

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/frontlines-iga-nephropathy/deciphering-iga-nephropathy-insights-into-the-diagnostic-process/26946/>

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Deciphering IgA Nephropathy: Insights into the Diagnostic Process

Announcer:

Welcome to *On the Frontlines of IgA Nephropathy* on ReachMD. On this episode, we'll discuss the diagnostic process for IgA nephropathy with Dr. Gates Colbert, who's a nephrologist at the Kidney and Hypertension Associates of Dallas and an Associate Clinical Professor at Texas A&M College of Medicine. Here's Dr. Colbert now.

Dr. Colbert:

So the way I practice when I have patients where I don't know their exact cause of kidney disease or I'm suspicious that they have IgA nephropathy, we want to do an algorithm stepwise pattern to make sure that we eliminate all possibilities and that this will point us to IgA nephropathy. So I always like to make sure that we get a recent renal function panel to determine their GFR—the potassium level—and you really want to compare that to how things have been going over the last few months or years. You've got to look back at that past lab work that's been done. Then you want to get a urinalysis, maybe a urine albumin/creatinine ratio or a urine protein/creatinine ratio. Does the patient have any active sediment in their urine? Look for any red blood cells, microscopic hematuria. Look for how much proteinuria they may have, and look at those quantifications as well. And then you always want to check serologies on these patients. So if you're worried about a gene involvement or you're trying to rule one out, you want to get their typical serologies that you would check for hepatitis, HIV lupus, kappa/lambda ratio, or an SPEP. Just make sure that all is normal and not something that we need to check on a secondary test. Additionally, you maybe want to check an anti-PLA2R too to rule out a primary membranous that may be slowly evolving. We don't have any sort of serologic measurement for IgA or galactose-deficient IgA, so we can't check that quite yet. Hopefully, we'll be able to in the future.

But ultimately, when you have protein in the urine and potentially a changing GFR, you really just have to send these patients for a kidney biopsy because that is our gold standard of how we're going to get the diagnosis and how we can get our patients treated as fast as possible. Additionally, with our new KDIGO guidelines for IgA nephropathy or glomerulonephritis, we're really pushing nephrology to do kidney biopsies earlier at a lower amount of proteinuria. I think, historically, we have been very conservative because we didn't want to put our patients through biopsies that may not make a huge impact on their treatment plans, but now it's been more and more recommended that we lower our threshold for proteinuria and active sediment and go for a kidney biopsy given their overall excellent safety record with our current radiological tools that maximize safety.

Announcer:

That was Dr. Gates Colbert talking about how we can diagnose patients with IgA nephropathy. To access this and other episodes in our series, visit *On the Frontlines of IgA Nephropathy* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!