Corrigendum to "KDIGO 2024 Clinical Practice Guideline for the Management of Antineutrophil Cytoplasmic Antibody (ANCA)–Associated Vasculitis." *Kidney International* 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:

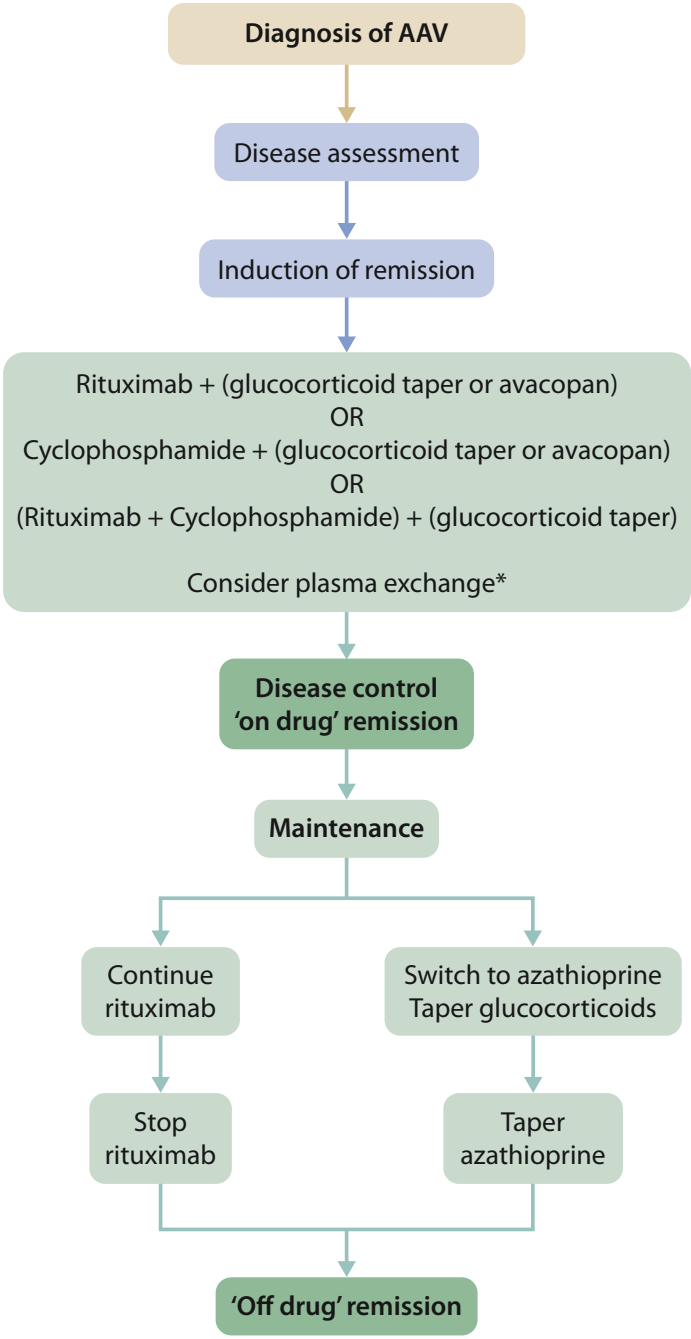

Figure 6| Practical treatment regimen for AAV. *Please see Practice Point 9.3.1.9 for details. AAV, ANCA-associated vasculitis; ANCA, antineutrophil cytoplasmic antibody.

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

Rituximab preferred	Cyclophosphamide preferred
• Children and adolescents • Pre-menopausal women and men concerned about their fertility • Frail older adults • Glucocorticoid-sparing especially important • Relapsing disease • PR3–ANCA disease	• 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
• 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	• 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
• Relapsing disease • PR3–ANCA disease • Frail older adults • Glucocorticoid-sparing especially important • Azathioprine allergy	• 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.

Corrigendum to "Executive summary of the KDIGO 2024 Clinical Practice Guideline for the Management of ANCA–Associated Vasculitis." *Kidney International* 2024;105(3):447–449

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The *KDIGO Clinical Practice Guideline for the Management of ANCA-Associated Vasculitis* Work Group has issued amendments to Figure 1 and Practice Point 9.3.1.9 of the guideline Executive Summary. The revised figure and text, 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 1) and cross-referenced Practice Point 9.3.1.9 in the caption as to when plasma exchange can be considered: