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Proteinuria in IgAN: The Signal, The Target, and the Treatment Goal

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Dr. De Vriese:
This is CE with GLC, and I'm Dr. An De Vriese. Here with me today is Dr. Jonathan Barratt.

Jonathan, what are your thoughts on the new goal for proteinuria in the updated KDIGO guidelines for IgAN?

Dr. Barratt:
Thanks, An. I think we both agree we need to manage our patients differently to how we have done in the past. We now have wonderful new treatments that allow us to modify the disease, and we want to be able to provide those to our patients at a much earlier stage in the disease.

And the KDIGO update has reflected that mindset by lowering the threshold to make a diagnosis of IgA nephropathy. Anyone with persistent proteinuria more than 0.5 grams per day should be considered for a kidney biopsy.

The goal of proteinuria reduction with both disease-modifying therapies and CKD treatments is to get the proteinuria below 0.5 grams per day, or ideally complete remission of proteinuria, so proteinuria below 0.3 grams per day, because we know there is a very close relationship between persistence of proteinuria and the amount of proteinuria and the rate of loss of kidney function.

And that has been known for many, many years, going back to the Toronto Registry over a decade ago, and more recent data from registries from Europe, from the UK, from China, from the United States, showing very clearly that patients with persistent proteinuria are at increased risk of loss of kidney function, and that includes those below 1 gram per day.

What we had in the previous KDIGO guideline was a target of 1 gram per 24 hours before we would think about intervening, particularly with potential disease-modifying therapies. And now that level has been dropped to 0.5 because of these registry data. And I think in time we're going to drop that 0.5 to 0.3 because we know any low level of proteinuria potentially is deleterious in patients with IgA nephropathy.

And so what our goal has to be is for any person with IgA nephropathy to never have to know what a dialysis machine looks like. And to achieve that in someone often who presents to us in their 20s or 30s, we need to have a very high standard of treatment success because we want these patients to be dialysis free for the next 40 or 50-plus years. And therefore we need to maintain as tight a control

of the disease as possible. And the best biomarker we have of disease activity or loss of disease control is the level of protein in the urine.

So I think the recent KDIGO update really was highly consistent, promoting early diagnosis, promoting early intervention if there is persistence of proteinuria above 0.5 grams per day, and a treatment goal of aiming for that proteinuria to be below 0.5 grams per day, but ideally less than 0.3 grams per day, because we need to be able to manage our patients with the therapies we have available to reduce as much as we possibly can that lifetime risk of kidney failure.

And I hope with the new treatments that we're seeing, we're going to get to that goal of no patient with IgA nephropathy ever having to see a dialysis machine in their lifetime.

Dr. De Vriese:
Thank you, Jonathan. I have an additional comment, though. Proteinuria is extremely valuable, of course, but it remains a nonspecific marker. It tells us that there is glomerular injury, but it doesn't tell us what is driving that injury at that particular moment. And that is where I believe microscopic hematuria can be very relevant.

For instance, if you have a patient with low-grade proteinuria but persistent microscopic hematuria, this patient may have ongoing inflammatory activity, ongoing immune-mediated injury that is potentially modifiable.

In contrast, if you have another patient with a similar degree of proteinuria but no microscopic hematuria, this patient may be in a more burnt-out phase where chronic structural damage predominates rather than active inflammation.

So I guess the combination of proteinuria and microscopic hematuria can help you to distinguish, at least to some extent, between activity and chronicity. And this distinction becomes particularly relevant as we now, as you said, have more therapeutic options that are targeting the different parts of the disease process.

If we're aiming to suppress active inflammation, the presence of persistent hematuria may be an additional signal that such intervention is indeed justified, even if proteinuria alone might appear only modest.

On the other hand, if proteinuria persists despite the resolution of hematuria, then we might question how much of that residual proteinuria reflects irreversible damage rather than treatable disease. And that should influence how aggressively we are escalating therapy.

So, in that sense, this new KDIGO proteinuria target is extremely valuable, but it should not be interpreted in isolation; it should be part of a broader clinical assessment.

I think the message is that we need to move from single-parameter decision-making to a more integrated approach.

Thank you, Jonathan, and also thanks to our audience for joining us.

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