

Corrigendum to “KDIGO 2024 Clinical Practice Guideline for the Management of Antineutrophil Cytoplasmic Antibody (ANCA)–Associated Vasculitis.” *Kidney Int.* 2024;105(3S):S71–S116

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Kidney Disease: Improving Global Outcomes (KDIGO) ANCA Vasculitis Work Group

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The KDIGO Clinical Practice Guideline for the Management of ANCA-Associated Vasculitis Work Group has issued amendments to guideline [Figures 6–8](#) and [13](#) and Practice Points 9.3.1.9 and 9.3.3.1. The revised figures and text passages, along with a brief summary of the accompanying changes, are presented below. The article has been corrected online to reflect these corrections.

The Work Group has streamlined the treatment algorithm ([Figure 6](#), pages S85 and S97) and cross-referenced Practice Point 9.3.1.9 in the caption as to when plasma exchange can be considered:

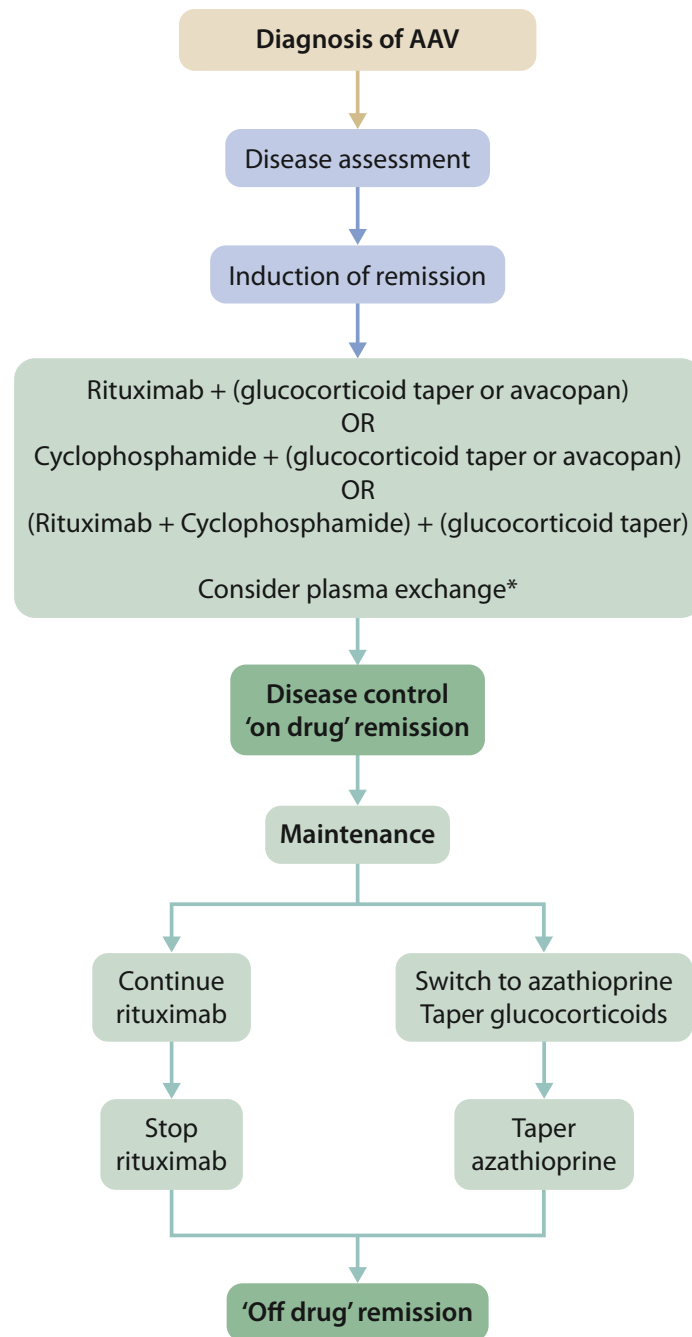


Figure 6 | Practical treatment regimen for AAV. *Please see Practice Point 9.3.1.9 for details. AAV, ANCA-associated vasculitis; ANCA, antineutrophil cytoplasmic antibody.

For clarity, a previous statement in the **Cyclophosphamide preferred** column of [Figure 7](#) (pages S86 and S98) suggesting a combination regimen consisting of rituximab and 2 intravenous pulses of cyclophosphamide has been moved to the caption as a footnote.

Rituximab preferred	Cyclophosphamide preferred
<ul style="list-style-type: none"> • Children and adolescents • Pre-menopausal women and men concerned about their fertility • Frail older adults • Glucocorticoid-sparing especially important • Relapsing disease • PR3–ANCA disease 	<ul style="list-style-type: none"> • Rituximab difficult to access • Severe GN (SCr >4 mg/dl [354 µmol/l])*

Figure 7 | Factors for consideration when choosing between rituximab and cyclophosphamide for induction therapy of AAV. *A combination of 2 intravenous pulses of cyclophosphamide with rituximab can be considered. AAV, ANCA-associated vasculitis; ANCA, antineutrophil cytoplasmic antibody; GN, glomerulonephritis; PR3, proteinase 3; SCr, serum creatinine.

The text accompanying the 3rd and 4th bullets in the **Intravenous cyclophosphamide** column and the entire listing in the **Oral cyclophosphamide** column of [Figure 8](#) (pages S86 and S98) have been reworded for added clarifications.

Intravenous cyclophosphamide	Oral cyclophosphamide
<ul style="list-style-type: none"> • Patients who already have a moderate cumulative dose of cyclophosphamide • Patients with lower white blood cell counts • Patients with ready access to an infusion center • Patients who may have trouble adhering to an oral regimen 	<ul style="list-style-type: none"> • Patients for whom cost is an important factor • Patients who do not have easy access to an infusion center • Patients for whom a self-administered oral regimen will not be difficult

Figure 8 | Considerations for the route of administration of cyclophosphamide for AAV. AAV, ANCA-associated vasculitis. ANCA, antineutrophil cytoplasmic antibody.

For [Figure 13](#) (pages S88 and S103), for the sake of clarity, parentheses were added to define the level of low baseline IgG.

Rituximab preferred	Azathioprine preferred
<ul style="list-style-type: none"> • Relapsing disease • PR3–ANCA disease • Frail older adults • Glucocorticoid-sparing especially important • Azathioprine allergy 	<ul style="list-style-type: none"> • Low baseline IgG (<300 mg/dl) • Limited availability of rituximab

Figure 13 | Considerations for using rituximab or azathioprine for AAV maintenance therapy. AAV, ANCA-associated vasculitis; ANCA, antineutrophil cytoplasmic antibody; IgG, immunoglobulin G; PR3, proteinase 3.

A small change to the Practice Point 9.3.1.9 (pages S87 and S99) has been implemented as underlined below:

Practice Point 9.3.1.9: Consider plasma exchange for patients with SCr >3.4 mg/dl (>300 mmol/l), patients requiring dialysis or with rapidly increasing SCr, and patients with diffuse alveolar hemorrhage who have hypoxemia.

has been revised to:

Practice Point 9.3.1.9: Consider plasma exchange for patients with SCr >3.4 mg/dl (>300 mmol/l), patients requiring dialysis or with rapidly increasing SCr, or patients with diffuse alveolar hemorrhage who have hypoxemia.

The underlined phrase “(life- or organ-threatening)” is now removed for Practice Point 9.3.3.1 (pages S89 and S103) as it imparts no added information value:

Practice Point 9.3.3.1: Patients with relapsing disease (life- or organ-threatening) should be reinduced (Recommendation 9.3.1.1.), preferably with rituximab.

has been revised to:

Practice Point 9.3.3.1: Patients with relapsing disease should be reinduced (Recommendation 9.3.1.1.), preferably with rituximab.

The authors would like to apologize for any inconvenience caused.
