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**Glomerulonephritis: What's new?**

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The KDIGO Clinical Practice Guideline on Glomerular Diseases is expected to be published in October 2021. Here, a highlight will be given on treatment approaches in primary glomerular diseases, namely minimal change disease (MCD), focal segmental glomerulosclerosis (FSGS), IgA nephropathy (IgAN), and membranous nephropathy (MN).

In adults with MCD, high dose oral corticosteroids (orally or other routes as appropriate) are recommended first-line treatment with a duration of no longer than 16 weeks. Tapering can begin at 2 weeks. For patients in whom corticosteroids are relatively contraindicated, initial therapy with cyclophosphamide, a calcineurin inhibitor, or mycophenolate mofetil (MMF) plus reduced-dose corticosteroid can be considered

For FSGS, patients without the nephrotic syndrome should be evaluated for a secondary cause and not be commenced on immunosuppression. For primary FSGS, high-dose corticosteroids be used as the first-line immunosuppressive treatment be continued until complete remission or as tolerated by patients, up to a maximum of 16 weeks, whichever is earlier. Responsive patients should receive corticosteroids for at least six months. Patients with steroid-resistant disease are recommended for cyclosporine or tacrolimus for at least 6 months rather than continuing with corticosteroid monotherapy.

For IgAN, the primary focus should be optimized supportive care plus maximally tolerated renin-angiotensin blockade with either an ACEi or ARB for all patients with proteinuria >0.5g/ 24 hours irrespective of the presence of hypertension. Patients who remain at high risk of progressive CKD despite maximal supportive care should be considered for enrolment into a clinical trial if possible or may be considered for a six-month course of corticosteroid therapy tailored to concomitant conditions such as G3b or above stages of CKD, diabetes, obesity, infection, peptic ulcer disease and uncontrolled psychiatric illness. Special consideration may be given to specific populations such as tonsillectomy in Japanese and MMF plus low-dose steroid or hydroxychloroquine in Chinese patients.

In MN patients at risk of progression, rituximab, or cyclophosphamide and steroids for six months, or tacrolimus-based therapy for at least six months can be considered, with the choice of treatment depending on the risk estimate.