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IgAN Insights: Reducing the Burden & Improving Care

Announcer:
Welcome to *Clinician's Roundtable* on ReachMD, and this episode is sponsored by Travere. Here's your host, Dr. Charles Turck.

Dr. Turck:
This is *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss how we can improve the quality of care for our patients with IgA nephropathy, or IgAN for short, is Dr. Gates Colbert, who's an Assistant Clinical Professor at Texas A&M College of Medicine. He's also a practicing physician with the Kidney and Hypertension Associates at Dallas located at Baylor University Medical Center. Dr. Colbert, welcome to the program.

Dr. Colbert:
Great to be here. Thank you.

Dr. Turck:
Well let's start with some background, Dr. Colbert. Why is preserving kidney function in our patients with IgAN so important?

Dr. Colbert:
So unfortunately in 2023, IgA nephropathy does not have a cure. It's a chronic disease state. And so once a patient first gets their diagnosis, we need to counsel and coach these patients on what is the best treatment for them for where they are now and where they're going to be in the years and decades ahead. And we know that the earlier we can get started, the more likely we can lessen the curve of the GFR fall over the years and decades going forward. So the quicker we can get started on preserving kidney function, the less likely chance and unfortunately likelihood that they are going to need renal replacement therapy or even a kidney transplant in the decades ahead.

Dr. Turck:
And based on your experience, how are we doing in terms of proactively preventing kidney damage?

Dr. Colbert:
So I would say right now we're doing an okay job. At least right now, about 15 to 20 percent of patients are moving on to dialysis within 10 years. So about 80 percent of patients don't need dialysis at 10 years. But obviously, when you look at this from a large perspective of our population with IgA nephropathy, that's still a lot of patients that are needing kidney replacement and renal replacement therapy. So I think that there is some room to improve and better outcomes that we need to have for our patients so that they're not needing dialysis or the kidney transplant, but also not experiencing the side effects that may come with the current treatments that we have available to them.

Dr. Turck:
So with all that being said, Dr. Colbert, what kind of physical and mental burden can a delay and receiving treatment have on our patients with IgAN?

Dr. Colbert:
So I think it's a big burden. I experience, in my clinic, that patients are not very happy and sometimes upset when they learn that they've had a chronic kidney disease problem like IgA nephropathy for a while. And as we educate them that earlier treatment is better, there may be some regret that they weren't able to get treatment faster than when we are starting it within my clinic and other clinics like what we have here. So I think that is something that we have to counsel our patients on, you know, earlier was better, but what can we do starting today? And how can we get them on the right treatments that are going to slow their CKD progression, lessen proteinuria, and

ultimately delay and avoid dialysis and kidney transplant.

I also think that we need to be aware that these patients have chronic disease state and that they are going to need counseling as we see them throughout their appointments going forward, motivating them, and encouraging them so that we can see adherence with treatments and get them the best outcomes possible that we know that they want.

Dr. Turck:
For those just joining us, this is *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Gates Colbert about the burden of IgA nephropathy, or IgAN.

So Dr. Colbert, would you share some strategies that could help us preserve kidney function?

Dr. Colbert:
Definitely. So recognition is the first strategy. We have to be screening patients with the right lab work because this is usually a disease state that could be hiding in the background. Some patients do present with blood in their urine or a foamy urine and that could be something that a patient might experience, but a lot of times, patients don't have those symptoms. We need to be checking bloodwork and definitely urine, a urinalysis and urine protein, because there are a great number of patients that are diagnosed with IgA nephropathy in the beginning because they have microscopic hematuria or proteinuria. So screening for that I think is very, very important.

Once we have that as a suspicion, we then move on to a biopsy of the kidney to really give us a definitive diagnosis.

And then once we have that type of diagnosis that's confirmed, we put them on medical therapy. Currently, it's recommended that we need to control their blood pressure as best as possible to guideline levels. And usually those are done with a RAS inhibitor like an ACE or an ARB. And then depending on their level of proteinuria, and there are different guidelines out there of what that level looks like, we may decide to put them on a more immunosuppressive agent to try to bring that protein level down. And there are several options available to us now.

Dr. Turck:
If we bring all this together, how can we implement those strategies while also addressing our patient's challenges?

Dr. Colbert:
So the first thing we have to do is educate our patients both on what their disease is, what the future looks like for this disease state in terms of expectations, and also what treatments are available and why these treatments are extremely important. So we would talk about the medications that we're starting. And then as we go through time, if we have to add on other medications such as steroid therapy or potentially a more targeted agent, we would need to educate them on why this treatment is beneficial. And even though it may come with some side effects that we need to watch out for and manage, what is the risk versus benefit? And hopefully the benefits are going to be much higher than the potential side effect profile. And our end goal is avoiding dialysis and avoiding kidney transplant. And that's why we have to be on these chronic therapies to achieve that ultimate goal that our patients want.

Additionally, I'd recommend working with dieticians, working with our nursing staff, and other healthcare professionals to try to understand the disease state and why we have a chronic strategy that may evolve over time to really get this patient into the best possible outcome.

Dr. Turck:
Now before we close, Dr. Colbert, are there any final thoughts you'd like to leave with our audience today?

Dr. Colbert:
Yes, so I would say if you're diagnosed with IgA nephropathy or you're taking care of patients with IgA nephropathy, in general, this is a good disease to have for CKD. 80 percent of these patients will not be on dialysis at 10 years. But unfortunately, we really need to be aggressive with all of them so that we can get that number without dialysis as high as possible.

In 2023, we have some tried-and-true medications that are recommended through guidelines, but also we have some brand new medications that are approved and going through the process of approval with the FDA. So it's really an exciting time in terms of breakthrough treatments that we could have for patients with IgA nephropathy. Additionally, there's a lot of clinical trials that are ongoing for new potential therapies going forward.

So I think it's an exciting time to have more tools to treat patients with this disease state.

Dr. Turck:
Well as those final thoughts bring us to the end of today's program, I want to thank my guest, Dr. Gates Colbert, for joining me to share

these best practices for managing patients with IgAN. Dr. Colbert, it was great having you on the program.

Dr. Colbert:
Yes, thank you, Dr. Turck.

Announcer:
This episode of *Clinician's Roundtable* was sponsored by Travere. To access other episodes in this series, visit ReachMD.com/Clinicians Roundtable, where you can Be Part of the Knowledge. Thanks for listening!