

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/clinicians-roundtable/how-classification-shapes-treatment-in-fsgs/84878/>

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How Classification Shapes Treatment in FSGS

Announcer:

This is *Clinician's Roundtable* on ReachMD. Today, Dr. Abdallah Geara will explain how to classify and treat focal segmental glomerulosclerosis, or FSGS. Dr. Geara is an Associate Professor of Clinical Medicine and Clinical Director of the Glomerular Diseases Program at the University of Pennsylvania in Philadelphia. Let's hear from him now.

Dr. Geara:

We know that in order for us to diagnose FSGS, we need a kidney biopsy, and the kidney biopsy does have some information that helps us in the classification of these patients. The classification of these patients, though, also requires us to take the clinical context into consideration. Also, a genetic evaluation should be part of our evaluation for FSGS and should help us in categorizing these patients into primary, secondary, and genetic. We also still have some percentage of patients who we cannot categorize clinically.

So we know that patients with sudden onset nephrotic syndrome, hypoalbuminemia, and proteinuria are the patients that will be looked at mostly as a primary FSGS. We also have to take genetic information into consideration, because some of these patients with sudden onset nephrotic syndrome could have a genetic background like APOL1. When you add it to a viral infection, they look exactly like primary FSGS.

When it comes to secondary FSGS, we're always looking for an etiology of FSGS. Medication, a clinical condition that is associated with FSGS, or other exposures, mainly viral exposures, should be taken into consideration. Most of the patients with secondary FSGS do have a progressive chronic kidney disease and do have proteinuria that could be in a nephrotic range, but a few of them do have full nephrotic syndrome.

Primary FSGS we think about being more of an autoimmune form of FSGS, where you have a formation of antibodies. We still are not 100 percent sure which antibody it is or how to measure these antibodies in clinical practice. So these patients tend to respond to steroids. They may have a relapsing or recurrent relapsing course, which does require a B-cell therapy with rituximab or inotuzumab.

When it comes to secondary, genetic, or undefined or undetermined FSGS, for these patients, usually the focus is on lowering the proteinuria to the lowest possible range. So this is where I use a combination of RAS inhibitors, SGLT2s, endothelin inhibitors, MRAs—mineralocorticoid antagonists—or even GLP-1s, specifically for a patient who has overweight or obesity.

If you have a clear genetic component of FSGS, this patient most likely will not require immunosuppressive therapy with glucocorticoids that carry a lot of side effects. So this is one of the reasons to do genetic testing. The other reason is to consider this patient for clinical trial. We know that, when it comes to APOL1, which is a common genetic factor for a patient to develop FSGS, we have at least three investigational therapies for FSGS secondary to APOL1 high-risk alleles. And the patient could be considered for referral for clinical trials that will eventually give them early access to a beneficial therapy.

Announcer:

That was Dr. Abdallah Geara discussing diagnosis and management of FSGS. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!