Top 5 Takeaways for Clinicians from the KDIGO 2021 Clinical Practice Guideline for the Management of Anti-GBM Glomerulonephritis

1 Diagnosis

In all patients with a rapidly progressive glomerulonephritis, a diagnosis should be made as quickly as possible, but if anti-GBM disease is suspected, treatment should be started without delay, even if diagnosis has not been confirmed (Figure 1).

2 Treatment

Immunosuppression with cyclophosphamide and glucocorticoids plus plasmapheresis should be initiated in all patients with anti-GBM except those who need dialysis at presentation, have 100% crescents or >50% global glomerulosclerosis in an adequate biopsy sample, and do not have pulmonary hemorrhage (Figure 1). Treatment for anti-GBM disease should start without delay if this diagnosis is suspected, even before the confirmed diagnosis.the patient displays steroid resistance, has an atypical clinical course, or is > 12 years of age at presentation.

3 Length of treatment

Plasma exchange should be performed until anti-GBM antibodies in serum are no longer detectable. Cyclophosphamide should be administered for 2–3 months and glucocorticoids tapered over 6 months. No maintenance therapy of anti-GBM disease is necessary with the exception of patients who are also anti-neutrophil cytoplasmic antibody (ANCA)-positive.

4 Refractory disease

In refractory anti-GBM disease, rituximab may be tried.

5 Kidney transplantation

Kidney transplantation in patients with kidney failure due to anti-GBM disease should be postponed until anti-GBM antibodies remain undetectable for at least 6 months.

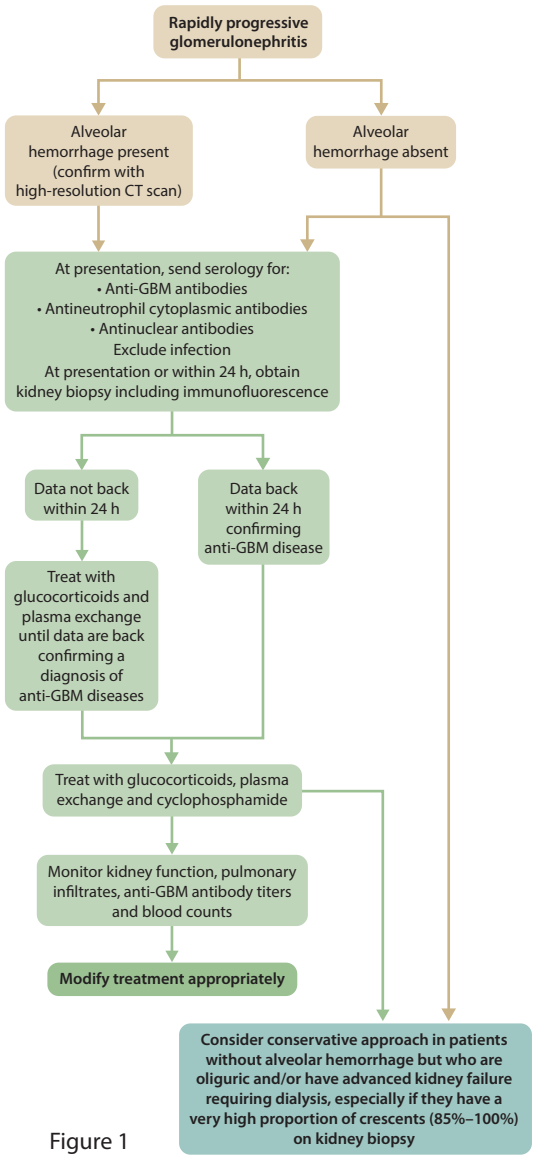

Figure 1