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Navigating KDIGO Guidance in IgAN

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**Dr. Latus:**
This is CE with GLC. I'm Dr. Jörg Latus. Here with me today is Dr. Jonathan Barratt.

So, Jonathan, we have seen a commentary recently published on the updated KDIGO IgAN guideline. What do our learners need to know?

**Dr. Barratt:**
So the central paradigm of the guideline has remained the same. We want early treatment. We want treatment at lower levels of proteinuria, so anyone with persistent proteinuria above 0.5 grams per day. And we want clinicians to think about addressing the immunological aspects of the disease, the formation of immune complexes and their deposition within the glomeruli. And we want clinicians to also think about managing the general CKD aspects of the disease.

So those 2 sides of the algorithm remain the same, but we have more treatment options than we had when we published the guideline in 2025. In the United States, we now have a complement inhibitor approved, iptacopan. We have an anti-APRIL monoclonal antibody, sibeprenlimab is approved, and we now have a BAFF and APRIL antagonist approved, atacicept, in addition to atrasentan, an endothelin receptor antagonist. And we're probably going to have new treatments approved later this year as well.

And so we wanted to make the KDIGO commentary reflect the addition of these new drugs and where they might fit in a future KDIGO guideline. So we brought in atrasentan under those CKD-type treatments alongside sparsentan, RAS inhibitors, SGLT2 inhibitors, and we brought in iptacopan and sibeprenlimab at the time because those were approved at the time of the commentary, in on the disease-modifying side of the algorithm, addressing the fundamental immunology of the disease. And of course, atacicept fits there as well.

So we've tried to update the algorithm to include those new treatments and where they will likely fit when we get round to updating the KDIGO guideline, which I hope will be within the next 12 months.

**Dr. Latus:**
So I think very exciting times for patients with IgA nephropathy, but I believe when we start therapy, I think it's very important to set realistic expectations with our patients.


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So IgA nephropathy is often a disease whose consequences may seem far away at the beginning of the disease or the therapy, and many patients do not initially perceive the urgency of treatment because symptoms can be limited and kidney function may still appear relatively preserved.

So therefore, when I talk to my patients, I always emphasize that treatment should be viewed as a marathon rather than a sprint, and we will see reductions in proteinuria very fast after we start our new therapies. But I think the primary objective is, of course, the long-term preservation of kidney function.

So I believe because IgA nephropathy is a chronic disease, sustained treatment, regular monitoring, and good adherence are essential to achieve durable kidney protection.

**Dr. Barratt:**
Yeah, I couldn't agree more. I think when I talk to my patients, it's about getting the message across. I never want them to ever know what a dialysis machine looks like, not in their 30s, not in their 40s, their 50s, their 60s, their 70s, and hopefully their 80s. But this is a marathon. This is a long-term process that we are going to have to work together with our patients, and it's really important they understand that.

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