Membranous Nephropathy - Summary Clinical Guideline (For the use of nephrology team only)

Reference No:CG-REN/4183/23

Diagnosis

Membranous nephropathy (MN) is one of the most common causes of nephrotic syndrome in non-diabetic adults. Renal biopsy is often required for diagnosis. However, in some cases, renal biopsy might not be required to confirm the diagnosis of MN in nephrotic patients with positive phospholipase A2 receptor (PLA2R) antibodies, preserved renal function and no other serological abnormalities. Patients with MN should be evaluated for associated conditions (secondary causes, see above), regardless of the presence of PLA2R antibodies.

Prognosis

As the natural course of MN is variable, it is important to weigh up the risk of loss of kidney function against the adverse effects of immunosuppressants when considering treatment options. KDIGO advises using clinical and laboratory criteria to assess the risk of progressive loss of kidney function (see Table MN1)

Low risk	Moderate risk	High risk	Very high risk
• Normal eGFR, proteinuria <3.5 g/d and serum albumin >30 g/l OR • Normal eGFR, proteinuria <3.5 g/d or a decrease >50% after 6 months of conservative therapy with ACEi/ARB	• Normal eGFR, proteinuria >3.5 g/d and no decrease >50% after 6 months of conservative therapy with ACEi/ARB AND • Not fulfilling high-risk criteria	• eGFR <60 ml/min/1.73 m²* and/or proteinuria >8 g/d for >6 months * OR • Normal eGFR, proteinuria >3.5 g/d and no decrease >50% after 6 months* of conservative therapy with ACEi/ARB AND at least one of the following: • Serum albumin <25 g/l† • PLA2Rab >50 RU/ml‡	• Life-threatening nephrotic syndrome OR • Rapid deterioration of kidney function not otherwise explained

Table MN1: Clinical criteria for assessing risk of progressive loss of kidney function (KDIGO GN guidelines 2021) [4]
* Patients with high level of proteinuria or anti-PLA2R levels should be re-evaluated earlier than 6 months after starting on maximal anti-proteinuric therapy.

Treatment

All patients with primary MN and proteinuria should receive optimal supportive care with RAAS inhibitor, statin, optimisation of blood pressure control. Anticoagulation with warfarin should be started for patients with serum albumin < 20 g/L. It is reasonable to wait 6 months for spontaneous remission while using maximal antiproteinuric therapy, especially for low and moderate risk patients. Patients with high level of proteinuria or anti-PLA2R levels **should be re-evaluated with respect to additional therapies earlier than 6 months** after starting on maximal anti-proteinuric therapy. (Figure MN1)

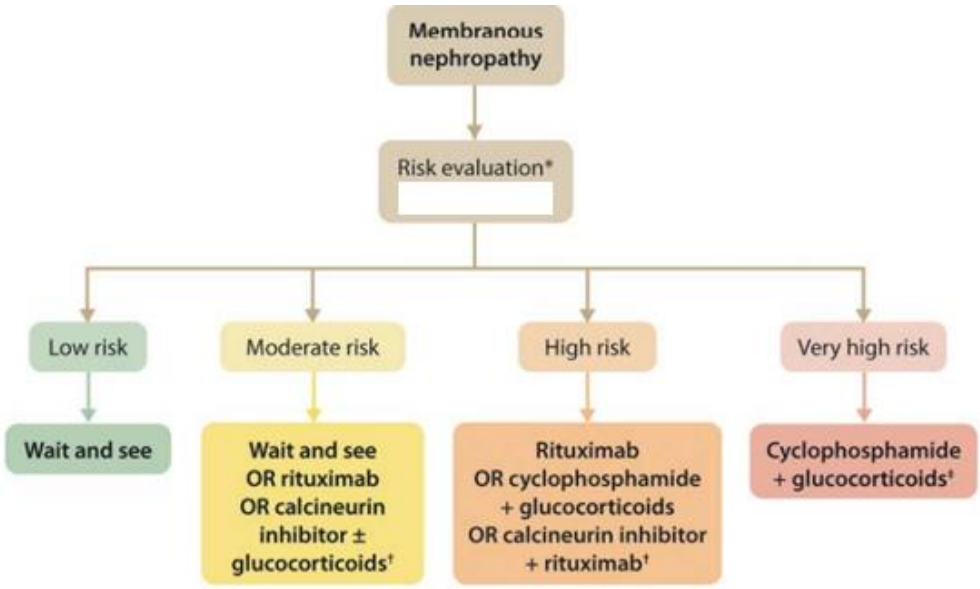

Figure MN1: Risk-based treatment for MN (from KDIGO GN guidelines 2021)

Documentation Controls

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