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Achieving Optimal Outcomes in Lupus Nephritis: Key Updates from the 2024 ACR Guidelines

Announcer:
You're listening to *Audio Abstracts* on ReachMD, and this episode is brought to you by Aurinia Pharmaceuticals. Here's Dr. Robin Dore.

Dr. Dore:
Hello, my name is Dr. Robin Dore, and I'm a board-certified rheumatologist and Clinical Professor of Medicine at the David Geffen School of Medicine at UCLA. Today, I'll be talking about the updated guidelines for lupus nephritis that were recently released by the American College of Rheumatology at the annual meeting.

As you know, systemic lupus erythematosus, or SLE, is a chronic autoimmune disease with underlying manifestations that that vary from patient to patient, which can make treatment challenging. Protecting organs by suppressing inflammation is currently our best course of action due to the aggressive nature of this disease. For patients with lupus nephritis, preserving kidney function is the primary goal to avoid the need for dialysis or kidney transplantation in the future, so early detection, prevention, and intervention are vital to patient outcomes.

To standardize patient care, the ACR recently updated their guidelines for the first time since 2012 to better align with advancements in the treatment landscape for lupus nephritis. These new guidelines highlight the importance of prevention and early detection by regular monitoring of proteinuria and kidney biopsies, so that a diagnosis can be made early in order to preserve kidney function and slow disease progression. They also emphasize the importance of prompt and aggressive therapeutic intervention and propose a triple therapy approach while recommending lower doses of glucocorticoids to minimize treatment-related toxicity.

So let's get into the details of the updated guidelines, starting with prevention. The ACR now strongly recommends screening for proteinuria in patients with SLE at least every six to 12 months, or when they experience an extra-renal flare. Regular renal function monitoring allows providers to identify the signs of kidney disease early and start therapeutic intervention to protect against irreversible nephron loss. One of the highlights of these updated guidelines is the recommendation for kidney biopsies to be performed and to begin glucocorticoid treatment as soon as they suspect lupus nephritis in patients with SLE. More specifically, kidney biopsies are now recommended for those with a protein creatinine ratio of more than 0.5 or those with unexplained impaired kidney function. In these instances, providers are advised to immediately start these patients on intravenous glucocorticoid therapy as a preventative measure to suppress acute inflammation while waiting for biopsy and histopathology results. Additionally, repeat kidney biopsies are recommended for lupus nephritis patients experiencing a flare for those with at least six months of ongoing or worsening conditions despite treatment. These guidelines also recommend to start each patient on hydroxychloroquine to prevent organ damage and disease progression, unless there is a contraindication to this therapy.

Notably, the ACR also adjusted their therapeutic recommendations. The newly updated guidelines recommend an advanced triple immunosuppressive regimen as a *first-line* treatment for patients with lupus nephritis to achieve complete renal response. This is a very impactful change from the previous set of guidelines. It is now recommended to take an aggressive approach immediately, which highlights the urgency of rescuing and preserving kidney function. This triple therapy regimen includes starting patients on intravenous glucocorticoids for one to three days, followed by tapering of oral glucocorticoids down to less than or equal to five milligrams per day by six months. This approach balances the immediate need to suppress inflammation with the goal of minimizing the adverse effects associated with prolonged glucocorticoid use.

The ACR also preferentially recommends an MPAA-based regimen over a CYC-based regimen as the second immunosuppressant, in

addition to a third immunosuppressant determined by the extent of the disease. The triple immunosuppressant therapy is recommended to be continued for at least three years in order to achieve complete renal response and to sustain remission, and proteinuria target goals are defined as less than 0.5 protein creatinine ratio within 12 months of starting the treatment. These changes reflect a more structured and proactive approach to monitoring and treating lupus nephritis, consistent with the KDIGO and EULAR lupus nephritis guidelines.

Overall, these new guidelines establish a new standard of care for patients with systemic lupus erythematosus and lupus nephritis. The American College of Rheumatology intends to update these guidelines annually, ensuring they remain aligned with the latest medical and scientific advancements.

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