bao H, Liu ZH, Xie HL *et al.* Successful treatment of class V+IV lupus nephritis with multitarget therapy. *J Am Soc Nephrol* 2008; **19**: 2001–2010.
619. Balow JE, Austin III HA, Muenz LR *et al.* Effect of treatment on the evolution of renal abnormalities in lupus nephritis. *N Engl J Med* 1984; **311**: 491–495.
620. Haubitz M, Bohnenstengel F, Brunkhorst R *et al.* Cyclophosphamide pharmacokinetics and dose requirements in patients with renal insufficiency. *Kidney Int* 2002; **61**: 1495–1501.
621. Pendse S, Ginsburg E, Singh AK. Strategies for preservation of ovarian and testicular function after immunosuppression. *Am J Kidney Dis* 2004; **43**: 772–781.
622. Somers EC, Marder W, Christman GM *et al.* Use of a gonadotropin-releasing hormone analog for protection against premature ovarian failure during cyclophosphamide therapy in women with severe lupus. *Arthritis Rheum* 2005; **52**: 2761–2767.
623. Ginzler EM, Dooley MA, Aranow C *et al.* Mycophenolate mofetil or intravenous cyclophosphamide for lupus nephritis. *N Engl J Med* 2005; **353**: 2219–2228.
624. Hu W, Liu Z, Chen H *et al.* Mycophenolate mofetil vs cyclophosphamide therapy for patients with diffuse proliferative lupus nephritis. *Chin Med J (Engl)* 2002; **115**: 705–709.
625. Ong LM, Hooi LS, Lim TO *et al.* Randomized controlled trial of pulse intravenous cyclophosphamide versus mycophenolate mofetil in the induction therapy of proliferative lupus nephritis. *Nephrology (Carlton)* 2005; **10**: 504–510.
626. El-Shafey EM, Abdou SH, Shareef MM. Is mycophenolate mofetil superior to pulse intravenous cyclophosphamide for induction therapy of proliferative lupus nephritis in Egyptian patients? *Clin Exp Nephrol* 2010; **14**: 214–221.
627. Korbet SM, Schwartz MM, Evans J *et al.* Severe lupus nephritis: racial differences in presentation and outcome. *J Am Soc Nephrol* 2007; **18**: 244–254.
628. Rovin BH, Appel GB, Furie RA *et al.* Efficacy and safety of rituximab (RTX) in subjects with proliferative lupus nephritis (LN): Results from the randomized, double-blind, phase III LUNAR study (abstract). *J Am Soc Nephrol* 2009; **20**: 77A.
629. Gunnarsson I, Sundelin B, Jonsdottir T *et al.* Histopathologic and clinical outcome of rituximab treatment in patients with cyclophosphamide-resistant proliferative lupus nephritis. *Arthritis Rheum* 2007; **56**: 1263–1272.
630. Karim MY, Pisoni CN, Khamashta MA. Update on immunotherapy for systemic lupus erythematosus—what's hot and what's not!. *Rheumatology (Oxford)* 2009; **48**: 332–341.
631. Li EK, Tam LS, Zhu TY *et al.* Is combination rituximab with cyclophosphamide better than rituximab alone in the treatment of lupus nephritis? *Rheumatology (Oxford)* 2009; **48**: 892–898.
632. Lu TY, Ng KP, Cambridge G *et al.* A retrospective seven-year analysis of the use of B cell depletion therapy in systemic lupus erythematosus at University College London Hospital: the first fifty patients. *Arthritis Rheum* 2009; **61**: 482–487.
633. Ramos-Casals M, Soto MJ, Cuadrado MJ *et al.* Rituximab in systemic lupus erythematosus: A systematic review of off-label use in 188 cases. *Lupus* 2009; **18**: 767–776.
634. Sousa E, Iseberg D. Treating lupus: from serendipity to sense, the rise of the new biologicals and other emerging therapies. *Best Pract Res Clin Rheumatol* 2009; **23**: 563–574.
635. Tieng AT, Peeva E. B-cell-directed therapies in systemic lupus erythematosus. *Semin Arthritis Rheum* 2008; **38**: 218–227.
636. Cameron JS, Turner DR, Ogg CS *et al.* Systemic lupus with nephritis: a long-term study. *Q J Med* 1979; **48**: 1–24.
637. Dooley MA, Jayne D, Ginzler EM *et al.* Mycophenolate versus azathioprine as maintenance therapy for lupus nephritis. *N Engl J Med* 2011; **365**: 1886–1895.
638. Contreras G, Pardo V, Leclercq B *et al.* Sequential therapies for proliferative lupus nephritis. *N Engl J Med* 2004; **350**: 971–980.
639. Houssiau FA, D'Cruz D, Sangle S *et al.* Azathioprine versus mycophenolate mofetil for long-term immunosuppression in lupus nephritis: results from the MAINTAIN Nephritis Trial. *Ann Rheum Dis* 2010; **69**: 2083–2089.
640. Griffiths B, Emery P, Ryan V *et al.* The BILAG multi-centre open randomized controlled trial comparing ciclosporin vs azathioprine in patients with severe SLE. *Rheumatology (Oxford)* 2010; **49**: 723–732.
641. Gunnarsson I, Sundelin B, Heimburger M *et al.* Repeated renal biopsy in proliferative lupus nephritis—predictive role of serum C1q and albuminuria. *J Rheumatol* 2002; **29**: 693–699.
642. Hill GS, Delahousse M, Nochy D *et al.* Predictive power of the second renal biopsy in lupus nephritis: significance of macrophages. *Kidney Int* 2001; **59**: 304–316.
643. Ioannidis JP, Boki KA, Katsorida ME *et al.* Remission, relapse, and re-remission of proliferative lupus nephritis treated with cyclophosphamide. *Kidney Int* 2000; **57**: 258–264.
644. Moroni G, Pasquali S, Quaglini S *et al.* Clinical and prognostic value of serial renal biopsies in lupus nephritis. *Am J Kidney Dis* 1999; **34**: 530–539.
645. Chen YE, Korbet SM, Katz RS *et al.* Value of a complete or partial remission in severe lupus nephritis. *Clin J Am Soc Nephrol* 2008; **3**: 46–53.
646. Gruppo Italiano per lo Studio della Nefrite Lupica (GISNEL). Lupus nephritis: prognostic factors and probability of maintaining life-supporting renal function 10 years after the diagnosis. *Am J Kidney Dis* 1992; **19**: 473–479.
647. Barr RG, Seliger S, Appel GB *et al.* Prognosis in proliferative lupus nephritis: the role of socio-economic status and race/ethnicity. *Nephrol Dial Transplant* 2003; **18**: 2039–2046.
648. Contreras G, Pardo V, Cely C *et al.* Factors associated with poor outcomes in patients with lupus nephritis. *Lupus* 2005; **14**: 890–895.
649. Gibson KL, Gipson DS, Massengill SA *et al.* Predictors of relapse and end stage kidney disease in proliferative lupus nephritis: focus on children, adolescents, and young adults. *Clin J Am Soc Nephrol* 2009; **4**: 1962–1967.
650. Rovin BH, Zhang X. Biomarkers for lupus nephritis: the quest continues. *Clin J Am Soc Nephrol* 2009; **4**: 1858–1865.
651. Hebert LA, Wilmer WA, Falkenhain ME *et al.* Renoprotection: one or many therapies? *Kidney Int* 2001; **59**: 1211–1226.
652. Wilmer WA, Rovin BH, Hebert CJ *et al.* Management of glomerular proteinuria: a commentary. *J Am Soc Nephrol* 2003; **14**: 3217–3232.
653. Coremans IE, Spronk PE, Bootsma H *et al.* Changes in antibodies to C1q predict renal relapses in systemic lupus erythematosus. *Am J Kidney Dis* 1995; **26**: 595–601.
654. Esdaile JM, Abrahamowicz M, Joseph L *et al.* Laboratory tests as predictors of disease exacerbations in systemic lupus erythematosus. Why some tests fail. *Arthritis Rheum* 1996; **39**: 370–378.
655. Esdaile JM, Joseph L, Abrahamowicz M *et al.* Routine immunologic tests in systemic lupus erythematosus: is there a need for more studies? *J Rheumatol* 1996; **23**: 1891–1896.

656. Ho A, Barr SG, Magder LS *et al.* A decrease in complement is associated with increased renal and hematologic activity in patients with systemic lupus erythematosus. *Arthritis Rheum* 2001; **44**: 2350–2357.
657. Ho A, Magder LS, Barr SG *et al.* Decreases in anti-double-stranded DNA levels are associated with concurrent flares in patients with systemic lupus erythematosus. *Arthritis Rheum* 2001; **44**: 2342–2349.
658. Moroni G, Radice A, Giammarresi G *et al.* Are laboratory tests useful for monitoring the activity of lupus nephritis? A 6-year prospective study in a cohort of 228 patients with lupus nephritis. *Ann Rheum Dis* 2009; **68**: 234–237.
659. Rovin BH, Birmingham DJ, Nagaraja HN *et al.* Biomarker discovery in human SLE nephritis. *Bull NYU Hosp Jt Dis* 2007; **65**: 187–193.
660. Giatras I, Lau J, Levey AS. Effect of angiotensin-converting enzyme inhibitors on the progression of nondiabetic renal disease: a meta-analysis of randomized trials. Angiotensin-Converting-Enzyme Inhibition and Progressive Renal Disease Study Group. *Ann Intern Med* 1997; **127**: 337–345.
661. Mercadal L, Montcel ST, Nochy D *et al.* Factors affecting outcome and prognosis in membranous lupus nephropathy. *Nephrol Dial Transplant* 2002; **17**: 1771–1778.
662. Mok CC. Membranous nephropathy in systemic lupus erythematosus: a therapeutic enigma. *Nat Rev Nephrol* 2009; **5**: 212–220.
663. Mok CC, Ying KY, Yim CW *et al.* Very long-term outcome of pure lupus membranous nephropathy treated with glucocorticoid and azathioprine. *Lupus* 2009; **18**: 1091–1095.
664. Pasquali S, Banfi G, Zucchelli A *et al.* Lupus membranous nephropathy: long-term outcome. *Clin Nephrol* 1993; **39**: 175–182.
665. Sloan RP, Schwartz MM, Korbet SM *et al.* Long-term outcome in systemic lupus erythematosus membranous glomerulonephritis. Lupus Nephritis Collaborative Study Group. *J Am Soc Nephrol* 1996; **7**: 299–305.
666. Donadio Jr JV, Burgess JH, Holley KE. Membranous lupus nephropathy: a clinicopathologic study. *Medicine (Baltimore)* 1977; **56**: 527–536.
667. Gonzalez-Dettoni H, Tron F. Membranous glomerulopathy in systemic lupus erythematosus. *Adv Nephrol Necker Hosp* 1985; **14**: 347–364.
668. Ordonez JD, Hiatt RA, Killebrew EJ *et al.* The increased risk of coronary heart disease associated with nephrotic syndrome. *Kidney Int* 1993; **44**: 638–642.
669. Mok CC, Ying KY, Lau CS *et al.* Treatment of pure membranous lupus nephropathy with prednisone and azathioprine: an open-label trial. *Am J Kidney Dis* 2004; **43**: 269–276.
670. Austin III HA, Illei GG, Braun MJ *et al.* Randomized, controlled trial of prednisone, cyclophosphamide, and cyclosporine in lupus membranous nephropathy. *J Am Soc Nephrol* 2009; **20**: 901–911.
671. Kasitanon N, Petri M, Haas M *et al.* Mycophenolate mofetil as the primary treatment of membranous lupus nephritis with and without concurrent proliferative disease: a retrospective study of 29 cases. *Lupus* 2008; **17**: 40–45.
672. Spetie DN, Tang Y, Rovin BH *et al.* Mycophenolate therapy of SLE membranous nephropathy. *Kidney Int* 2004; **66**: 2411–2415.
673. Szeto CC, Kwan BC, Lai FM *et al.* Tacrolimus for the treatment of systemic lupus erythematosus with pure class V nephritis. *Rheumatology (Oxford)* 2008; **47**: 1678–1681.
674. Ruiz-Irastorza G, Ramos-Casals M, Brito-Zeron P *et al.* Clinical efficacy and side effects of antimalarials in systemic lupus erythematosus: a systematic review. *Ann Rheum Dis* 2010; **69**: 20–28.
675. Tsakonas E, Joseph L, Esdaile JM *et al.* A long-term study of hydroxychloroquine withdrawal on exacerbations in systemic lupus erythematosus. The Canadian Hydroxychloroquine Study Group. *Lupus* 1998; **7**: 80–85.
676. Siso A, Ramos-Casals M, Bove A *et al.* Previous antimalarial therapy in patients diagnosed with lupus nephritis: influence on outcomes and survival. *Lupus* 2008; **17**: 281–288.
677. Kaiser R, Cleveland CM, Criswell LA. Risk and protective factors for thrombosis in systemic lupus erythematosus: results from a large, multi-ethnic cohort. *Ann Rheum Dis* 2009; **68**: 238–241.
678. Pons-Estel GJ, Alarcon GS, McGwin Jr G *et al.* Protective effect of hydroxychloroquine on renal damage in patients with lupus nephritis: LXV, data from a multiethnic US cohort. *Arthritis Rheum* 2009; **61**: 830–839.
679. Illei GG, Takada K, Parkin D *et al.* Renal flares are common in patients with severe proliferative lupus nephritis treated with pulse immunosuppressive therapy: long-term followup of a cohort of 145 patients participating in randomized controlled studies. *Arthritis Rheum* 2002; **46**: 995–1002.
680. Esdaile JM, Joseph L, MacKenzie T *et al.* The pathogenesis and prognosis of lupus nephritis: information from repeat renal biopsy. *Semin Arthritis Rheum* 1993; **23**: 135–148.
681. Daleboudt GMN, Bajema IM, Goemaere NNT *et al.* The clinical relevance of a repeat biopsy in lupus nephritis flares. *Nephrol Dial Transplant* 2009; **24**: 3712–3717.
682. Birmingham DJ, Nagaraja HN, Rovin BH *et al.* Fluctuation in self-perceived stress and increased risk of flare in patients with lupus nephritis carrying the serotonin receptor 1A -1019 G allele. *Arthritis Rheum* 2006; **54**: 3291–3299.
683. Clough JD, Lewis EJ, Lachin JM. Treatment protocols of the lupus nephritis collaborative study of plasmapheresis in severe lupus nephritis. The Lupus Nephritis Collaborative Study Group. *Prog Clin Biol Res* 1990; **337**: 301–307.
684. Linnik MD, Hu JZ, Heilbrunn KR *et al.* Relationship between anti-double-stranded DNA antibodies and exacerbation of renal disease in patients with systemic lupus erythematosus. *Arthritis Rheum* 2005; **52**: 1129–1137.
685. Rovin BH, Song H, Birmingham DJ *et al.* Urine chemokines as biomarkers of human systemic lupus erythematosus activity. *J Am Soc Nephrol* 2005; **16**: 467–473.
686. Rovin BH, Nadasdy G, Nuovo GJ *et al.* Expression of adiponectin and its receptors in the kidney during SLE nephritis (abstract). *J Am Soc Nephrol* 2006; **17**: 256A.
687. Rovin BH, Stillman IE. Kidney. In: Lahita RG, Tsokos GT, Buyon JP, Koike T (eds). *Systemic Lupus Erythematosus*, 5th edn. Elsevier: Waltham, MA, 2011, pp 769–814.
688. Garcia-Carrasco M, Mendoza-Pinto C, Sandoval-Cruz M *et al.* Anti-CD20 therapy in patients with refractory systemic lupus erythematosus: a longitudinal analysis of 52 Hispanic patients. *Lupus* 2010; **19**: 213–219.
689. Rauova L, Lukac J, Levy Y *et al.* High-dose intravenous immunoglobulins for lupus nephritis—a salvage immunomodulation. *Lupus* 2001; **10**: 209–213.
690. Ogawa H, Kameda H, Amano K *et al.* Efficacy and safety of cyclosporine A in patients with refractory systemic lupus erythematosus in a daily clinical practice. *Lupus* 2010; **19**: 162–169.
691. Ogawa H, Kameda H, Nagasawa H *et al.* Prospective study of low-dose cyclosporine A in patients with refractory lupus nephritis. *Mod Rheumatol* 2007; **17**: 92–97.
692. Miyasaka N, Kawai S, Hashimoto H. Efficacy and safety of tacrolimus for lupus nephritis: a placebo-controlled double-blind multicenter study. *Mod Rheumatol* 2009; **19**: 606–615.
693. Daugas E, Nochy D, Huang DL *et al.* Antiphospholipid syndrome nephropathy in systemic lupus erythematosus. *J Am Soc Nephrol* 2002; **13**: 42–52.
694. Tektonidou MG. Renal involvement in the antiphospholipid syndrome (APS)-APS nephropathy. *Clin Rev Allergy Immunol* 2009; **36**: 131–140.
695. Tektonidou MG, Sotsiou F, Moutsopoulos HM. Antiphospholipid syndrome (APS) nephropathy in catastrophic, primary, and systemic lupus erythematosus-related APS. *J Rheumatol* 2008; **35**: 1983–1988.
696. Crowther MA, Ginsberg JS, Julian J *et al.* A comparison of two intensities of warfarin for the prevention of recurrent thrombosis in patients with the antiphospholipid antibody syndrome. *N Engl J Med* 2003; **349**: 1133–1138.
697. Finazzi G, Marchioli R, Brancaccio V *et al.* A randomized clinical trial of high-intensity warfarin vs. conventional antithrombotic therapy for the prevention of recurrent thrombosis in patients with the antiphospholipid syndrome (WAPS). *J Thromb Haemost* 2005; **3**: 848–853.
698. Kwok SK, Ju JH, Cho CS *et al.* Thrombotic thrombocytopenic purpura in systemic lupus erythematosus: risk factors and clinical outcome: a single centre study. *Lupus* 2009; **18**: 16–21.
699. Tandon A, Ibanez D, Gladman DD *et al.* The effect of pregnancy on lupus nephritis. *Arthritis Rheum* 2004; **50**: 3941–3946.
700. Carvalheiras G, Vita P, Marta S *et al.* Pregnancy and systemic lupus erythematosus: review of clinical features and outcome of 51 pregnancies at a single institution. *Clin Rev Allergy Immunol* 2010; **38**: 302–306.
701. Imbasciati E, Tincani A, Gregorini G *et al.* Pregnancy in women with pre-existing lupus nephritis: predictors of fetal and maternal outcome. *Nephrol Dial Transplant* 2009; **24**: 519–525.
702. Wagner SJ, Craici I, Reed D *et al.* Maternal and foetal outcomes in pregnant patients with active lupus nephritis. *Lupus* 2009; **18**: 342–347.
703. Levy RA, Vilela VS, Cataldo MJ *et al.* Hydroxychloroquine (HCQ) in lupus pregnancy: double-blind and placebo-controlled study. *Lupus* 2001; **10**: 401–404.

704. Hogan SL, Nachman PH, Wilkman AS *et al.* Prognostic markers in patients with antineutrophil cytoplasmic autoantibody-associated microscopic polyangiitis and glomerulonephritis. *J Am Soc Nephrol* 1996; **7**: 23–32.
705. de Groot K, Harper L, Jayne DR *et al.* Pulse versus daily oral cyclophosphamide for induction of remission in antineutrophil cytoplasmic antibody-associated vasculitis: a randomized trial. *Ann Intern Med* 2009; **150**: 670–680.
706. Hogan SL, Falk RJ, Chin H *et al.* Predictors of relapse and treatment resistance in antineutrophil cytoplasmic antibody-associated small-vessel vasculitis. *Ann Intern Med* 2005; **143**: 621–631.
707. Jayne DR, Gaskin G, Rasmussen N *et al.* Randomized trial of plasma exchange or high-dosage methylprednisolone as adjunctive therapy for severe renal vasculitis. *J Am Soc Nephrol* 2007; **18**: 2180–2188.
708. de Lind van Wijngaarden RA, Hauer HA, Wolterbeek R *et al.* Chances of renal recovery for dialysis-dependent ANCA-associated glomerulonephritis. *J Am Soc Nephrol* 2007; **18**: 2189–2197.
709. Nachman PH, Hogan SL, Jennette JC *et al.* Treatment response and relapse in antineutrophil cytoplasmic autoantibody-associated microscopic polyangiitis and glomerulonephritis. *J Am Soc Nephrol* 1996; **7**: 33–39.
710. Walters GD, Willis NS, Craig JC. Interventions for renal vasculitis in adults. A systematic review. *BMC Nephrol* 2010; **11**: 12.
711. Jayne D, Rasmussen N, Andrassy K *et al.* A randomized trial of maintenance therapy for vasculitis associated with antineutrophil cytoplasmic autoantibodies. *N Engl J Med* 2003; **349**: 36–44.
712. Guillevin L, Cohen P, Mahr A *et al.* Treatment of polyarteritis nodosa and microscopic polyangiitis with poor prognosis factors: a prospective trial comparing glucocorticoids and six or twelve cyclophosphamide pulses in sixty-five patients. *Arthritis Rheum* 2003; **49**: 93–100.
713. Jones RB, Tervaert JW, Hauser T *et al.* Rituximab versus cyclophosphamide in ANCA-associated renal vasculitis. *N Engl J Med* 2010; **363**: 211–220.
714. Stone JH, Merkel PA, Spiera R *et al.* Rituximab versus cyclophosphamide for ANCA-associated vasculitis. *N Engl J Med* 2010; **363**: 221–232.
715. Cole E, Cattran D, Magil A *et al.* A prospective randomized trial of plasma exchange as additive therapy in idiopathic crescentic glomerulonephritis. The Canadian Apheresis Study Group. *Am J Kidney Dis* 1992; **20**: 261–269.
716. Lauque D, Cadranet J, Lazor R *et al.* Microscopic polyangiitis with alveolar hemorrhage. A study of 29 cases and review of the literature. Groupe d'Etudes et de Recherche sur les Maladies "Orphelines" Pulmonaires (GERM"O" P). *Medicine (Baltimore)* 2000; **79**: 222–233.
717. Klemmer PJ, Chalermkulrat W, Reif MS *et al.* Plasmapheresis therapy for diffuse alveolar hemorrhage in patients with small-vessel vasculitis. *Am J Kidney Dis* 2003; **42**: 1149–1153.
718. Holguin F, Ramadan B, Gal AA *et al.* Prognostic factors for hospital mortality and ICU admission in patients with ANCA-related pulmonary vasculitis. *Am J Med Sci* 2008; **336**: 321–326.
719. Rutgers A, Slot M, van Paassen P *et al.* Coexistence of anti-glomerular basement membrane antibodies and myeloperoxidase-ANCAs in crescentic glomerulonephritis. *Am J Kidney Dis* 2005; **46**: 253–262.
720. Silva F, Specks U, Kalra S *et al.* Mycophenolate mofetil for induction and maintenance of remission in microscopic polyangiitis with mild to moderate renal involvement—a prospective, open-label pilot trial. *Clin J Am Soc Nephrol* 2010; **5**: 445–453.
721. Stassen PM, Tervaert JW, Stegeman CA. Induction of remission in active anti-neutrophil cytoplasmic antibody-associated vasculitis with mycophenolate mofetil in patients who cannot be treated with cyclophosphamide. *Ann Rheum Dis* 2007; **66**: 798–802.
722. Hu W, Liu C, Xie H *et al.* Mycophenolate mofetil versus cyclophosphamide for inducing remission of ANCA vasculitis with moderate renal involvement. *Nephrol Dial Transplant* 2008; **23**: 1307–1312.
723. Sanders JS, Huitma MG, Kallenberg CG *et al.* Prediction of relapses in PR3-ANCA-associated vasculitis by assessing responses of ANCA titres to treatment. *Rheumatology (Oxford)* 2006; **45**: 724–729.
724. Hiemstra TF, Walsh M, Mahr A *et al.* Mycophenolate mofetil vs azathioprine for remission maintenance in antineutrophil cytoplasmic antibody-associated vasculitis: a randomized controlled trial. *JAMA* 2010; **304**: 2381–2388.
725. Stegeman CA, Tervaert JW, de Jong PE *et al.* Trimethoprim-sulfamethoxazole (co-trimoxazole) for the prevention of relapses of Wegener's granulomatosis. Dutch Co-Trimoxazole Wegener Study Group. *N Engl J Med* 1996; **335**: 16–20.
726. Pagnoux C, Mahr A, Hamidou MA *et al.* Azathioprine or methotrexate maintenance for ANCA-associated vasculitis. *N Engl J Med* 2008; **359**: 2790–2803.
727. Lionaki S, Hogan SL, Jennette CE *et al.* The clinical course of ANCA small-vessel vasculitis on chronic dialysis. *Kidney Int* 2009; **76**: 644–651.
728. Weidanz F, Day CJ, Hewins P *et al.* Recurrences and infections during continuous immunosuppressive therapy after beginning dialysis in ANCA-associated vasculitis. *Am J Kidney Dis* 2007; **50**: 36–46.
729. Martinez V, Cohen P, Pagnoux C *et al.* Intravenous immunoglobulins for relapses of systemic vasculitides associated with antineutrophil cytoplasmic autoantibodies: results of a multicenter, prospective, open-label study of twenty-two patients. *Arthritis Rheum* 2008; **58**: 308–317.
730. Dickenmann M, Oettl T, Mihatsch MJ. Osmotic nephrosis: acute kidney injury with accumulation of proximal tubular lysosomes due to administration of exogenous solutes. *Am J Kidney Dis* 2008; **51**: 491–503.
731. Jayne DR, Chapel H, Adu D *et al.* Intravenous immunoglobulin for ANCA-associated systemic vasculitis with persistent disease activity. *QJM* 2000; **93**: 433–439.
732. Eriksson P. Nine patients with anti-neutrophil cytoplasmic antibody-positive vasculitis successfully treated with rituximab. *J Intern Med* 2005; **257**: 540–548.
733. Keogh KA, Wylam ME, Stone JH *et al.* Induction of remission by B lymphocyte depletion in eleven patients with refractory antineutrophil cytoplasmic antibody-associated vasculitis. *Arthritis Rheum* 2005; **52**: 262–268.
734. Stasi R, Stipa E, Del Poeta G *et al.* Long-term observation of patients with anti-neutrophil cytoplasmic antibody-associated vasculitis treated with rituximab. *Rheumatology (Oxford)* 2006; **45**: 1432–1436.
735. Finkelstein JD, Merkel PA, Schroeder D *et al.* Antiproteinase 3 antineutrophil cytoplasmic antibodies and disease activity in Wegener granulomatosis. *Ann Intern Med* 2007; **147**: 611–619.
736. Nowack R, Grab I, Flores-Suarez LF *et al.* ANCA titres, even of IgG subclasses, and soluble CD14 fail to predict relapses in patients with ANCA-associated vasculitis. *Nephrol Dial Transplant* 2001; **16**: 1631–1637.
737. Gera M, Griffin MD, Specks U *et al.* Recurrence of ANCA-associated vasculitis following renal transplantation in the modern era of immunosuppression. *Kidney Int* 2007; **71**: 1296–1301.
738. Nachman PH, Segelmark M, Westman K *et al.* Recurrent ANCA-associated small vessel vasculitis after transplantation: A pooled analysis. *Kidney Int* 1999; **56**: 1544–1550.
739. Little MA, Hassan B, Jacques S *et al.* Renal transplantation in systemic vasculitis: when is it safe? *Nephrol Dial Transplant* 2009; **24**: 3219–3225.
740. Levy JB, Turner AN, Rees AJ *et al.* Long-term outcome of anti-glomerular basement membrane antibody disease treated with plasma exchange and immunosuppression. *Ann Intern Med* 2001; **134**: 1033–1042.
741. Johnson JP, Moore Jr J, Austin III HA *et al.* Therapy of anti-glomerular basement membrane antibody disease: analysis of prognostic significance of clinical, pathologic and treatment factors. *Medicine (Baltimore)* 1985; **64**: 219–227.
742. Jindal KK. Management of idiopathic crescentic and diffuse proliferative glomerulonephritis: evidence-based recommendations. *Kidney Int Suppl* 1999; **70**: S33–S40.
743. Cui Z, Zhao MH, Xin G *et al.* Characteristics and prognosis of Chinese patients with anti-glomerular basement membrane disease. *Nephron Clin Pract* 2005; **99**: c49–c55.
744. Levy JB, Hammad T, Coulthart A *et al.* Clinical features and outcome of patients with both ANCA and anti-GBM antibodies. *Kidney Int* 2004; **66**: 1535–1540.
745. Li FK, Tse KC, Lam MF *et al.* Incidence and outcome of antiglomerular basement membrane disease in Chinese. *Nephrology (Carlton)* 2004; **9**: 100–104.
746. Lindic J, Vizjak A, Ferluga D *et al.* Clinical outcome of patients with coexistent antineutrophil cytoplasmic antibodies and antibodies against glomerular basement membrane. *Ther Apher Dial* 2009; **13**: 278–281.
747. Segelmark M, Hellmark T, Wieslander J. The prognostic significance in Goodpasture's disease of specificity, titre and affinity of anti-glomerular-basement-membrane antibodies. *Nephron Clin Pract* 2003; **94**: c59–c68.
748. Hirayama K, Yamagata K, Kobayashi M *et al.* Anti-glomerular basement membrane antibody disease in Japan: part of the nationwide rapidly progressive glomerulonephritis survey in Japan. *Clin Exp Nephrol* 2008; **12**: 339–347.
749. Shah MK, Huggins SY. Characteristics and outcomes of patients with Goodpasture's syndrome. *South Med J* 2002; **95**: 1411–1418.
750. Stegmayr BG, Almroth G, Berlin G *et al.* Plasma exchange or immunoadsorption in patients with rapidly progressive crescentic

- glomerulonephritis. A Swedish multi-center study. *Int J Artif Organs* 1999; **22**: 81–87.
751. Proskey AJ, Weatherbee L, Easterling RE *et al.* Goodpasture's syndrome. A report of five cases and review of the literature. *Am J Med* 1970; **48**: 162–173.
752. Levy JB, Lachmann RH, Pusey CD. Recurrent Goodpasture's disease. *Am J Kidney Dis* 1996; **27**: 573–578.
753. Adler S, Bruns FJ, Fraley DS *et al.* Rapid progressive glomerulonephritis: relapse after prolonged remission. *Arch Intern Med* 1981; **141**: 852–854.
754. Hind CR, Bowman C, Winearls CG *et al.* Recurrence of circulating anti-glomerular basement membrane antibody three years after immunosuppressive treatment and plasma exchange. *Clin Nephrol* 1984; **21**: 244–246.
755. Klasa RJ, Abboud RT, Ballon HS *et al.* Goodpasture's syndrome: recurrence after a five-year remission. Case report and review of the literature. *Am J Med* 1988; **84**: 751–755.
756. Choy BY, Chan TM, Lai KN. Recurrent glomerulonephritis after kidney transplantation. *Am J Transplant* 2006; **6**: 2535–2542.
757. Joshi K, Nada R, Minz M *et al.* Recurrent glomerulopathy in the renal allograft. *Transplant Proc* 2007; **39**: 734–736.
758. Counsell C. Formulating questions and locating primary studies for inclusion in systematic reviews. *Ann Intern Med* 1997; **127**: 380–387.
759. Atkins D, Best D, Briss PA *et al.* Grading quality of evidence and strength of recommendations. *BMJ* 2004; **328**: 1490.
760. Guyatt GH, Oxman AD, Kunz R *et al.* Going from evidence to recommendations. *BMJ* 2008; **336**: 1049–1051.
761. Uhlig K, Macleod A, Craig J *et al.* Grading evidence and recommendations for clinical practice guidelines in nephrology. A position statement from Kidney Disease: Improving Global Outcomes (KDIGO). *Kidney Int* 2006; **70**: 2058–2065.
762. AGREE Collaboration. Development and validation of an international appraisal instrument for assessing the quality of clinical practice guidelines: the AGREE project. *Qual Saf Health Care* 2003; **12**: 18–23.
763. Shiffman RN, Shekelle P, Overhage JM *et al.* Standardized reporting of clinical practice guidelines: a proposal from the Conference on Guideline Standardization. *Ann Intern Med* 2003; **139**: 493–498.
764. *Finding what Works in Health Care: Standards for Systematic Reviews*. IOM (Institute of Medicine): Washington, DC 2011.
765. *Clinical Practice Guidelines we can Trust*. IOM (Institute of Medicine): Washington, DC 2011.