

Key Takeaways for Clinicians from the KDIGO 2025 Clinical Practice Guideline for the Evaluation, Management, and Treatment of ADPKD: Pregnancy and reproductive issues



1 Hormone therapy

When considering hormone therapy in women with ADPKD, liver imaging should be performed when feasible to document liver cysts and possible PLD, to inform discussion about options for contraception, hormonal replacement, and other indications (Figure 1).

2 Preconception counseling

Preconception counseling for people with ADPKD addresses a range of topics, including medication adjustments for women, information on reproductive options and potential pregnancy outcomes, and the distinct risks anticipated for both the mother and a child at risk of inheriting the condition. It should be offered to both men and women with ADPKD who are of reproductive age (Figure 1).

3 Reproductive options

Reproductive options without testing of fetus/embryo include accepting 50% chances of offspring with ADPKD, or using egg (in the case of an affected female) or sperm (in the case of an affected male) donation from a donor not affected by ADPKD. Reproductive options with testing of fetus/embryo include preimplantation genetic testing and prenatal testing (Figure 2).

4 Management during pregnancy

During pregnancy, BP, kidney function, soluble fms-like tyrosine kinase-1-to-placental growth factor ratio (sFlt-1/PlGF), and proteinuria should be monitored in women with ADPKD, similar to women with CKD. Low-dose aspirin (75–150 mg daily) should be prescribed from week 12 to week 36 in pregnant women with ADPKD (Figure 1).

5 Blood pressure monitoring

More frequent BP monitoring, preferably weekly home BP monitoring, is advised in all women with ADPKD who become pregnant, most importantly, in those with preexisting hypertension or hypertension diagnosed during their pregnancy.

6 Postpartum review

Women with ADPKD should be seen by a nephrologist within 6 months after delivery for a postpartum kidney review. Women with ADPKD may have bladder instability or urinary incontinence after delivery and should be offered pelvic-floor physical therapy (Figure 3).

Figure 1 Women with ADPKD of childbearing age

Hormone therapy
<ul style="list-style-type: none"> Counsel about risk/benefit of estrogen/progesterone therapy in ADPKD women with regard to PLD IUDs (including levonorgestrel-releasing IUD) and gestagen OCPs may be preferred for women with PLD
Preconception counseling
<ul style="list-style-type: none"> Discontinue potential teratogenic drugs before becoming pregnant (e.g., tolvaptan, RASi) Review the risks of preeclampsia, pregnancy induced hypertension, and premature delivery in ADPKD women Genetic counseling. Information on risk of inheritance of ADPKD for each pregnancy, nature of fetal/childhood outcomes in affected offspring, and the potential risk/benefit of PGT/PT/egg-sperm donation
Management during pregnancy
<ul style="list-style-type: none"> Regular monthly assessment of BP, kidney function, and proteinuria by a health care provider Home BP monitoring is encouraged Suggested target BP <135/85 mm Hg Low dose of aspirin from week 12 to week 36 is recommended for all pregnant ADPKD women Monthly screening for UTI is advised. Those with positive urine cultures should be treated adequately Encourage increased fluid intake
Management after pregnancy
<ul style="list-style-type: none"> Tolvaptan is contraindicated during breastfeeding and should not be prescribed during this time Some ACEi such as enalapril or captopril have very low penetration into human milk and can be used with careful monitoring of the infant for signs of hypotension, if other agents are not adequately controlling blood pressure. Women with bladder instability or urinary incontinence after pregnancy should be offered pelvic floor physical therapy, especially when tolvaptan will be prescribed

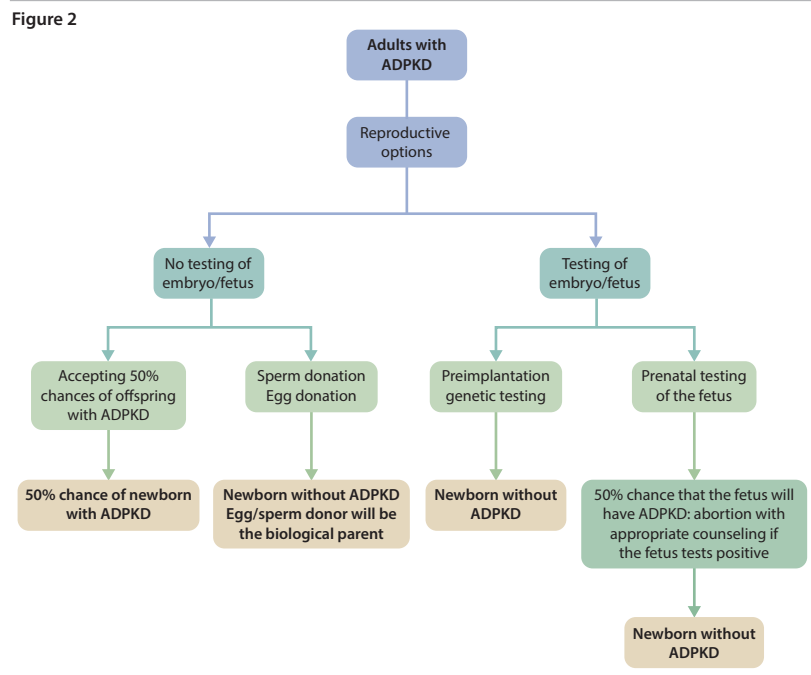


Figure 3

- Test kidney function
- Reintroduction of medications depending on lactation state
- Return to pre-pregnancy target blood pressure