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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Translating Guidelines to Action in IgAN: Embracing a Simultaneous Dual-Concordant Approach

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Dr. Lafayette:
Welcome. This is CE on ReachMD. I'm Dr. Richard Lafayette. Here with me today, I'm honored to be with Dr. Yuzuki Suzuki. And today, we're talking about the updated KDIGO guidelines for IgA nephropathy and their implications for practice.

So I'll go right to Professor Suzuki and ask him to explain what is new in the guidelines.

Dr. Suzuki:
Thank you, Richard, for the question. So the most important change in the new KDIGO IgA nephropathy guideline is a clear shift toward earlier and more aggressive disease modification. The first, the recommended proteinuria target has been lowered, so we are no longer satisfied with less than 1 g/day. The new goal is below 0.5 g/day and ideally, below 0.3 g because even the low-grade persistent proteinuria is associated with long-term kidney failure risk.

The second, the guideline emphasizes a simultaneous dual approach to optimize the CKD-supportive care together with targeted immunomodulatory therapy in patients at risk, rather than a slow, stepwise escalation.

Dr. Lafayette:
I agree. I think the new guidelines really are focused on the fact that patients have done poorly with IgA nephropathy, especially when they're not diagnosed early, treated aggressively, and that we've seen that patients above 0.3 g/day of proteinuria can really suffer devastating consequences, and we have to really watch them, treat them aggressively. And that we need to, again, be very thoughtful about both those things that are targeting IgA nephropathy itself and to be aggressive in dealing with any chronic kidney disease that they have at the time of diagnosis.

Now, of course, things are changing so rapidly that in the guidelines, when they were published in the United States, we did have the approval of sparsentan, we had the approval of targeted budesonide. But since then, there's been multiple other agents approved, including complement inhibitor, iptacopan, another endothelin blocker, atrasentan.

And now we have the first approval of even more targeted therapy at B-cell interventions with APRIL inhibitors, monoclonal antibodies to APRIL, and fusion proteins which inhibit BAFF/APRIL. So things are really changing.

Dr. Suzuki, where do you think all this fits into this simultaneous approach?

Dr. Suzuki:
At present, APRIL inhibitors are not yet included in the guideline, but they clearly fit conceptually into the upstream disease-modifying strategy and may become an important part of future personalized treatment once long-term data are available.

So I think they could be introduced early, potentially in combination with optimized CKD therapy, to prevent irreversible nephron loss rather than reacting to it later.

Dr. Lafayette:
Yeah, I agree. I think it's a wonderful time where we really can take these aspirational guidelines, which say find people early, treat them aggressively, stop their GFR from progressing at all, differently than people who have healthy kidney function, and get their proteinuria low. I think just 3 years ago, that would have been a very difficult task, at least not with very severe immunosuppression and a lot of interventions. And now, with these tools, we have a good chance that we can actually achieve it.

So, again, our time is up on this session. I hope you find our perspectives useful. Thanks, everybody, for listening.

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