Lupus Nephritis

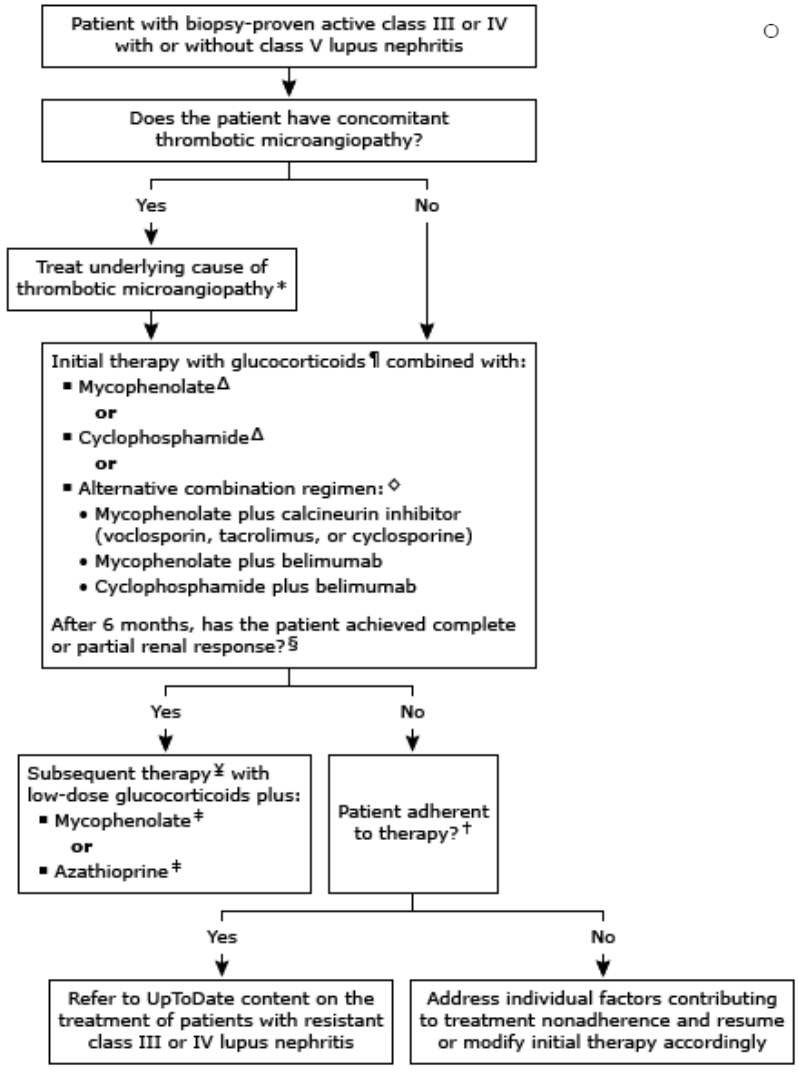
Types

Class	Histologic Pattern	Clinical Features
I	Minimal Mesangial	Usually asymptomatic
II	Mesangial proliferative	Microscopic hematuria Favorable prognosis
III	Focal	Hematuria, proteinuria (possible nephrotic syndrome) HTN, decrease GFR
IV	Diffuse	*Most common type Clinical features similar to those to focal lupus nephritis Poor prognosis
V	Membranous	Nephrotic syndrome
VI	Advanced sclerosing	Progressive CKD with bland urinary sediment Immunosuppressive therapy not recommended

Kidney biopsy (with shared nephrology decision-making) if

- Increasing Cr without explanation
- Proteinuria > 1000 mg/24 h
- Proteinuria >500 mg/24h w/ hematuria
- Proteinuria >500 mg/24h w/ cellular cast

Treatment of class III or IV lupus nephritis



* Patients with concomitant thrombotic microangiopathy should receive therapy for the underlying etiology of thrombotic microangiopathy in addition to the treatment of lupus nephritis. Refer to UpToDate content on the management of acquired thrombotic thrombocytopenic purpura, complement-mediated thrombotic microangiopathy, or antiphospholipid syndrome.

¶ Oral glucocorticoid therapy (prednisone or equivalent) is typically started at 0.5 to 1 mg/kg per day (maximum 60 mg/day) for most patients. In patients with severe active disease (eg, acute kidney injury, crescentic glomerulonephritis, severe extrarenal disease), we administer IV pulse methylprednisolone (250 to 1000 mg given over 30 minutes daily for 1 to 3 days) prior to initiation of oral glucocorticoids to induce a rapid antiinflammatory effect. Some clinicians use IV pulse methylprednisolone in all patients as this may enable the use of lower doses of oral glucocorticoids. Refer to UpToDate content on glucocorticoid dosing and taper for focal or diffuse lupus nephritis.

Δ The efficacy of mycophenolate and cyclophosphamide as initial therapy for focal or diffuse lupus nephritis is comparable. Mycophenolate is preferred for patients with concerns about fertility since cyclophosphamide may adversely affect fertility. Conversely, IV cyclophosphamide may be preferred for patients with preexisting gastrointestinal conditions or who may have difficulty adhering to oral therapy. Refer to UpToDate content on dosing and duration of mycophenolate and cyclophosphamide for initial therapy.

◇ The role of combination regimens as initial therapy is not well established, and some experts reserve this approach for patients who do not demonstrate a clinical response within 3 to 4 months with either mycophenolate or cyclophosphamide. Others may choose to use these combination regimens as initial therapy. Refer to UpToDate content on alternative initial therapies for focal or diffuse lupus nephritis.