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Expert Opinions on Characteristics of Patients With IgA Nephropathy (IgAN) at High Risk of Progression

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What is your opinion on the risk of progression in IgA nephropathy?

Dr. Rizk:
So in IgA nephropathy, a lot of effort international effort I should say has been put to validate specific pathologic findings that carry prognostic information above and beyond what you would glean from clinical information.

These pathologic findings add prognostic information to whatever we have clinically, and those are known as the Oxford classification or the MEST-C score. And each letter in that score, the M, the E, the S, the T, and the C, stand for particular pathologic findings. So M is mesangial proliferation. E is endothelial hypercellularity. S is segmented sclerosis. T stands for tubular interstitial fibrosis, and C for crescents presence or absence of crescents.

And so each of these scores uh is coded 0 or 1, or sometimes 0, 1, and 2. So they have a scale. And for each parameter, the higher the score, the worse the prognosis.

I also want to emphasize that there are subtleties in the biopsy that may or may not be picked up on by the MEST-C score that, as a nephrologist, you really need to be mindful of. First of all, you have to make sure the biopsy specimen is adequate, and that means you have enough glomeruli to rely on that biopsy. Second, things that could be very significant in a young patient, like global glomerular sclerosis, is not coded in the MEST-C uh Oxford classification but can be of significant prognostic value.

So it's important that we also read through the lines, not just rely on the MEST-C score kind of summary.

Dr. Sethi:
The kidney biopsy shows an IgA nephropathy with active inflammatory markers such as endocapillary hypercellularity, crescents, or necrosis, or even active bright C3 staining on the biopsy. In my pres opinion, these patients are going to progress towards a chronic lesion.

Dr. Herlitz:
Because IgA unfolds over decades, it's really important to appreciate how much chronic scarring there is. We really shouldn't have any significant glomerular or tubulointerstitial scarring, so even the presence of a few sclerotic glomeruli in a biopsy in a 20- or 30-year-old patient should be a cause for concern.

And I find that one of the biggest challenges that I have in communicating with nephrologists about biopsies is this underappreciation of the chronic changes and how important even mild chronic changes are, since these patients are going to need 50, 60, or maybe even 70 years of kidney function.

Dr. Nester:
It does turn out that the MEST score may actually be quite useful uh in helping us determine, but it goes along with what we've said for other glomerular diseases if your patient already has a good deal of scarring, or the S portion on their biopsy, or the T portion which is

also a collage, if you will, of additional scarring on the biopsy then these patients may, in fact, be the ones that will progress more likely.

Announcer:
How are the clinical features along with the biopsy and MEST-C findings utilized to predict risk of progression?

Dr. Rizk:
A tool that was developed in looking at both clinical, uh demographic, and pathologic parameters uh that you can input into a calculator and the calculator is available online for free and you input that information and then calculate the percent risk or chance that the patient will end up having a 50% decline in kidney function or go to end-stage kidney disease within 5 to at the most 7 years.

So that information is collected at the time of biopsy, um and they ultimately updated that uh prediction tool, or created a modified prediction tool, uh to recalculate that risk one way post-biopsy 1 year post-biopsy, and 2 years post-biopsy. And that's nice because you can see what your risk was at baseline, at the time of the diagnostic biopsy, and then you can recalculate it a year or two later.

All the information you require to calculate that risk is readily available. It's age, sex, uh blood pressure, medications you know if the patients are on ACE inhibitors or angiotensin receptor blockers, are they on immunosuppressives yes, no and then some of the clinic and pathologic findings as well.

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