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Managing Lupus Nephritis with Early and Collaborative Care Strategies

Announcer:
You're listening to *Living Rheum* on ReachMD, and this episode is sponsored by Aurinia Pharmaceuticals. Here's your host, Dr. Gates Colbert.

Dr. Colbert:
Welcome to *Living Rheum* on ReachMD. I'm Dr. Gates Colbert, and joining me to discuss early treatment and collaborative care strategies for lupus nephritis are Drs. Michelle Petri and Abdallah Geara. Dr. Petri is the Director of the Lupus Center and a Professor of Medicine in the Division of Rheumatology at Johns Hopkins University. Dr. Petri, thanks for being here today.

Dr. Petri:
My pleasure.

Dr. Colbert:
And Dr. Geara is an Associate Professor of Clinical Medicine and the Clinical Director of the Glomerular Disease Program at the Perelman School of Medicine at the University of Pennsylvania. Dr. Geara, it's great to have you here today as well.

Dr. Geara:
Thank you, I appreciate the invite.

Dr. Colbert:
So let's start with you, Dr. Petri. Can you tell us about the prevalence of lupus nephritis among patients with SLE?

Dr. Petri:
We know from Centers for the Disease Control studies that there are 200,000 people with lupus in the United States. And on average, 50 percent of patients with lupus will develop lupus nephritis. But it's more common in African Americans, Hispanic Americans, and somewhat surprisingly, it's more common in men than women with lupus. And unfortunately, not only is lupus more common in African Americans and Hispanic Americans, but the outcomes are worse in them as well.

Dr. Colbert:
Given that prevalence, Dr. Geara, how do we diagnose lupus nephritis?

Dr. Geara:
So in order to diagnose lupus nephritis, it does require a kidney biopsy to confirm the diagnosis and have an established diagnosis of lupus nephritis. Before we get to a kidney biopsy, there are a few steps that are done during the screening phase for lupus nephritis. So patients who have lupus are frequently screened for lupus nephritis using urinalysis and basic metabolic panel to check on the creatinine level or any level of proteinuria or albuminuria or hematuria.

Dr. Colbert:
Great. So once we have a diagnosis of lupus nephritis, Dr. Geara, what do the latest KDIGO guidelines recommend for managing and treating these patients?

Dr. Geara:
The KDIGO guidelines were updated recently, so we have a version of 2024, which was actually an update of the version of 2021. And the reason for this update is because over the last 3 to 4 years, we had the result of two major trials, and we had the approval of two medications for lupus nephritis. And actually, these are the first two medications that are approved for lupus nephritis. And with this, the

guidelines have changed and do recommend several potential therapies for lupus nephritis. In addition to the traditional mycophenolate, mofetil, and cyclophosphamide, now we have the option to add the calcineurin inhibitor voclosporin, and we have the option to add the biologic belimumab, and these are all part of the guidelines as a first-line therapy.

Dr. Colbert:
Yes, I agree. As a nephrologist myself, it's nice to have updated guidelines for these complicated diseases as well as have new medications that we can use for our patients when previously, we've been using just tried-and-true immunosuppression.

So let's move forward. How about the EULAR guidelines, Dr. Petri? Can you walk us through these recommendations and how they might impact the approach in clinical practice?

Dr. Petri:
In 2023, EULAR updated the lupus guidelines, but these are not lupus nephritis specific. But for lupus in general, there were two major changes from the previous guidelines. The first is limiting prednisone. And this is because 15 years after the diagnosis of lupus, 80 percent of the permanent organ damage is due to prednisone, either directly or indirectly. So the 2023 EULAR guidelines recommend that the maintenance prednisone dose be not higher than 5 mg. Now obviously, this can't be completely generalized to lupus nephritis, so even in the most recent renal clinical trials, the starting prednisone dose is about 20 to 25 mg, but with a plan to rapidly taper it. And I think this is essential in our clinical practice of lupus nephritis as well. Now the second part of the 2023 guidelines that I think is generalizable to all lupus is the necessity to introduce immunosuppression and/or biologics early in the treatment course, both to control disease activity, but also to allow that successful prednisone taper so that the maintenance dose never gets above 5 mg. And this is why we can't accept mycophenolate or the EuroLupus cyclophosphamide as the sole therapy for lupus nephritis anymore. First, because the 1-year complete renal response is quite abysmal with those therapies; we're talking about only 20 percent reaching a complete renal response. But also because they don't work well, people are on more prednisone than we want them to be. This is why it's really important to have the two new approved therapies because they can be added right at the time of the biopsy, either a calcineurin inhibitor or the biologic belimumab.

Dr. Colbert:
For those just tuning in, you're listening to *Living Rheum* on ReachMD. I'm Dr. Gates Colbert, and I'm speaking with Drs. Michelle Petri and Dr. Abdallah Geara about management strategies for lupus nephritis.

Now, Dr. Geara, collaborative care is another important aspect of managing lupus nephritis. So how do you work with the members of the multidisciplinary team and even the patient themselves to select a treatment approach and address their symptoms?

Dr. Geara:
This is a very important question because now that we have newer therapies, we have to find a way to make sure that the patients are receiving them. So we know there is a lot of challenge with compliance for our patients. And these challenges with compliance have several facets. Some of them are due to system problems, and some of them are due to the way we approach or deliver the counseling for our patients. And also, there are patient-related issues where they do not adjust to their disease very well and they have problem with compliance. So in order to have the best results possible, it is important to approach this from all of these aspects.

And as far as collaborative care with other providers, this is an important aspect in order to increase the trust of the patient in their plan of care. It's not infrequent, for example, for a patient coming to the clinic to have their main concern, their joint pain or the side effect of their medication. But while as an nephrologist we're focused on improving the kidney function, improving the protein level, and inducing remission in their kidney, the patient's focus might be on their joint pain or on their rash or so on. So really, it's important to include rheumatology in this discussion in order to approach the care in a holistic way where we are approaching all different aspects: the aspects that are really vital for the organ and also the aspects that are really important for the patient in order to get the best results possible.

The way the counseling is provided to the patient is through a common decision approach between the physician and the patient in order to find the best way for the patient that works for them. So in addition to addressing their concerns, the patient needs to be involved in the decision regarding their therapy. Because as Dr. Petri was mentioning, most of our therapies do not have the best results, and in addition to that, it has a lot of side effects and adverse effects with all of this therapy.

So combining all of these challenges, it is important to engage these patients in this discussion early on so that they do not get frustrated during the first few weeks of their therapy where they're seeing most of the side effects and they're not seeing any result or any palpable result early on, and they give up on their medical care very early in their treatment.

Dr. Colbert:

And before we close, Dr. Petri, how can everything we discussed today, such as identification of patients, treatment options, and using collaborative approaches to care for our patients, how will this impact our patients with lupus nephritis?

Dr. Petri:
The first important point is early identification. The rheumatologist or other treating physician should really be doing a spot urine protein to creatinine ratio at every visit. Right now, our guidelines say if it hits 500 mg, refer for a renal biopsy. But we do know that as soon as the proteinuria is abnormal, meaning above 250 mg, that patient is already 70 percent likely to have a kidney biopsy that has an actionable result, meaning a proliferative lupus nephritis. So I think soon we will even be biopsying before 500 mg.

The second important point is that you really need multitarget therapy now. Mycophenolate or the EuroLupus cyclophosphamide regimen is inadequate in the majority of our patients, so everyone must change; nephrologists, rheumatologists, and whoever the treating physician is must embrace the new approved therapies.

The third is we have to recognize that lupus nephritis is always chronic kidney disease. By the time we diagnose it, the patient has already lost 1/3 of their nephrons. So we must be aggressive in our therapy. We must also recognize that proteinuria is not a perfect marker of disease activity because it can also be from kidney damage. We're learning more about the best ways to manage chronic kidney disease in lupus, but we have much more to learn.

Dr. Colbert:
Well, given these impacts, I want to thank my guests, Dr. Michelle Petri and Dr. Abdallah Geara, for sharing their perspectives on how we can manage our patients with lupus nephritis. Dr. Petri, Dr. Geara, it was great speaking with you both today.

Dr. Petri:
Thank you. It's always a pleasure to be at a meeting with nephrologists.

Dr. Geara:
Thank you. I appreciate the invite and the opportunity to discuss lupus nephritis.

Announcer:
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