Top 12 Takeaways from the KDIGO 2025 Clinical Practice Guideline for the Management of IgA Nephropathy

1 Diagnosis of IgA nephropathy (IgAN)

IgAN can only be diagnosed with a kidney biopsy, as there are no validated serum or urine biomarkers for the diagnosis. To ensure an early diagnosis and prompt treatment, a kidney biopsy should be considered in all adults with proteinuria ≥0.5 g/d (or equivalent) in whom IgAN is a possible diagnosis (Figure 1).

2 Prognosis

Clinical and histologic data at the time of kidney biopsy can be used for risk stratification by the International IgAN Prediction Tools (Figure 1). However, neither the International IgAN Prediction Tools nor the Oxford Classification MEST-C score should be used to decide on a specific therapy. There are no validated prognostic serum or urine biomarkers other than eGFR and proteinuria.

3 Treatment goals in patients with IgAN at risk of progressive loss of kidney function

The treatment goal in patients with IgAN at risk of progressive loss of kidney function (i.e., proteinuria ≥0.5 g/d [or equivalent] while on or off treatment) is to reduce the rate of loss of kidney function to the physiological state (i.e., <1 ml/min/yr for most adults) for the rest of the patient's life. Currently, the only validated early biomarker to help guide clinical decision-making is urine protein excretion, which should be maintained at a minimum of <0.5 g/d (or equivalent), and ideally at <0.3 g/d (or equivalent).

4 Focus of the management of patients with IgAN who are at risk of progressive loss of kidney function

The focus of the management in most patients should be to ***simultaneously***: i) prevent or reduce IgA-IC formation and IgA-IC–mediated glomerular injury (whether this requires lifelong or intermittent therapy is currently unknown) and ii) manage the consequences of existing IgAN-induced nephron loss (likely lifelong).

5 Managing the consequences of IgAN-induced nephron loss

All patients should receive extensive lifestyle advice on smoking and vaping cessation, weight control, dietary sodium restriction (<2 g/d), and regular exercise. Blood pressure should be controlled to a target of ≤120/70 mm Hg.

6 Managing the IgAN-specific drivers of nephron loss (Figure 2)

A 9-month course of Nefecon is suggested for patients with IgAN who are at risk of progressive loss of kidney function. Where Nefecon is not available, patients should be treated with a reduced-dose systemic glucocorticoid regimen combined with antimicrobial prophylaxis. Tonsillectomy alone or with pulsed glucocorticoids is recommended by the Japanese Society of Nephrology for the treatment of patients with IgAN, but it should not be performed as a treatment of IgAN in non-Japanese patients. Similarly, in Chinese patients in whom glucocorticoids are being considered, MMF may be used as a glucocorticoid-sparing agent.

7 Managing IgAN-associated chronic kidney disease (Figure 2)

All patients with IgAN should be treated with an optimized maximally tolerated dose of either an ACEi or an ARB. Where approved, patients who are at risk of progressive loss of kidney function may be treated with sparsentan, which should replace, rather than be prescribed together with, a RASi. These patients may also be treated with an SGLT2i.

8 Special situations: Nephrotic syndrome

In the rare patient with IgAN and nephrotic syndrome, it is often unclear whether nephrotic syndrome is a specific variant of IgAN or the coexistence of minimal change disease. Patients with a kidney biopsy demonstrating mesangial IgA deposition and light and electron microscopy features otherwise consistent with MCD should receive treatment analogous to that of MCD (see KDIGO 2021 GD Guideline Chapter 5). Patients with nephrotic syndrome whose kidney biopsy has coexistent features of MPGN should be managed in the same way as those who are at risk of progressive loss of kidney function.

9 Special situations: RPGN

Rapidly progressive IgAN is defined as a ≥50% decline in eGFR over ≤3 months, where other causes of RPGN and AKI have been excluded. Patients with rapidly progressive IgAN should be offered treatment with cyclophosphamide and systemic glucocorticoids in accordance with the KDIGO 2024 Guideline for ANCA–Associated Vasculitis.

10 Special situations: AKI

AKI may occur in rapidly progressing IgAN, but often accompanies disease flares with visible hematuria. Treatment should focus on supportive care with consideration for a repeat kidney biopsy if there is no improvement in kidney function within 2 weeks of cessation of hematuria.

11 Special situations: Pregnancy planning

All women of childbearing potential should be offered preconception counseling focused on cessation of RASi, SGLT2i, sparsentan, Nefecon, and systemic glucocorticoids. Blood pressure control should be optimized with alternative antihypertensive medications prior to conception. Neither SGLT2i nor sparsentan should be used while breastfeeding. Enalapril can be used if a RASi is clinically indicated.

12 Special situations: IgAN in children

The KDIGO 2025 Guideline for the Management of IgAN and IgAV has harmonized its guidance with that of the 2025 IPNA recommendations available at: https://link.springer.com/article/10.1007/s00467-024-06502-6

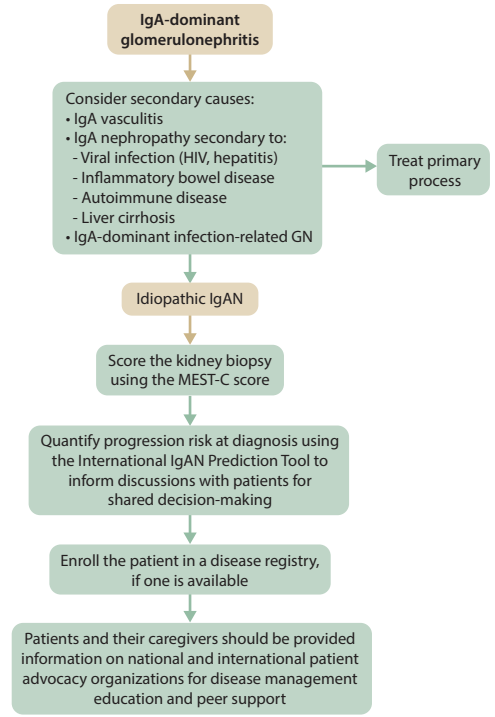

Figure 1

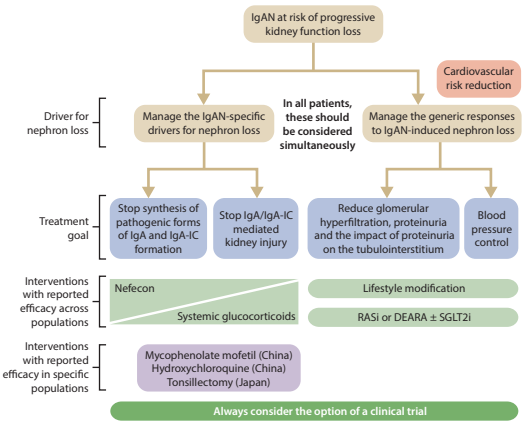

Figure 2

Abbreviations: ACEi, angiotensin-converting enzyme inhibitor; AKI, acute kidney injury; ANCA, antineutrophil cytoplasmic antibody; ARB, angiotensin II receptor blocker; eGFR, estimated glomerular filtration rate; GD, glomerular diseases; IgA-IC, immunoglobulin A–containing immune complex; IgAV, immunoglobulin A vasculitis; IPNA, International Pediatric Nephrology Association; MCD, minimal change disease; MEST-C, mesangial [M] and endocapillary [E] hypercellularity, segmental sclerosis [S], interstitial fibrosis/tubular atrophy [T], and crescents [C]; MMF, mycophenolate mofetil; MPGN, mesangioproliferative glomerulonephritis; RAS(i), renin-angiotensin system (inhibitor); RPGN, rapidly progressive glomerulonephritis; SGLT2i, sodium glucose cotransporter-2 inhibitors.